Documents for the Record

Subcommittee on Health Hearing
"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"
February 26, 2025

Majority:

- February 26, 2025 – Letters submitted by Chairman Carter:
  - February 24, 2025 – Letter from the Board of Directors of the Community Oncology Alliance
  - February 26, 2025 – Coalition Letter to Chairman Carter
  - February 25, 2025 – Letter to Chairman Carter from The Rx in Reach GA Coalition
  - February 23, 2025 – Letter from the Coalition of State Rheumatology Organizations
  - February 26, 2025 – Letter from the American Pharmacists Association
  - February 26, 2025 – Letter from the American Society of Health-System Pharmacists
  - February 26, 2025 – Letter from the National Association of Specialty Pharmacy
  - February 25, 2025 – Letter from RxCoalition
  - February 26, 2025 – Letter from the Alliance of Community Health Plans
- February 26, 2025 – Letter from the Pharmaceutical Care Management Association
- February 26, 2025 – Letter from the National Association of Nutrition and Aging Services Programs
- February 26, 2025 – Letter from the American College of Physicians
- February 26, 2025 – Letter from the AARP
- February 26, 2025 – Letter from the National Community Pharmacists Association
- February 26, 2025 – Letter from the Business Group on Health
- February 26, 2025 – Letter from the ERISA Industry Committee (ERIC)
- February 24, 2025 – Letter from the HIV+Hepatitis Policy Institute

Minority:

- February 26, 2025 – Document submitted by Rep. DeGette
- February 26, 2025 – Article submitted by Rep. DeGette
- February 24, 2025 – Letter from National Patient Advocate Foundation
- Fact sheet from the Healthcare Association of New York State
- February 24, 2025 – Letter from a coalition of national patient advocacy organizations
- February 21, 2025 – Letter from the Association of American Medical Colleges (AAMC)
- February 19, 2025 – Letter from America's Essential Hospitals

- February 12, 2025 – Statement from the American Hospital Association
- Fact sheet from the American Hospital Association
- February 12, 2025 – Statement from the American Lung Association
- February 24, 2025 – Letter from the State of Michigan Department of Health and Human Services (MDHHS) Behavioral Health Advisory Council (BHAC)
- February 20, 2025 – Letter from the Catholic Health Association of the United States
- February 10, 2025 – Letter from the California Hospital Association
- February 12, 2025 – Letter from the California Hospital Association
- Statement from the Diabetes Leadership Council and Diabetes Patient Advocacy Coalition
- February 23, 2025 – Letter from Seattle Children's
- February 12, 2025 – Statement from Families USA
- February 6, 2025 – Statement from the Modern Medicaid Alliance
- February 3, 2025 – Letter from the Federal AIDS Policy Partnership
- February 19, 2025 – Statement from Justice in Aging
- January 2025 Fact Sheet from Legal Action Center and Coalition for Whole Health
- February 13, 2025 – Statement from Leading Physician Groups
- February 24, 2025 – Letter from Leukemia & Lymphoma Society
- February 24, 2025 – Letters from California Medical Association
- February 24, 2025 – Letter from Mental Health Association in Michigan
- February 14, 2025 – Statement from the Mental Health Liaison Group
- February 24, 2025 – Statement from the Modern Medicaid Alliance
- February 20, 2025 – Letter from the National Multiple Sclerosis Society
- February 20, 2025 – Letter from coalition of Nurse Practitioner organizations
- February 24, 2025 – Statement from the Partnership for Medicaid
- February 6, 2025 – Statement from the Partnership for Medicaid
- February 24, 2025 – Letter from UnidosUS
- January 29, 2025 – Letter from the Mental Health Liaison Group
- February 24, 2025 – Letter from coalition of children's health group
- February 24, 2025 – Statements from American Academy of Pediatrics
- February 21, 2025 – Letter from Disability and Aging Collaborative (DAC) and Consortium for Constituents with Disabilities (CCD)
- February 19, 2025 – Letter from coalition of local government organizations
- February 24, 2025 – Letter from coalition of Colorado organizations
- February 25, 2025 – Letter from the American Academy of Family Physicians (AAFP)
- Statement from the Federation of American Hospitals
- February 25, 2025 – Statement from the Children's Hospital Association
- February 24, 2025 – Statement from the Association for Community Affiliated Plans, Community Catalyst, Families USA, First Focus Campaign for Children, and the National Alliance on Mental Illness
- February 25, 2025 – Letter from the Alliance for Childhood Cancer
- February 25, 2025 – Letter from a coalition of survivors of domestic violence and sexual assault

- February 25, 2025 – Statement from the American Cancer Society Cancer Action Network
- February 25, 2025 – Statement from the Association of American Medical Colleges (AAMC)
- February 24, 2025 – Letter from California Prop 35 Medicaid Coalition
- February 24, 2025 – Letter from California's Children's Hospital Association
- February 25, 2025 – Letter from the Colorado Behavioral Healthcare Council
- February 25, 2025 – Statement from SEIU
- February 25, 2025 – Letter from the Southern Poverty Law Center
- February 26, 2025 – Statement from AHIP

COMMUNITY ONCOLOGY ALLIANCE

Dedicated to Advocating for Community Oncology Patients and Practices

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February 24, 2025

The Honorable Earl L. "Buddy" Carter
Chairman
Energy & Commerce Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member
Energy & Commerce Health Subcommittee
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Carter and Ranking Member DeGette:

On behalf of the Board of Directors of the Community Oncology Alliance ("COA"), I write to you today to ask that you please advance meaningful bipartisan legislation to stop pharmacy benefit managers ("PBMs") from harming Americans with cancer and other serious diseases. We truly hope the hearing on PBMs, which you are holding this week, will be the springboard to launch bipartisan legislation to stop PBM abuses.

Regardless of the propaganda the top PBMs try to spin—as you know, the six largest PBMs control 94 percent of the prescription drug market—the empirical studies supported by data, two reports by the Federal Trade Commission, numerous news investigations, and countless personal stories have thoroughly documented PBM abuses. Specifically, PBMs delay and even deny lifesaving drugs, create barriers to timely, quality medical care, and increase the cost of drugs to patients, employers, and the government/taxpayers.

Just last week, I spoke with two individuals with experiences that spotlight how PBMs abuse cancer patients.

A Medicare patient with metastatic breast cancer had to go without her critical oral cancer medication for six days because of delays by the PBM mail order pharmacy, which she is mandated to use rather than getting the drug directly from her oncology clinic, integrated with her care. Furthermore, when the drug she was taking was changed, the mail order pharmacy kept mailing the drug and now she has $45,000 of unusable medication that can't be returned.

A mother has a 20-year old daughter with glioblastoma (brain cancer) and was unable to get her daughter's medication in time, in part due to onerous required PBM paperwork, so she was forced to pay for the medication out-of-pocket. She then switched insurance and encountered the identical problem with another top PBM.

I will stop there, but we can provide countless other stories about patients who have encountered problems with PBMs, especially when PBMs force patients to use their mail order pharmacies. These distant facilities disjoint cancer treatment from what should be comprehensive, integrated treatment at the site-of-care. This disjointing of care when PBMs mandate use of their own mail order pharmacies leads to treatment delays and denials, drug waste, and higher costs.

As I am sure you well know, the top PBMs are creating pharmacy "deserts" across the country, especially in rural areas. This is because the top PBMs mandate the use of their

own mail order pharmacies or force pharmacies to accept low-ball drug reimbursement. So, this PBM problem not only adversely impacts cancer patients and other Americans with serious diseases but also the entire health care ecosystem. PBMs profit while patients suffer.

Among other legislative provisions, Congress must open up the "black hole" that PBMs have created by shining the light of transparency on how PBMs operate. They should not be allowed to mandate the use of their own mail order pharmacies; in fact, they should not be allowed to own any type of pharmacy, which is a blatant conflict of interest. Furthermore, the rebates they extort should not be tied to the drug price as a percentage.

These and other priority fixes that COA recommends the 119th Congress legislate are contained in the *COA Prescription for Health Care Reform*.[1]

PBM abuses must be stopped immediately. It is not overly dramatic to say that lives are at stake. There has already been so much bipartisan progress made on identifying problems with PBMs and on specific legislative fixes. We implore that the Energy & Commerce Health Subcommittee hearing this week be a prelude to the House immediately advancing meaningful, bipartisan PBM legislation.

Thank you for your leadership on this critical issue plaguing our nation's health care. We welcome the opportunity to help in any way possible.

Sincerely,

Ted Okon
Executive Director

[1] https://communityoncology.org/wp-content/uploads/2025/02/COA_Prescription_Reform_FINAL.pdf

February 26, 2025

The Honorable Buddy Carter
Chairman, House Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20510

The Honorable Diana DeGette
Ranking Member, House Energy & Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, D.C. 20510

Dear Chairman Carter, Ranking Member DeGette and members of the subcommittee:

We, the undersigned organizations, wish to commend you for immediately addressing in the 119th Congress one of the country's most important health policy imperatives – bringing an end to the anti-competitive, anti-consumer and anti-patient practices of pharmacy benefit managers (PBMs). It is our hope that your subcommittee's hearing on PBM reform on Feb. 26 will be the start of an expedited process that will end with Congress passing—and President Trump signing—legislation that will fix our broken prescription drug pricing system and make medicines more affordable and accessible for the American people.

As your subcommittee demonstrated by reaching an agreement on this issue in the last Congress, PBM reform is a thoroughly bipartisan objective. What's more, there is overwhelming public support from patients, consumers, pharmacists, physicians, employers and rural Americans, among others, for substantive action to address the PBM manipulations that have millions of people paying more than they should for the prescription drugs they need.

As the Federal Trade Commission detailed in July 2024 and January 2025, the PBM industry—with the four largest PBMs controlling over 80% of the prescription drug marketplace—has constructed a system that enables PBMs to enrich themselves at the expense of consumers, employers, retail pharmacies and taxpayers. These middlemen demand large rebates from drug manufacturers in exchange for preferential placement on formularies and then steer patients toward those more expensive medicines while restricting access to more affordable generics and biosimilars. Further, the January 2025 report documents how PBMs are forcing patients to use PBMs' affiliated pharmacies and then marking up the prices of drugs sold in those pharmacies, sometimes by thousands of percent over their original acquisition costs. As has been discussed openly, this practice is occurring while the same PBMs put American community retail pharmacies out of business.

The end result is that patients pay higher out-of-pocket costs, which are based on the drug's original list price rather than the discounted price the PBMs negotiate for themselves.

This unacceptable situation will continue and will, in fact, worsen as the Fortune 20 corporations that own the PBMs continue to use their enormous profits to engage in vertical integration throughout the healthcare system. Legislation to rein in their abuse and bring relief to the American people is needed now.

Several Senate and House committees moved forward with multiple bills in the last Congress, all aimed at addressing the anti-competitive and anti-consumer practices of PBMs. Reform legislation developed by this subcommittee must contain critical elements that will provide relief to patients

and families at their local pharmacies, employers dealing with rising healthcare costs, and taxpayers who are currently overpaying for government-provided benefit programs.

This includes several reforms that leadership from both parties prioritized in the 2024 end-of-year funding package, including delinking the price of medicines from PBM revenues, rebate pass-through, fair pharmacy contract terms in Medicare Part D and NADAC-based reimbursements in Medicaid managed care. These measures are essential to lowering drug costs and improving access for patients, and must be prioritized in the final package.

As you know so well, PBM reform legislation came so very close to being included in the American Relief Act that Congress adopted last December. Given the bipartisan support that exists on this issue—and the groundwork that has already been done by your subcommittee and others—there is no reason to delay action. We strongly encourage you to advance legislation that will shift power from the PBMs back to the American people and improve both the health and the finances of your constituents.

The organizations signing this letter thank you for your leadership on this matter and stand ready to support your efforts to achieve more affordable prescription medications.

Sincerely,

Acromegaly Community

Advocates For Responsible Care

Alzheimer's San Diego

America's Agenda

Apothecary Shoppe

Applied Pharmacy Solutions

Arizona Bleeding Disorders

Arizona Chronic Care Together

Arizona Myeloma Network

Arizona Prostate Cancer Coalition

Ark Insurance Solutions, LLC

Axis Advocates

Bag It Cancer AZ

Biomarker Collaborative

BioUtah

Bleeding Disorders of the Heartland

Blue Shield of California

Brain Injury Association of NE

Cancer Community Clubhouse

Cancer Support Community of Arizona

Caring Ambassadors Program

Centro Civico Mexicano

Coalition of State Rheumatology Organizations

Coalition of Texans with Disabilities

Coborn's, Inc.

Combined Health Agencies Drive

Community Health Action Network

Community Liver Alliance

Epilepsy Foundation of San Diego County

Exon 20 Group

Familia Unida Living with MS

FMI-The Food Industry Association

Gaucher Community Alliance

HIV+Hepatitis Policy Institute

ICAN, International Cancer Advocacy Network

IMPACT Melanoma

Infusion Access Foundation

International Bipolar Foundation

Let's Kick ASS Palm Springs (AIDS Survivor Syndrome)

Liver Coalition of San Diego

Liver Health Foundation

Lupus and Allied Diseases Association, Inc.

Lupus Foundation New England

Lupus Foundation of Southern Arizona

Lupus Foundation of Southern California

Massachusetts Independent Pharmacists Association

Massachusetts Pharmacists Association

MET Crusaders

Mexican American Opportunity Foundation

NAMI South Carolina

National Association of Chain Drug Stores

National Association of Social Workers - Texas Chapter

National Community Pharmacists Association

National Consumers League

National Grange

National Infusion Center Association

Nebraska Kidney Association

Nebraska Pharmacists Association

Nebraska Rural Health Association

Neuropathy Action Foundation

Nevada Cancer Coalition

Nevada Chronic Care Collaborative

Nevada Pharmacy Alliance

New England Venture Capital Association

ONEgeneration

Palmetto Health Collective

Partners in Care Foundation

Partnership to Fight Chronic Disease

PBM Accountability Project

PD-L1 Amplifieds

Rare and Undiagnosed Network

Rare New England

Redmoon Project

Rio Grande Valley Diabetes Association

Ruby A. Neeson Diabetes Awareness Foundation

Rx in Reach GA Coalition

Sierra Compounding Pharmacy

Society of Utah Medical Oncologists

South Carolina Advocates for Epilepsy

Tennessee Association of Adult Day Services

Texas Healthcare & Bioscience Institute

Texas Renal Coalition

The Strilite Foundation, Inc.

Utah Academy of Family Physicians

Utah Hemophilia Foundation

Advocates for Responsible Care Rx in Reach GA Coalition

February 25, 2025

The Honorable Earl "Buddy" Carter
U.S. House of Representatives
2432 Rayburn House Office Building
Washington, DC

Dear Congressman Carter:

Thank you for your continued leadership and commitment to championing policies aimed at addressing harmful Pharmacy Benefit Manager (PBM) business practices that negatively impact American patients access to affordable medications. As you know only too well, the time to finish the job on PBM reform is now – patients have waited too long for relief!

Multiple recent congressional hearings detailed how PBMs are the driving force behind escalating drug costs for consumers and employers, using their control of the marketplace and of drug formularies to drive patients toward higher-priced drugs and restrict access to less expensive generics and biosimilars. Just six PBMs control over 90% of all prescription drug prescribing.

We were encouraged to see the support for PBM reform at the end of the year when it was so close to passing in an end of the year package. While many in Washington, D.C. have turned a blind eye to these bad actors, we are writing to express our sincere gratitude and appreciation for your tireless efforts to rein in PBMs' predatory practices. Thanks to your principled and unwavering leadership, the need for PBM reform is understood in Congress and among the general public. There has never been a better time to keep Congress focused on PBM reform. We ask that you continue to lead on this issue and encourage your colleagues in the House to introduce and pass legislation that addresses the exploitive practices of PBMs across our country.

For some time now, the alarm has been raised about pharmacy benefit managers (PBMs) – middlemen corporations that manipulate the prescription drug marketplace, leading to the affordability challenges millions of Americans face when they go to the pharmacy for the medicines they need. With next week's Energy and Commerce hearing set to address PBM reform, the time is now to alleviate the suffering of American patients, consumers, and employers. This is an urgent problem that deserves immediate action.

What's more, PBMs stand between patients and their physicians in medical decision making, determining what drugs will be prescribed based on what is best for the PBM's financial bottom line rather than the preferred option for the patient's health and well-being.

The Federal Trade Commission made clear that action must be taken. Its report issued this year stated there is reason to believe PBMs acted illegally to foreclose competition in the prescription drug marketplace and used their power to maximize profits at the expense of patients. Congress needs to hold PBMs accountable so that patients see savings and the pharmacy counter.

The bipartisan support that PBM reform legislation has received is monumental and would achieve delinking and targeted rebate passthrough policies which will deliver meaningful reform for patients across the country. This legislation passed out of committee unanimously months ago. The time has come for Congress to buckle down and finish the job on PBM reform.

Delinking policies are an essential element in this fight for accountability as they eliminate the anti-consumer incentives which allow PBMs to make more money when drug costs are higher. Because the rebates they negotiate (and keep) with manufacturers are based on a percentage of a drug's list price, PBMs are incentivized to steer patients toward higher priced medications. PBM reform must 'de-link' PBM revenues from drug prices, paying PBMs a fair market-based fee for their services without any connection to the price of a medication. Targeted rebate passthrough is an essential in any legislation truly seeking to reduce costs for American patients.

As advocates, we have been working on passing PBM reform at the state level since 2020. We deeply appreciate your leadership on this critical issue, your partnership in always having the best interest of patients at the forefront and know you will do everything within your ability to ensure your colleagues stay the course to ensure Congress passes meaningful and comprehensive PBM reform.

Sincerely,

The Rx in Reach GA Coalition

(Members attached)

Dorothy Leone-Glasser, RN, HHC.
Executive Director, Advocates for Responsible Care (ARxC)
| O: [redacted] | D: [redacted] |E: [redacted]
www.arxc.org
Facebook: https://www.facebook.com/AdvocatesforResponsibleCare/
Twitter: https://twitter.com/ARxCAdvocates

Chair, Life Sciences Patient Advocacy Alliance

www.rxinreachga.org
Project Chair, Rx in Reach GA Coalition
Facebook: https://www.facebook.com/rxinreachga/
Twitter: https://twitter.com/RxinReachGA
Hashtag: #RxinReach

The Rx in Reach GA Coalition consists of members from 50 health-centered physician, nurses, community and patient organizations advocating for legislation that ends the financial and discriminatory barriers to securing vital medical care, medical innovation and medication for patients while defending health equity.

ARC Advocates for Responsible Care

ABNA Atlanta Black Nurses Association

AADE American Association of Diabetes Educators

ACP Georgia Chapter

Allergy & Asthma Network

anf atlanta neuroscience foundation

ani atlanta neuroscience institute

American Cancer Society Cancer Action Network

Georgia AIDS Coalition

Arthritis Foundation

American College of Rheumatology

Coalition on Skin Diseases

Coalition for Responsible Kidney Care

Crohn's & Colitis Foundation

National Eczema Association

Georgia Asthma Coalition

GASCO Georgia Society of Clinical Oncology

Georgia Life Sciences

Georgia First

Georgians for a Healthy Future

GSMA 125 Years of Service

Hemophilia of Georgia

Georgia Academy of Family Physicians

GPI Georgia Pain Initiative

GPPA Georgia Psychiatric Physicians Association

Georgia Society of Ophthalmology

Georgia Society of Dermatology and Dermatologic Surgery

Global Healthy Living Foundation

IDSA

ITSAN

LACES

LPCA

Help Us Solve The Cruel Mystery LUPUS Foundation of America Georgia Chapter

Lung Cancer Alliance

Medical Association of Georgia

MHA Mental Health America

Metro Atlanta Rheumatology Society M.A.R.S.

National Multiple Sclerosis Society

MTS

NAMI Georgia

NPAF National Patient Advocate Foundation

National Psoriasis Foundation

Redmoon Project

Ruby A. Neeson Foundation

SisterLove

Team Type 1

TRAGIC

U.S. Pain Foundation

www.rxinreachga.org
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CSRO
Coalition of State Rheumatology Organizations

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February 23, 2025

The Honorable Buddy Carter
2432 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
2111 Rayburn House Office Building
Washington, DC 20515

Re: Subcommittee on Health hearing to examine PBM reform policies

Dear Representative Carter and Representative DeGette:

The Coalition of State Rheumatology Organizations (CSRO) supports policies that curb the abusive practices of pharmacy benefit managers (PBMs) and urges Congress to include bipartisan policies that delink drug prices from PBM income and pass through all rebates and discounts directly to the patient within any end-of-year package. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic disease is systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

PBM Practices Harm Patients

Rheumatology patients were among the first to experience the harmful repercussions of pharmacy benefit manager (PBM) business practices because rheumatologic conditions regularly require complex, and often expensive, specialty medications. These PBM business practices were built on a system of perverse incentives, where the higher a drug's list price, the greater the income potential for the PBM. As a result, prescription drug formularies are designed to maximize PBM revenues. Time and time again, we've seen our patients switched between different medications when PBMs change their formularies to higher-priced drugs when they have more to gain from rebates and fees set at a percentage of the list price. These tactics benefit the PBMs financially, while our patients see none of the savings accrued to the PBMs.

The three largest PBMs —Caremark Rx, Express Scripts (ESI), and OptumRx— control 80% of the prescriptions filled in the United States, according to the Federal Trade Commission.[i] This vertical integration allows the PBMs to control which medication patients can take (through formulary construction), when they can take these medications (through utilization management), where they can purchase their medications (through pharmacy networks), and how much they must pay for their drugs (through cost-sharing). Currently, all of these decision points are leveraged to maximize PBM profits rather than provide the patient with the best care at the greatest savings. This consolidated healthcare system is not good for patients or the government as it causes competition that only raises drug prices.

Formulary design decisions are disastrous for patients who pay coinsurance because their out-of-pocket cost is based on list price of the medication – not what the PBM actually pays. An analysis by Drug Channels estimates that the spread between list and net price for insurers was over $200 billion in 2021.[ii] A 2021 report by the Texas Department of Insurance demonstrated that patients see marginal benefit from the supposed PBM "savings." Of $5,709,118,113 in rebates generated by PBMs for Texas insurers, only 21% made it back to patients in the form of direct savings.[iii]

Break the Connection between PBM Compensation and Drug Prices

CSRO supports measures that break the connection between the PBM's compensation and the list price of the drug. Such policies would disincentivize PBMs from preferring higher priced medications because they would no longer benefit from the size of the rebate or fee. Instead, PBMs would be reimbursed on a flat compensation fee – a model currently used by several more transparent PBMs. This approach would improve program stewardship and beneficiary access to affordable, clinically driven coverage. In the employer market, innovative PBMs are successfully using this model and provide fully transparent compensation models that offer savings to employers and patients. We support legislation at the state and federal level that applies this model to all PBMs.

Pass Manufacturer Rebates Directly onto Patients

PBMs claim to negotiate aggressive rebates and discounts that supposedly benefit employers and help keep premiums down. However, as demonstrated in the Texas report, those "savings" rarely trickle down to the patient. List prices appear to be fictional for everyone *except* the patient, whose cost-sharing is often based on the full price. It's time for rebates and other price concessions to benefit the patient – not the PBMs, especially as many patients are enrolled in health insurance plans that utilize high deductibles and/or significant cost sharing.

CSRO supports policies that require manufacturer rebates and other price concessions to be passed on to the patient as they are the ones bearing the brunt of skyrocketing drug costs. Given the immense vertical integration of PBMs and health insurance companies, policies that allow rebates to go directly to the health plan may have little impact in reducing patient expenses. Instead, rebates that go directly to the patient allow patients to see *immediate* savings at the point of sale. Not only will reducing patients' out-of-pocket costs improve adherence with better health outcomes, but it will also foster transparency and fairness in the healthcare system.

On behalf of CSRO and the patients we serve, we thank the Health Subcommittee for its bipartisan work to address PBM abuses. We urge Congress to protect patients by advancing measures that incorporate both delinking and rebate pass through. We appreciate your consideration, and we are happy to provide further details upon request.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

[i] Federal Trade Commission. "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices." September 2024.

[ii] Drug Channels. "Warped Incentives Update: The Gross-to-Net Bubble Exceeded $200 Billion in 2021 (rerun)."

July 2022.

[iii] Texas Department of Insurance. "Prescription Drug Cost Transparency-Pharmacy Benefit Managers". 2021.

APhA
American Pharmacists Association

February 26, 2025

The Honorable Brett Guthrie
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Earl "Buddy" Carter
Chairman
U.S. House of Representatives
Health Subcommittee on Energy and Commerce
2432 Rayburn House Office Building
Washington, DC 20515

Dear Chair Guthrie, Health Subcommittee Chair Carter, and members of the House Committee on Energy and Commerce:

The American Pharmacists Association (APhA) appreciates the opportunity to submit this statement for the record for the *"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients" hearing*. APhA supports the urgent need for Congress to pass meaningful pharmacy benefit manager (PBM) reforms and applauds your leadership in addressing this critical issue.

To support this Committee's efforts, this week, APhA is relaunching our "End PBM Harmful Practices Now," campaign where close to 5,000 of our nation's pharmacists from across the country previously contacted their members of Congress to pass PBM reforms to keep local pharmacy doors open to serve their communities.

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA is appreciative of the Committee's efforts to address the role PBMs have on the rising costs of prescription drugs and its unsustainable impact on pharmacies, pharmacists, and our patients. Furthermore, we are happy to congratulate pharmacist, and Health Subcommittee Chair Carter and full Committee Chair Guthrie for their years of leadership on these issues, as well as many other members of the Subcommittee and full committee, including pharmacist Rep. Diana Harshbarger. We are also pleased that Mr. Hugh Chancy, RPh, a member of APhA, is on the panel for this hearing. We have no doubt that Mr. Chancy will provide in-depth insight and knowledge into this proceeding.

APhA expresses our gratitude for the many bipartisan efforts Congress has made in the past to reform the operations and harmful business practices of PBMs. This hearing illustrates that effort. APhA believes that addressing PBM reform will begin to transition towards achieving a health care system that prioritizes patient well-being, promotes competition, ensures fair pricing, increases access to essential medications, and ultimately reduces the costs of prescription drugs.

APhA appreciates the efforts the Committee has engaged in to address PBM reform, including last year's passage in the House of the "Lower Cost, More Transparency Act," and we were disappointed that it did not become law. As you are aware, that bill would have addressed several provisions supported by our nation's pharmacists and our patients, such as the ban on spread pricing in Medicaid managed care programs, which occurs when the PBM charges the states more than they pay the pharmacy for the medication and then keeps the difference as profit rather than using it to reduce patients' prescription drug costs.

As we move forward with PBM reform legislation, APhA would like to see the Committee address the lack of transparency PBMs have engaged in that has created an environment of anti-competitive and deceptive business practices that harm patients and pass on hidden costs to pharmacies, plan sponsors, and employers, which often increases the costs of prescription drugs for American families.

Specifically, APhA urges the Committee to prioritize the following bipartisan, bicameral PBM reforms that were removed from last year's end-of-year health care package:

- **Enacting PBM reform in Medicare and Medicaid:** The Congressional Budget Office has estimated that these provisions, alongside additional PBM reforms, could save U.S. taxpayers **nearly $4 billion**. These reforms are essential to curbing PBM-driven prescription drug cost inflation, preventing pharmacy closures, and protecting patients' access to their preferred pharmacies.

  APhA strongly encourages Congress to pass the following provisions from the most recent healthcare package as part of the March 14th funding package or another legislative vehicle:

- Sec. 112. Requiring a survey of retail community pharmacy drug prices to establish benchmarks for fair Medicaid reimbursement, with implementation within six months of enactment.
- Sec. 113. Banning PBM spread pricing in Medicaid-managed care, which has unfairly profited PBMs at the expense of states and patients, effective mid-2026.

- Sec. 226. Ensuring pharmacy access and choice for Medicare beneficiaries by enforcing reasonable and transparent Part D contract terms and establishing an "any willing pharmacy" participation standard, beginning January 1, 2028.

While the PBM reforms scheduled to take effect in 2026 and 2028 would be critical steps forward, our pharmacists and patients need help now. Without immediate action in 2025, many pharmacies will be forced to close—leaving seniors without access to the pharmacist-provided preventive care they rely on.

Data submitted and compiled in an interim report by the Federal Trade Commission (FTC), states (mainly Medicaid programs), and commercial markets have clearly shown that PBMs:

- artificially inflate the cost of drugs without fully reimbursing pharmacies for the drugs they dispense.
- increase purchasers' and patients' drug prices through price discrimination.
- use "list prices" that do not reflect the final cost of drugs.
- force harmful retroactive direct and indirect fees and other "clawback" mechanisms on pharmacies, forcing smaller and independent pharmacies to close.

A second interim report from the FTC found that the larger PBMs, which control nearly 80% of the PBM market, imposed markups of hundreds and thousands of percent on numerous specialty generic drugs dispensed at their affiliated pharmacies—including drugs used to treat cancer, HIV, and other serious diseases and conditions." The Big 3 PBMs also reimbursed their affiliated pharmacies at a higher rate than they paid unaffiliated pharmacies on nearly every specialty generic drug examined.

The above examples are indicative of the problems PBMs create when they are unregulated and unmonitored. PBMs are often incentivized to engage in deceptive practices that steer patients away from lower-cost medicines, such as biosimilars or generics, which ultimately results in higher costs to the patient and increased drug prices. Another consequence of these harmful business practices is the closure of pharmacies across the country, which cannot afford to operate under the current underwater reimbursement model by which the PBM system exists. Pharmacies are often forced to close their doors when reimbursed below the acquisition costs of the medications they dispense or must deal with clawbacks through the PBMs, where they are forced to pay more than it costs to acquire the medication from the wholesaler and dispense it to maintain patients' access to their trusted community pharmacists. Over the last four years, more than 2,200 community pharmacies have closed, including over 300 independent pharmacies in 2023 alone. Because many Americans are closer to a pharmacy than any other primary care or health care provider, the closure of pharmacies creates a real patient access issue, creating pharmacy deserts, especially in rural or underserved areas that often need access to health care services. This trend is unstainable and will result in many more pharmacies shutting their doors, thus limiting patient access to critical care.

Thank you for the opportunity to comment on this very important hearing. APhA is committed to assisting with this issue and working with the Committee to find meaningful solutions to enact PBM reforms necessary to safeguard community pharmacies and ensure patient access to essential care—especially in the rural and underserved areas that need it most. If you have any additional questions or would like to arrange meetings with community pharmacies in your congressional districts to discuss the impact of harmful PBM business practices on local communities, please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at [redacted].

Sincerely,

Michael Baxter

Michael Baxter
Vice President, Federal Government Affairs

February 26, 2025

The Honorable Chairman Brett Guthrie
House Energy and Commerce Committee
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Frank Pallone
House Energy and Commerce Committee
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Chairman Earl L. "Buddy" Carter
The Energy and Commerce Committee
Health Subcommittee
2432 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Diana DeGette
The Energy and Commerce Committee
Health Subcommittee
2111 Rayburn House Office Building
Washington, DC 20515

Re: Hearing on Examining How Reining in PBMs Will Drive Competition and Lower Costs for Patients

Dear Representatives Guthrie, Carter, Pallone, and DeGette:

ASHP appreciates the subcommittee holding this important hearing on pharmacy benefit manager (PBM) practices that adversely impact competition and patient access to care. The American Society of Health-System Pharmacists (ASHP) is the collective voice of pharmacists who serve as patient care providers in hospitals, health systems, ambulatory clinics, and other healthcare settings spanning the full spectrum of medication use. The organization's more than 60,000 members include pharmacists, student pharmacists, and pharmacy technicians. Our members have seen firsthand how PBM practices can hurt patients. PBMs can play an important role in managing prescription drug benefits for private group and individual insurance as well as Medicare Advantage and Medicaid managed care plans. However, some PBM practices have put patients' health and safety at risk and restricted underserved individuals' access to safe and affordable prescription drugs.

Ban PBM Co-Pay Adjustment Programs: A "copay adjustment program" includes pharmacy benefit designs that allow enrollees to use manufacturer copay coupons when they pay for their prescription medications but does not count the value of that coupon toward their deductibles and out-of-pocket maximum amounts. As a result, manufacturer price concessions that were intended to provide fiscal relief to financially challenged patients are being rerouted away from patients to PBM profits. We recommend that at a minimum, manufacturer coupons should be counted towards the patient's out-of-pocket maximum and instituted in a manner designed to simplify reimbursement and promote transparency for both patients and pharmacies.

Bring Transparency to PBM-Manufacturer Rebates Arrangements: Often the negotiated rate between a PBM and a manufacturer so adversely impacts a pharmacy's ability to cover its acquisition cost for a product that the cost to the pharmacy is greater than a drug's acquisition cost. We recommend that point-of-sale reimbursement be sufficient to cover a pharmacy's acquisition cost for a drug. Additionally, we recommend that all contracts clearly outline

prescription and pharmacy performance measures, fees, and expectations, as they relate to reimbursement. There should be complete transparency about expectations and benchmarks related to performance and outcomes.

Pharmacy Fees: Pharmacy fees have increased exponentially over the last few years. According to data released by CMS, "performance-based pharmacy price concessions, net of all pharmacy incentive payments, increased, on average, nearly 170 percent per year between 2012 and 2020 and now comprise the second largest category of DIR received by sponsors and PBMs, behind only manufacturer rebates."[1] These fees were originally created to incentivize quality. However, they have become arbitrary and extensive. For instance, many times the quality metric a pharmacy fee is based on is irrelevant to the setting and medical condition a drug is used to treat. Pharmacy fees are typically unknown until a drug is dispensed and the claim adjudicated. Until recently, these fees were enforced retroactively, placing pharmacists in financial peril. While the retroactive collection of fees is expected to terminate based on CMS's recent ruling, vague administrative fees and unclear performance measures may not be impacted.[2] We recommend prohibiting PBMs from collecting administrative, prescription, quality, performance, or other care-related fees retroactively. We also recommend an individual or group plan, and its PBM, be prohibited from enforcing pharmacy fees except when the quality measure on which a fee is based directly relates to the patient's condition and is appropriate for the care setting. Lastly, we recommend that any performance-based fees be clearly outlined in scope and magnitude within the contract with a pharmacy, allowing pharmacies to properly forecast budgeting and understand expectations.

Prohibiting White and Brown Bagging: White bagging occurs when a PBM requires patient medications be distributed through a narrow network of specialty pharmacies that are often affiliated with the PBM before the drugs are then sent to a site of care, such as a hospital, where they will be dispensed by a provider. Hospitals have strict quality controls. By circumventing the traditional and regulated hospital supply chain, white bagging raises such patient safety risks as diversion and drug spoilage. Brown bagging occurs when a PBM ships medications to a patient, who then must take the pharmaceutical to the provider for administration. These medications typically require special storage and handling. White bagging and brown bagging put pharmaceuticals at risk of spoilage, contamination, and diversion, putting patients' health at risk. We recommend Congress prohibit PBMs from imposing white and brown bagging.

Protecting the 340B Program and Providers Against Discrimination: Safety-net hospitals rely on the 340B Drug Pricing Program to provide healthcare services, including care for uninsured and underinsured patients. However, PBMs have been discriminating against 340B providers, including excluding them from networks or making them use PBM software and other services at additional costs with the intent of reducing reimbursements for 340B purchased drugs. We recommend Congress prohibit PBMs from discriminating against 340B providers with the intent of reducing reimbursements for 340B purchased drugs, including such practices as excluding

[1] Federal Register / Vol. 87, No. 89 / Monday, May 9, 2022 / Rules and Regulations; page 27834).
[2] *Id.*

340B providers from networks or requiring payment of fees or the use of specific claims software as a means of increasing drug costs beyond 340B levels.

Expanding Access to Biosimilars: Uptake of biosimilars lags behind coverage of small molecule generic drugs. Insurers and their PBMs typically only cover one preferred brand of any given biologic product, excluding all other biosimilar products. This is contrary to how plans cover small molecule drugs where they are required to cover all commercially available generics. We recommend Congress require that an individual or group plan, and its PBM, that covers multiple generic small molecule drugs in a formulary treat biosimilars in a similar fashion. Thus, an individual or group health plan, and its PBM, that cover a reference (brand name) biologic or any biosimilar of the reference product, must cover all biosimilars of that product.

ASHP thanks you for holding this important hearing, which will ensure participants, beneficiaries, and enrollees have access to safe and effective drugs. We look forward to continuing to work with you on this issue. If you have questions or if ASHP can assist in any way, please contact Frank Kolb at [redacted].

Sincerely,

Tom Kraus
American Society of Health-System Pharmacists
Vice President, Government Relations

Hearing of the United States House Committee on Energy and Commerce
Subcommittee on Health
On
"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"
Testimony
By
Sheila Arquette, President and CEO
National Association of Specialty Pharmacy (NASP)
February 26, 2025

Chairman Carter, Ranking Member DeGette and Members of the Subcommittee:

I write today on behalf of the National Association of Specialty Pharmacy (NASP) to express support for the House Committee on Energy and Commerce Subcommittee on Health's efforts to address unfair and anticompetitive practices that narrow the pharmacy marketplace and negatively impact patients. We are so grateful for the leadership of Chairman Carter and the bipartisan support of Ranking Member DeGette to address and advance these important policy reforms at the beginning of the 119th Congress.

NASP represents the entire spectrum of specialty pharmacy industry stakeholders, including the nation's leading specialty pharmacies and practicing pharmacists; nurses; technicians; pharmacy students; non-clinical healthcare professionals and executives; pharmacy benefit managers (PBMs); pharmaceutical manufacturers; group purchasing organizations; wholesalers and distributors; integrated delivery systems and health plans; patient advocacy organizations; independent accreditation organizations; and technology, logistics and data management companies. The association represents all types of specialty pharmacies: independent pharmacies, academic medical center and hospital-health system based pharmacies, regional and national chain pharmacies, grocery store-owned specialty pharmacies, some health plan-owned specialty pharmacies, and home infusion pharmacies.

What is Specialty Pharmacy

Specialty pharmacies support patients who have complex health conditions like rheumatoid arthritis, multiple sclerosis, hemophilia, cancer, organ transplantation and rare diseases. The medications a specialty pharmacy dispenses are typically expensive. Historically, there are limited generic or biosimilar alternatives to specialty drugs. Specialty prescription medications are not routinely dispensed at a typical retail pharmacy because the medications are focused on a smaller number of patients and require significant patient education and monitoring on

utilization and adherence. Unless accredited as a specialty pharmacy by an independent, nationally recognized, third party accreditation organization, typical retail pharmacies are not designed to provide the intense and time-consuming patient care services that specialty medications require. Though many specialty medications are taken orally, still many need to be injected or infused. The services a specialty pharmacy provides include patient training in how to administer the medications, comprehensive treatment assessment, ongoing patient monitoring, side effect management and mitigation, and frequent communication and care coordination with caregivers, physicians and other healthcare providers. A specialty pharmacy's expert services drive patient adherence, proper management of medication dosing and side effects, and ensure costly and complex drug therapies and treatment regimens are used correctly and not wasted.

Anticompetitive Practices and Impact on Specialty Pharmacy

While the number of specialty medications only comprises 2.2 percent of the total number of prescriptions dispensed in the United States, these medications represent approximately 50 percent of overall drug spend in the U.S., which by the end of 2021, was estimated to be about $301 billion.[1] Distribution for most specialty medications is limited, with payers working to keep them even smaller. The specialty dispensing market is heavily dominated by the largest PBMs and the health insurers that own those PBMs.

Over the years, anticompetitive market practices, including significant reductions in reimbursement to non-affiliated pharmacies[2] have led to a significant narrowing of pharmacy networks. **Timely effort by Congress is needed to address comprehensive pharmacy and patient protections that allow all types of specialty pharmacy businesses to fairly compete and ensure patients have access to the specialty pharmacy of their choice. These comprehensive protections are included in PBM reforms that gained overwhelming bipartisan and bicameral support during the 118th Congress and were packaged together for congressional consideration at the end of the 2024 calendar year.**

Background

In 2022, after over a decade of pharmacies facing DIR clawback abuse, CMS finalized a Medicare Part D rule, eliminating a regulatory loophole (exception) that had long permitted the significant growth of pharmacy DIR fees. Beginning in January 2024, CMS required that all pharmacy price concessions – as newly defined for the first time – be applied at the point-of-sale, when a beneficiary receives their prescription. The specific purpose of this change was to ensure that patient out-of-pocket costs are assessed with all concessions applied, giving the

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Trends in U.S. Prescription Drug Spending: 2016-2021*. ASPE, U.S. Department of Health and Human Services, 2021.
[2] The term non-affiliated pharmacies refers to pharmacies that are not owned or controlled by the major health plans or their owned/affiliated Pharmacy Benefit Managers (PBMs).

beneficiary the lowest possible price, and therefore, the lowest possible co-pay. However, **the Biden Administration's final Part D rule did not establish any standards or protections to ensure that the negotiated price inclusive of all price concessions that is paid by plans to pharmacies is reasonable to cover a pharmacy's costs.**

NASP immediately raised the alarm with CMS and Congress that to prevent ongoing anticompetitive Part D practices, further action was needed.

Congressional Effort to Protect Pharmacies – Any Further Delay is Detrimental to Pharmacy Businesses and Patients

Prior to the 2022 Part D final rule, pharmacy DIR claw back fees significantly harmed specialty pharmacies, forcing many to decline participation in Medicare Part D networks, resulting in limiting beneficiary access and pharmacy choice; causing others to restructure their operations, laying off staff and cutting back on higher-cost inventory; and ending the stocking and dispensing of certain drugs to treat certain conditions. Many specialty pharmacies were forced to sell their pharmacies due to the harm caused by excessive pharmacy DIR claw back fees, with many being purchased by the large vertically integrated pharmacies.

While the final 2022 Part D rule took a first step toward needed reform of DIR, **we want the Subcommittee and the Trump Administration to understand the problems that are negatively impacting pharmacy network participation and patient access continue to persist because the Biden Administration's action did not go far enough. Specialty pharmacies have faced significant upfront reimbursement reductions, putting their finances underwater. There is no negotiated rate at the point-of-sale. More patients are being steered to certain PBM-affiliated pharmacies and rates paid to specialty pharmacies have plummeted to record low levels.**

During the 118th Congress, a bipartisan effort led by Chairman Carter and others on the Health Subcommittee and Committee leaders in the Senate advanced bills in the House and Senate that would address two key priorities for non-affiliated specialty pharmacies:

- **Ensure plans no longer violate the any willing provider statute, ensuring reimbursement to pharmacies and other Part D network terms are reasonable to ensure network participation by pharmacies.**
- **Eliminate spread pricing practices in Medicaid that reduce payments to pharmacies.**

Any Willing Provider Statute - Reasonable Pharmacy Reimbursement to Support Pharmacy Network Participation

CMS currently does not provide regulatory protections for ensuring that pharmacies will not be reimbursed at such a low level that they are unable to remain in a network, and therefore, accessible to patients.

Over the years, CMS has recognized that any willing provider statutory requirements permit the agency to regulate reasonable reimbursement provisions.[3] NASP has commented to CMS that the agency exercise its authority in enforcing this part of the statute to protect pharmacy payments going forward. CMS acknowledged these comments, stating in the final Calendar Year 2023 Part D rule that the agency would consider future rulemaking to address stakeholder concerns over CMS establishing safeguards to guarantee that pharmacies participating in Medicare Part D receive a reasonable rate of reimbursement.[4] However, nothing was done, requiring Congress to act. The House Energy and Commerce Committee and the Senate Finance Committee collaborated to address pharmacies' concerns, negotiating on a legislative proposal at the end of 2024 that would, for the first time, establish real pharmacy protections that would support specialty pharmacy businesses and those across the pharmacy community and the patients they serve. **NASP now urges the House Committee on Energy and Commerce Subcommittee on Health to take action out of the gate in the 119th Congress and advance PBM reform legislation to request that the agency begin the rulemaking process to address pharmacies' concerns without further delay.**

FTC Action – PBM Reform and Pharmacy Market Concerns

In 2024[5] and 2025[6], the Federal Trade Commission (FTC) released reports, following a multi-years long investigation, highlighting significant concerns regarding some PBM activities and their impact on specialty drug access and pharmacies. The FTC's July 2024 report found that pharmacies affiliated with some of the largest PBMs received 68% of the dispensing revenue from specialty drugs in 2023, up from 54% in 2016. The FTC reported that this trend indicates a growing concentration of dispensing revenue among PBM-affiliated pharmacies, potentially limiting access to specialty drugs through non-affiliated pharmacies. This practice results in the steering of patients toward PBM-affiliated pharmacies, thereby limiting competition and choice for beneficiaries.

The FTC highlighted that some PBMs impose unfair, arbitrary, and harmful contractual terms on non-affiliated pharmacies, adversely affecting their financial viability and ability to serve patients and communities.

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[3] 79 Fed. Reg. 1918, 1970 (Jan. 10, 2014).
[4] 87 Fed. Reg. at 27845 (May 2022).
[5] Federal Trade Commission. *Interim Staff Report: Prescription Drug Middlemen: An Analysis of the Role of Pharmacy Benefit Managers in the Pharmaceutical Supply Chain* (July 2024). Available at: https://www ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen
[6] Federal Trade Commission. *Second Interim Staff Report: Prescription Drug Middlemen: An Analysis of the Role of Pharmacy Benefit Managers in the Pharmaceutical Supply Chain* (January 2025). Available at: https://www ftc.gov/news-events/news/press-releases/2025/01/ftc-releases-second-interim-staff-report-prescription-drug-middlemen

The FTC's findings underscore the need for increased transparency and regulatory oversight of PBM practices to ensure fair pricing and access to specialty and retail medications for consumers.

Conclusion

NASP is pleased that with the Subcommittee Chairman's leadership and Ranking Member's support and the additional leadership of the Chairman of the Full Committee, the PBM reforms discussed today can advance, supporting the viability of pharmacies, network competition, and beneficiary access to the specialty pharmacy of their choice. We urge the Subcommittee to insist that action be taken early this year to establish protections to ensure pharmacies are no longer exploited by plans or their partners.

NASP appreciates the opportunity to provide testimony for the record for today's hearing. If we can provide additional information as the Committee proceeds with its effort to advance PBM reforms that protect pharmacies, please call on us.

February 25, 2025

The Hon. Brett Guthrie
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Hon. Frank Pallone
Ranking Member
House Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

The Hon. Buddy Carter
Chairman
House Energy & Commerce
Health Subcommittee
2432 Rayburn House Office Building
Washington, DC 20515

The Hon. Diana DeGette
Ranking Member
House Energy & Commerce
Health Subcommittee
2111 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Carter, and Ranking Member DeGette:

As pharmacists and pharmacy owners and operators across all practice settings, we strongly encourage continued scrutiny of some market-dominant pharmacy benefit manager (PBM) middlemen practices that inflate prescription drug costs for more than 300 million Americans, force pharmacy closures in many small towns and under-resourced areas, and block access to Americans' pharmacies of choice.

We trust that under your leadership, the House Energy and Commerce Health Subcommittee hearing this week will set the stage for immediate action to enact PBM reforms that gained overwhelming bipartisan and bicameral support during the 118th Congress.

Since January 2018, more than 5,800 U.S. pharmacies have closed, representing nearly 10 percent of all pharmacies. In 2023 alone, 1,338 pharmacies shut down, followed by 1,364 more in 2024, averaging 3.7 closures per day. Speaking with one voice, we urge the U.S. Congress to immediately send to the president's desk the must-pass PBM reforms in Medicare and Medicaid that would finally address harmful PBM practices.

During the 118th Congress, our organizations and individual members provided examples of harmful PBM practices we have warned about for upwards of 15 years. Left unabated and unchecked by federal action, these tactics and their devastating effects will continue to escalate and, without early action in the 119th Congress, will reach new extremes in 2025.

Thankfully, recognition of the damaging practices by some of the dominant PBMs is now prevalent among Republicans and Democrats, conservatives and progressives, federal and state governments, employers, unions, patient groups, providers, rural and urban health advocates, and a wide range of media outlets.

The following aspects of reform are absolutely necessary to ensure that a reform package is effective and can be supported by pharmacies:

- Medicaid managed care pharmacy payment reform and a ban on spread pricing by requiring 100 percent pass-through to the pharmacy of the ingredient costs and of the professional dispensing fee which could allow the federal government and states to save billions of dollars.

    - Ensuring fair and adequate Medicaid managed care pharmacy reimbursement from PBMs to cover the cost of acquiring and dispensing prescription drugs.

    - Requiring National Average Drug Acquisition Cost (NADAC) survey participation to help establish benchmarks for Medicaid reimbursement to pharmacies, which can be used to ensure fair reimbursement to pharmacies in Medicaid-managed care and in the commercial markets.

- Requiring the Centers for Medicare and Medicaid Services (CMS) to define and enforce "reasonable and relevant" Medicare Part D contract terms, including information about reimbursement and dispensing fees, and establishing in Medicare Part D an approach by which "any willing pharmacy" can truly participate and serve patients. More than 50 million Medicare Part D beneficiaries rely on prescription drug plans managed by PBMs. This change would ensure they have access to a broader network of pharmacies that can provide them with essential care.

These policies have been the subject of bipartisan and bicameral work across committees of jurisdiction, creating a robust package of Medicare, Medicaid, and commercial market reforms that also include:

- Promoting transparency of insurer claims and reimbursement information to the pharmacy, including independent audits and enforcement measures in Medicare Part D.

- Prohibiting PBM compensation in Medicare Part D from being tied to the manufacturer's list price of a drug.

- Prohibiting spread pricing in commercial markets.

We urge Congress to enact this year what should be considered must-pass legislation: PBM reforms that Congress has developed and agreed upon and which Americans and their pharmacies desperately need.

Sincerely,

National Association of Chain Drug Stores
National Community Pharmacists Association
American Pharmacists Association
National Association of Specialty Pharmacy
FMI – The Food Industry Association
National Grocers Association
National Alliance of State Pharmacy Associations

cc: Members, House Committee on Energy & Commerce

February 26, 2025,

The Honorable Earl L. "Buddy" Carter
House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
House of Representatives
Washington, D.C. 20515

Dear Health Subcommittee Chair Carter and Ranking Member DeGette,

The Alliance of Community Health Plans (ACHP) commends your leadership and continued commitment to pharmacy benefit manager (PBM) transparency. In the 2024 elections, voters made clear they seek affordable drug prices. We're pleased the Energy and Commerce Subcommittee on Health has continued to focus on the need for PBM transparency and urge congressional leadership to capitalize on the momentum of the last Congress to sign comprehensive PBM transparency into law.

ACHP is the only national organization advancing a unique payer-provider aligned model of health care that fosters true competition, delivering high-quality coverage and care. As regional and non-profit insurers, ACHP member companies provide affordable coverage options to tens of millions of Americans in nearly 40 states and D.C., remaining in their markets even when other carriers exit. The sustainability of regional health plans is paramount to an innovative and competitive insurance industry, ensuring consumers are free to select the coverage they want.

PBM functions are a necessary component of the drug supply chain, especially assisting community health plans with small pharmacy staff to process claims, track drug utilization and manage formularies. However, the massive consolidation and market dominance of three PBMs combined with misaligned incentives underscore the need for transparency and reforms.

ACHP member companies support moving PBMs to a fee-based, transparent industry, like those included in the year-end health care package that ultimately fell out of the December continuing resolution. The legislation required PBMs to report money paid to brokers and consultants, subjected PBM subsidiaries and affiliates to the same transparency as the PBMs themselves and delinked PBM compensation from the cost of the drug in Part D. Lowering drug costs has been a key health care priority for President Trump, who has repeatedly referred to PBMs as middlemen who must be cut out in order to lower costs.

For far too long, drug pricing in America has resembled a Ponzi scheme, benefiting a few at the expense of many. Currently, many PBMs operate in a black box and the hidden deals attached to PBM compensation are directly increasing drug prices for consumers. It is past time for Congress to take action.

Thank you for your continued efforts and leadership on PBM transparency. It is critical lawmakers pass comprehensive PBM transparency to bring much-needed relief to patients at the pharmacy counter. We

look forward to collaborating on steps the 119th Congress can take to ensure a more transparent and competitive PBM market that will empower nonprofit, regional health plans to lower prescription drug costs on behalf of the patients our members serve. Please contact Dan Jones, Senior Vice President, Federal Affairs ([redacted]) to discuss these recommendations further and support the Energy and Commerce Committee's bold agenda.

Regards,

Ceci Connolly
President and CEO, ACHP

Cc: Energy and Commerce Committee Chairman Brett Guthrie and Ranking Member Frank Pallone

Statement for the Record

Pharmaceutical Care Management Association

325 7th Street NW

Suite 900

Washington, DC 20004

Submitted to the

United States House of Representatives
Energy & Commerce Committee
Subcommittee on Health

"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"

February 26, 2025

Introduction

The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs).[i] Employers and unions choose to hire PBMs to secure lower costs for prescription drugs and achieve better health outcomes for patients. While employers could negotiate directly with drug companies and pay the prices each pharmacy charges the general public, they all choose to work with PBMs because of the value our companies provide to them and the patients they cover. Over the next 10 years, PBMs will save employers, health plans, labor unions, state and federal governments, and patients $1.2 trillion.[ii]

PBMs focus on enabling access and lowering prescription drug costs for patients and the wide range of health plan sponsors who choose to hire them – specifically by:

- Negotiating rebates from brand drug companies and discounts from drugstores to reduce costs for patients, their families, and health plans – saving an average of $1,154 per patient per year.[iii] These savings are fully under the control of the PBM client in every aspect.
- Encouraging the use of more affordable alternative drugs, such as lower-cost brands, generics, and biosimilars.
- Offering services that benefit patients, such as home delivery.
- Managing and helping patients access high-cost specialty medications.
- Identifying and rooting out fraud, reducing waste, preventing potentially harmful drug interactions, and improving adherence.

Congress is focused on lowering drug costs and improving care for patients. So are PBMs. In this statement, we share how PBMs have proactively sought business solutions to address changing demands, review policies that PCMA members support to encourage a competitive market for prescription drugs, and explain how many policies under active consideration that would limit employer choice and PBMs' ability to drive down costs could lead to harmful unintended consequences for patients.

PBMs are addressing challenges to patient affordability and access in response to the desires of the private market. Recently, large and small PBMs across the country rolled out programs adapting their business models around five patient-centric areas:[iv]

1. Lowering out-of-pocket costs for patients
2. Providing more transparent information about pharmacy benefits, costs, and access
3. Working with health plans to break down barriers around biosimilars
4. Strengthening the retail pharmacy market and giving patients access to pharmacies regardless of where they live
5. Supporting lower list prices and comprehensive coverage options for GLP-1s and other prescription drugs

It is crucially important that as policymakers consider proposals to intervene in the commercial market with PBM mandates and limitations, they do so with a more complete understanding of the numerous ways the market continues to change and adapt.

As an industry, we welcome any opportunity to discuss and advance ways to improve the prescription drug marketplace so Americans can better afford their prescription drugs. But we continue to emphasize the need to focus on the true cause of high drug prices, and that is the

prices that brand drug manufacturers independently set and independently raise. During the September 19, 2023, House Oversight Committee hearing, Dr. Rena Conti of Boston University noted, “Drug prices are set high in the United States because, simply, drug manufacturers can charge them, and we will pay them.” This statement continues to be true.

We want to immediately clarify any misunderstanding that PBMs favor high-list-price products. Our companies support and advocate for lower list prices on all prescription drugs. Our mission is to negotiate for lower net costs for employers and clients, which means lower costs for patients. Lower list prices means a better starting point for those negotiations, and PBMs fully support efforts to bring down list prices.

Understanding the factors driving drug costs must include a look at the entire supply chain, including drug companies and all others with impact on the cost of prescription drugs. For instance, there is irrefutable evidence of certain drug companies repeatedly abusing the patent system to keep more affordable alternatives from entering the marketplace, which allows those companies to maintain higher profit margins than nearly any other industry at the expense of patients.

As the committee assesses how best to improve the prescription drug market, we encourage review of all of these entities and their business models, profit incentives, and underlying motives for pushing or attempting to block certain pieces of legislation.

PBMs Are Innovating to Create a More Transparent Market with Even More Options While Prioritizing Patients

When a PBM does not perform as expected, employers and unions have choices. With more than 73 full-service PBMs in the market, employers and unions can and do take their business elsewhere.[v] For example, in 2023, Blue Shield of California chose to restructure the management of its pharmacy benefit offerings, dropping one of the largest PBMs in the country in favor of a diversified model that broke up services among five different companies.[vi]

In response to consumer demands in this competitive market, PBMs are continually innovating and adapting to either carve out a new niche or to gain or maintain market share. As part of their requests for proposals (RFPs) when putting their pharmacy benefits out to bid, PBMs’ customers lay out the terms of the benefits they intend to provide, the transparency and information they want to receive, and the audit rights they require to ensure those terms are met. Once they select a PBM that meets all of their requirements, these details are formalized in their contracts. In a May 2022 letter to the FTC, the School Employees Retirement System of Ohio described this dynamic, stating, “SERS’ PBM contracts are on a transparent pricing basis, with 100% pass-through of rebates and pharmacy pricing. All rebates and pricing discounts are applied directly to SERS members as reduced pharmacy premiums every year. The pass-through contract provision is independently audited biannually, confirming that all monies related to the retiree prescription drug benefit are passed back to SERS.”[vii]

Addressing demands for more transparency

Drug companies continue to increase prices, an average of 4% in January 2025, and PBMs are innovating by developing new programs that lower drug costs and increase affordable access for patients. Recently, large and small PBMs across the industry have rolled out new, innovative programs that provide more actionable transparency for patients, lower out-of-pocket costs at the pharmacy counter, and improve access to needed drugs.[viii]

Stakeholders in health care are calling for more transparency and value to combat rising drug prices set by drug companies. Many PBMs are now offering new programs that make pharmacy benefits easier for employers and unions and their plan participants to understand. Efforts are underway to bring more detailed visibility to employers through reporting mechanisms. Updates to plan sponsor reporting include offers of better pricing transparency through drug level details,[ix,x] cost-plus pricing models with a simplified reimbursement structure, and value-based models that promote efficient care and better patient outcomes.[xi]

Providing tools that offer patients more transparency helps facilitate convenient access to information that empowers patient savings and improves adherence. PBMs also have online web portals and digital apps for patients that provide real-time, actionable information, allowing them to search for the lowest-cost prescription alternatives, find or compare across pharmacies, or access their prescription histories.[xii,xiii]

Innovating for patient affordability and access

Many challenges with patient affordability result from exposure to drug companies' high list prices. Ensuring patient access and affordability and improving clinical outcomes are core functions of PBMs. PBMs work with employers and unions to understand how best a PBM can effectively meet the needs of their populations and drive down costs. PBMs are offering programs to employers and unions that limit what is paid by patients to $0 or a low-dollar amount for many common prescription drugs.[xiv]

Addressing the climbing list prices set by manufacturers for specialty drugs, PBMs are creating strategies that improve affordable access to these medications. Using clinical teams, PBMs help plan sponsors and plan participants manage specialty drug costs, such as by providing disease-specific estimates to predict future drug costs and spending,[xv] adding multiple manufacturers for the same reference product and biosimilars to their formularies while achieving reduced net cost to the plan sponsor,[xvi] offering $0 cost-share for select biosimilars,[xvii] and addressing access for high-cost drugs such as glucagon-like peptide 1 (GLP-1) weight loss medications.

PBMs are responding to the evolving GLP-1 drug class to support employers and patients.[xviii] PBMs offer plan sponsors comprehensive programs that combine weight loss aids (such as GLP-1s) and lifestyle changes[xix,xx] and are encouraging the use of best practices around GLP-1s to contain costs and promote access to patients in need.[xxi] Using all tools available, PBMs recommend coverage and formulary placement of GLP-1s for weight management to employers and unions when appropriate, allowing them to design benefits that work for their populations.[xxii]

Evolving pharmacy reimbursement models and advancing clinical care

Pharmacists are a part of communities across the country, and they have frequent face-to-face interactions with patients – "roughly twice as frequently as [patients] visit primary care physicians" and even more often for those who live in rural areas.[xxiii] Pharmacies are integral to a PBM's success in helping patients access their medications. For this reason, PCMA supports policies such as the Equitable Community Access to Pharmacist Services Act, which grants pharmacists Medicare "provider" status during a public health emergency so that once a federal public health emergency is declared, there will be no delay in pharmacists' ability to assist and be paid.

As the practice of pharmacy evolves, so should the payment models for pharmacist services.

Many PBMs are revising the traditional reimbursement models used for many years to bring more transparency and reflect the value delivered by pharmacists. Starting this year, there will be new offerings to employers and unions in the commercial market that reimburse pharmacies based on drug acquisition cost, a set markup, and a fee to reflect the quality of pharmacy services provided.[xxiv,xxv,xxvi] PCMA's members are also taking note of the market shift to paying for value and innovating current models to expand pharmacist reimbursement for clinical services offered in retail settings.[xxvii]

PBMs support pharmacists in rural communities by offering increased reimbursement to true independent pharmacists.[xxviii] Reimbursement models are evolving with the health care market to include enhanced performance and better health outcomes from pharmacists, allowing a pharmacist to apply their clinical knowledge and practice at a level commensurate with their training and licensing.[xxix,xxx]

PBMs are innovating their offerings, and the private market is addressing many of the issues Congress is debating. Any legislative changes to the health care system, including additional limitations placed on employers, unions, and their PBMs, should be designed to lower drug costs. Limiting PBM tools that drive down costs would increase costs by reducing competition and giving drug companies and pharmacies greater leverage to the detriment of patients, taxpayers, employers, and unions.

<u>Legislation Aimed at Drug Pricing Should Address the Drugmakers That Set Prices</u>

Efforts to lower drug costs must start with an understanding that prices are set by drug companies. When a drug company sets its initial price, that price dictates costs throughout the supply chain – from the wholesaler's negotiation for discounts from the manufacturer, to the markups paid by pharmacies as they stock their stores, to the amount ultimately paid by the insurance plan sponsor and the patient and the amount paid to each pharmacy.

While there are numerous drug supply and payment chain participants, only one is responsible for setting and raising drug prices. Brand and generic drug manufacturers always exercise full control over the pricing of their products. In recent years, we have seen brand manufacturers exercise this ability by lowering prices in response to policies that motivate them to do so. For example, when insulin manufacturers were faced with the looming threat of removal of the Average Manufacturer Price cap – which would have required companies that chose to raise prices at a rate outpacing inflation to pay Medicaid rather than simply supply the drug to Medicaid at a deeply discounted price – they dramatically decreased list prices on several popular insulin products by 70–80%.[xxxi, xxxii, xxxiii] Prior to this move, insulin accounted for a significant percentage of rebates in Medicare Part D,[xxxiv] and because **we always stand for lower drug prices that result in reduced drug costs**, not only did PCMA applaud this move, but we also encouraged other manufacturers to follow suit. **Lower list prices for drugs can decrease costs throughout the supply chain, lowering the net cost for employers and, often, patient cost-sharing. PCMA will always celebrate lower list prices because PBMs strive for lower drug costs.**

In almost every industry – and especially health care – the most effective way to lower costs is through leveraging increased competition. That is why **we must ensure that patent protections and market exclusiveness meant to balance rewarding innovation with securing affordable access for patients does not block competition and keep prices high**.

PCMA's policy platform calls on Congress to take steps to address competition in the

prescription drug market, including the following:

1. **Reform patent laws and regulations to accelerate competition.**
2. **Ensure market exclusivity is used to incentivize innovative drug research and is capped at the interval Congress deems appropriate.**
3. **Penalize abuse of the citizen petition process.**
4. **Promote generic and biosimilar competition.**

PBMs negotiate $148 billion in savings from manufacturers and pharmacies annually,[xxxv] and those savings directly benefit employers, unions, retirees, and patients.

Rebates have never been the cause of high drug prices. **Rebates are simply the mechanism PBMs are required to use in order to achieve savings. This is because of a 1936 law called the Robinson-Patman Act and subsequent court rulings.[xxxvi] PBMs are primarily concerned with maintaining the ability to negotiate discounts from drug companies on behalf of employers, unions, taxpayers, and patients. If the law allowed for it, those savings could be achieved through different approaches.** Since we are currently required to comply with this system, it is important to note that numerous reports have shown that rebates are not correlated with list prices or price increases. For example, an HHS OIG report from 2019 noted, "Even when brand-name drugs had increases in both unit reimbursement and unit rebates, the increase in rebates was not always the same magnitude as the increase in reimbursement."[xxxvii] Another expert analysis found that price increases for rebated and non-rebated drugs were essentially the same,[xxxviii] and PCMA's research demonstrates that list price increases "are not correlated with changes in prescription drug rebates."[xxxix]

A little-known truth is that most drugs do not have rebates at all. One analysis found that nine out of 10 prescription drugs with the highest price increases since 2018 did not have rebates.[xl] Another analysis of 2016 data found that 89% of prescriptions written in 2016 had no rebates, 81% of all Part D drugs analyzed did not have rebates, and 64% of brand drugs analyzed did not have rebates.[xli]

How much of the rebates PBMs negotiate from drug companies go directly to plans?

- According to GAO**,** 99.6% of rebates in Medicare Part D are passed directly back to Part D plans that – as required by law – use those rebates to keep premiums affordable or to otherwise support beneficiaries.[xlii]
- In the commercial market, 91% of rebates go to plan sponsors.[xliii]

What do employers do with drug rebates?

- According to a recent survey of nearly 700 employers, 90% of employers that received rebates in the past 12 months applied them toward at least one activity to offset the cost of their prescription drug benefits. Among those employers, 45% directed rebates toward at least one activity specifically aimed at reducing out-of-pocket costs for their employees.[xliv]

How much of the drug dollar do PBMs retain?

- Ninety-four percent of the drug dollar is retained by drug manufacturers, pharmacies, and wholesalers – with PBMs receiving only 6% and spending 67% of that amount to provide services, ultimately retaining just 2% of the drug dollar.[xlv]
- The same data also shows that drug companies keep 65% of that drug dollar,[xlvi] giving the

industry some of the highest profit margins of any industry.[xlvii]

Do rebates impact drug prices?

- Statistical analysis of the top brand drugs in Medicare Part D found no correlation between rising list prices set by drug companies and the change in rebates negotiated with PBMs.[xlviii]
- The HHS OIG found that PBM-negotiated rebates led to lower prescription drug costs in Part D.[xlix]
- For more than a third of the brand-name drugs it reviewed, OIG found that rebates declined as costs increased. It also found that the majority (95.6%) of Medicare Part D brand-name drug costs increased regardless of rebates over the five-year period examined.[l]
- Drug companies take enormous price increases for Part D drugs without rebates and for Part B drugs, for which PBMs do not negotiate rebates.[li]

So what is driving drug prices higher?

- Over the past several years, increased expenditures on specialty drugs have been a key driver in keeping overall drug spending high. According to the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), "The cost of specialty drugs has continued to grow, totaling $301 billion in 2021, an increase of 43% since 2016. Specialty drugs represented 50% of total drug spending in 2021."[lii]
- Between 2008 and 2021, launch prices for new drugs increased exponentially by 20% per year. From 2020 to 2021, 47% of new drugs were initially priced above $150,000 per year. Prices increased by 11% per year, even after adjusting for estimated manufacturer discounts and changes in certain drug characteristics, such as more oncology and specialty drugs (e.g., injectables, biologics) introduced in recent years.[liii]

While drug pricing does in fact start and end with drug companies, we recognize that every member of the drug supply chain shares the responsibility of ensuring patients are able to get the drugs they need. We are ready to come to the table to discuss solutions that prioritize patients, something the current proposals fail to do, as they take into account only the desires of special interest groups.

<u>Directing Reform Efforts at PBMs Will Lead to Unintended Consequences</u>

Just like Congress and Center for Medicare and Medicaid Services (CMS) have full control over government health care programs, **employers and unions should have the right to determine the structure of their benefit designs** with equal choice and flexibility. They should have the option of determining how they would like to pay the PBM they select to provide services. Policies that prevent employers and unions from paying for value or incentivizing optimal performance are misguided – they do nothing to improve patient affordability or improve the competitive market for drugs. As changes are considered, it will be important to prioritize patients, preserve employers' and unions' choices, and maintain balance so the private market can continue to control costs.

Many bills under consideration eliminate important choices, such as "spread pricing," a tool used to efficiently manage costs. Today, employers and unions have choices on how to reimburse pharmacies. They can choose "pass-through" contracting, in which the plan sponsor pays the PBM a fee as well as whatever the pharmacy charges, or "spread pricing," in which the sponsor lets the PBM hold the risk that plan participants may use more expensive pharmacies

to fill their prescriptions – and 34% of employers choose spread pricing.[liv]. While larger employers may select pass-through contracts, as they have the scale to deal with the variability of pharmacy charges, smaller employers may choose spread contracts because of the pricing predictability and savings they derive. Spread pricing is not, as some stakeholders have described, simply charging the pharmacy one rate and then marking up the price and charging the employer or union a higher rate to produce a profit. **Banning this contract provision eliminates an option employers and unions use to gain greater predictability. States that have banned spread pricing have seen drug costs increase in Medicaid, including in the Ohio Medicaid program, which paid an additional $38 million for prescriptions after moving away from spread-based contracts.[lv]**

Employers and unions should also continue to have the option of encouraging beneficiaries to use lower-cost pharmacies to get their drugs. This is a benefit to the patient, the employer or union, and taxpayers. A ban on the use of pharmacy networks that promote steering would further increase costs. Studies have demonstrated that encouraging the use of lower-cost options like home delivery results in savings. Mail delivery is expected to save Medicare Part D and Medicaid Managed Care programs over $100 billion over the next 10 years.[lvi]

One of the key tenets of the PBM industry is to prefer the drugs that cost the least after all discounts. In coordination with independent clinical experts on a pharmacy and therapeutics committee, PBMs typically develop a recommended formulary for plan sponsors, who may customize it. Government mandates that dictate formulary design and force plans to cover more expensive drugs would increase premiums for patients (and increase program costs for taxpayers) and reduce leverage in negotiations with manufacturers. The resulting higher drug costs would be a direct result of limiting the necessary PBM tools used to control cost.

PBMs are the private market solution to managing drugs costs and are equipped to harness market competition to lower drug costs. Recently, the CMS released its selected drug list for 2026 Medicare price negotiations. In selecting drugs for negotiation under the Inflation Reduction Act's direct negotiation provision, CMS chose several drugs that already have competition that the private market can and does leverage. CMS will need to be mindful of the effect of these selections on other drugs in the same market and be sure to provide a clear off-ramp to remove selected drugs to avoid suppressing competition from biosimilar and generic manufacturers.

A number of economists and health policy experts have written about their research-based views that certain anti-PBM bills will do more harm than good in terms of increasing costs, stifling economic growth, and limiting the choices and contracting flexibility that employers and unions appreciate today when it comes to health benefit design and coverage, including the following:

- AEI Senior Fellow Alex Brill publishes a report on the unintended consequences and increased costs of misguided proposals for PBM reform.[lvii]
- Former chief economist for the Council of Economic Advisers in the prior Trump administration, recent Trump appointee to Chief Counsel for Advocacy at the Small Business Administration, and University of Chicago Professor of Economics Casey Mulligan published findings on the economic impact of ending pay-for-PBM performance and the massive $32 billion financial windfall to pharma.[lviii]
- In 2023, Competitive Enterprise Institute (CEI) published a study written by newly appointed Special Assistant to the President for Economic Policy at the National Economic Council Joel Zinberg, MD, on how PBMs drive down the cost of prescription drugs, which concludes

that “PBMs are a pro-competitive creation of the market for prescription drugs that improve consumer welfare” and that current legislative proposals are “likely to be counterproductive, resulting in reduced competition, higher costs, and an end to the natural evolution in the market of terms and arrangements which benefit the actors in the drug distribution system.”[lix]

- The Brookings Institution released a new analysis that provides an overview of recent legislation targeting PBMs being considered by Congress and how the policies will not effectively lead to lower costs. The analysis concludes that eliminating rebates and spread pricing could actually have the opposite intended effect by weakening PBMs’ negotiating power against Big Pharma – the root cause of high prescription drug prices.[lx]

Similarly, lawmakers should beware of misguided approaches meant to give handouts to pharmacies at the expense of employers, unions, taxpayers, and patients. Bills that focus on restricting the practices of PBMs fail to understand the importance of negotiating discounts from drug manufacturers and pharmacies. Restricting PBMs’ abilities to negotiate with pharmacies by mandating inclusion of all pharmacies into pharmacy networks, preventing performance-based accountability programs, and mandating reimbursement floors, would result in much higher drug costs in federal health care programs.[lxi] PBMs use credentialing, audits, and performance-based contracts to do things like ensuring that pharmacies are appropriately equipped to meet the needs of specific patient populations, requiring pharmacies to demonstrate appropriate financial stability, and ensuring patient safety.

Further, recent proposals in Congress have suggested prohibiting PBMs from being compensated based on a drug’s list price or utilization, thereby ending a pay-for-PBM performance model that has effectively delivered savings to employers and unions for years. This drastic change in how PBMs work will cost employers, taxpayers, and patients exorbitantly – and will provide a massive $32 billion financial windfall for drug companies who are able to avoid discounting their products, keeping what otherwise would be rebates as profit.[lxii]

Throughout the U.S. economy, people and businesses are incentivized to perform well through the opportunity to benefit from the effects of their labor. Delinking would work in a manner contrary to established economic principles known to produce better outcomes. As one paper notes “pay for performance is one of the most cited conclusions in economics, where it is frequently noted that ‘incentives matter.’”[lxiii] Thus, **delinking would not correct misaligned incentives as alleged; instead, it would shift incentives away from driving down drug costs** – PBMs’ stated mission. Lawmakers should be wary of this policy, as it “has the potential to significantly (i) increase drug prices, (ii) reduce drug utilization, and (iii) redistribute billions of dollars annually from patients and taxpayers to pharmacy companies and drug manufacturers.”[lxiv]

When these economic principles play out in numbers, we see that delinking in Medicare alone would result in much higher costs: “Annual federal spending on Medicare Part D premiums would increase $3 billion to $10 billion plus any concomitant increase in Medicare subsidies for out-of-pocket expenses. … [And additional] Medicare spending would require the federal government to tax more, spend less outside of Medicare, and/or borrow more, which has additional effects on the broader economy.”[lxv] In addition to these substantial economic harms, delinking PBM compensation from a drug’s list price singles out one supply and payment chain participant, while all others continue to be paid based on that long-standing standard. Drug companies, wholesalers, pharmacies, and even physicians (in the case of physician-administered drugs) are compensated on a basis that ties back to the list price of a drug.

Drug rebates are used to lower drug costs. When a PBM capitalizes on a competitive drug market and negotiates higher rebates, that equates to lower drug costs for patients and plan sponsors. The ability to pay a differential for exceptional performance incentivizes better performance. Preventing PBMs from being rewarded for doing a better job runs counter to the efforts made to shift the health care system toward paying for value. Some current policy proposals even seek to prevent compensation based on covered lives or processed claims, further exacerbating the problem by not only preventing rewards for exceptional effectiveness in negotiating lower drug costs but also prohibiting rewards for efficiently processing high numbers of claims.

Specialty drugs have continued to rise in price. From 2010 to 2019, specialty spending jumped from $9.4 billion to $46.8 billion.[lxvi] Specialty drugs represented 50% of total drug spending in 2021,[lxvii] and in 2023, the median cost for non-oncology specialty medicines was $44,000, while oncology therapies had a median annual cost of $299,000.[lxviii] PBMs play a vital role in managing these costs. **By encouraging the use of mail-service and specialty pharmacies, PBMs will help generate more than $274 billion in savings over the next 10 years, with savings from mail-order pharmacies projected to be over $23.5 billion and savings on specialty medications projected to generate more than $250 billion.[lxix]** For all these reasons, Congress must carefully evaluate proposals to ensure the intended effects.

Conclusion

PBMs exist to reduce drug costs for plan sponsors and, most importantly, for the patients our companies serve. Much of this value is generated by the savings PBMs negotiate with pharmaceutical manufacturers and pharmacies. PBMs are enabled to negotiate most effectively when there is a competitive prescription drug market.

Through their work, PBMs lower the cost of health coverage, reduce drug costs, and support better and more affordable prescription drug access for patients, which means more people can get on and stay on the medications they need. For many years, evidence has shown a return of 10:1 on investments in PBM services for their private sector and government partners.[lxx] As a result, PBMs will lower the cost of health care by $1.2 trillion over the next 10 years.[lxxi]

America's businesses know the needs of their employees best and value choice and flexibility when it comes to making decisions on pharmacy benefits. We urge Congress not to disrupt the commercial market by removing choices from employers and unions and mandating a one-size-fits-all approach to pharmacy benefits. PCMA looks forward to working collaboratively with Congress and other stakeholders to build on the existing private market framework to address prescription drug affordability challenges and improve functionality for patients. As this process moves forward, we would be happy to work with you to minimize unintended consequences that would lead to higher costs for employers, unions, patients, and taxpayers.

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National Voice. Local Action.

February 26, 2025

The Honorable Buddy Carter
Chairman
House Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Diana Degette
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Carter and Ranking Member Degette:

The National Association of Nutrition and Aging Services Programs commends the Subcommittee for convening today's hearing "An Examination of How Reining in PBM's Will Drive Competition and Lower Costs for Patients."

NANASP is an association with more than 1000 members who primarily work with older adults providing them with important social and human services in particular nutrition. The issue of lowering drug costs is constantly on the minds of older adults we serve.

We were disappointed that the 118th Congress was unable to complete work on comprehensive PBM reform legislation. However, we are encouraged that this hearing is being held so early in the new Congress and can provide momentum for the later adoption of legislation. In our mind, we view as essential that any final legislation must address and promote transparency within PBM contracting and commercial market prices, which according to the Congressional Budget Office could reduce the deficit by more than $ 2 billion while also contributing to lowering drug prices.

We also consider it essential to have this commitment to transparency extended to PBM practices in Medicare Part D. It is fundamentally wrong to have Medicare patients spend 4 times as much as plan sponsors for the highest rebated drugs in Part D.

We hope today's hearing will examine more closely the real impact of consolidation in the PBM marketplace resulting in fewer options and less competition, while also not achieving lower costs for patients. We hope that legislation can include language requiring PBMs and health plans to share savings from rebates and discounts directly with the patients so they too can enjoy lower prices. Proper adherence to prescription drugs improves the quality of life for many older adults. However, if access to these drugs is limited due to high prices for seniors, the health benefits will not be realized by all.

Finally, we encourage both the House and Senate to continue to work in a bipartisan fashion to achieve genuine PBM reforms. Marketplace fairness can be accomplished while also lowering drug prices. That should be an achievable goal.

Sincerely,

Bob Blancato
Executive Director
NANASP

Statement of the
American College of Physicians
to the U.S. Energy and Commerce Health Subcommittee Hearing
on
"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"
February 26, 2025

The American College of Physicians (ACP) is pleased to provide comments in response to the House Energy and Commerce Health Subcommittee's hearing on "*An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients*." We thank Chairman Carter and Ranking Member DeGette for holding this hearing to explore bipartisan policies that would drive down the rising costs of prescription drugs for patients by examining Pharmacy Benefit Managers (PBMs) business practices. With the continued rise in costs of prescription drugs, patients and physicians need reliable and timely information on medication pricing so that they can ensure patients' access to treatment. Our recommendations, outlined below, are consistent with ACP's policy to increase the accessibility and affordability of prescription drugs. These policy solutions include improving price transparency practices in PBMs and providing more oversight of PBM mergers and acquisitions to promote market competition.

ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Lower the Costs of Prescription Drugs by Reforming PBMs

PBMs administer prescription drug coverage for more than 266 million Americans in private and public health plans, making them the principal purchasers of prescription drugs in the United States. While they are supposed to help make prescription drugs more affordable, the reality is that prescription drug prices continue to rise. Prescription drug prices have increased by more than 10 percent per year for each of the top 20 brand-name drugs prescribed to American seniors, and PBMs negotiate rebates from those higher prices.

As outlined in an ACP policy position paper on the costs of prescription drugs, the U.S. spends more on prescription drugs than other high-income countries, with average annual spending of $1,443 per

capita on pharmaceutical drugs and $1,026 per capita on retail prescription drugs. As physicians, we utilize prescription drugs as fundamental tools in patient care, helping us to improve health outcomes. Unfortunately, we have seen firsthand how high prescription drug prices can hinder access to life-saving treatments for our patients. Patients face difficult decisions on whether to spend their money on prescription drugs or pay for other necessities such as groceries, utilities, transportation, etc. Many find themselves resorting to cutting back and/or skipping doses of their medications, which can lead to serious health complications. It is estimated that medication non-adherence results in increased hospitalization and mortality rates and costs the U.S. health care system anywhere from $100-$300 billion a year.

As a country, we cannot continue to go down this costly trajectory. We need sound policy solutions to prevent unjustified drug pricing increases to protect patients' access to care. Legislation is needed to address the lack of transparency and accountability with PBMs. The contracts negotiated between health plans and PBMs, which include fees and shares of rebates, are all kept confidential. ACP supports policies that would ensure that the rebates and other savings that PBMs claim to negotiate are really being used to help lower prescription drug costs for patients. Further, we need more clarity on how PBMs determine the price and cost of prescription drugs.

ACP has written several letters and statements in support legislation to drive down the costs of prescription drugs, several of which focus on PBM reform. We remain steadfast in our commitment to supporting legislation that will improve transparency, accountability and competition regarding the business practices of PBMs. We have supported several pieces of legislation in the last Congress that would have reformed PBMs, and we urge the Energy and Commerce Health Subcommittee to bring forth these bipartisan policy solutions in the 119th Congress.

Support for The Lower Costs, More Transparency Act

ACP supports pricing transparency by health care organizations. We supported the passage of the Lower Costs, More Transparency Act, which passed the House in the 118th Congress. We support its reintroduction and passage in this Congress. The legislation contains price publication requirements for PBMs, as well as for hospitals, ambulatory surgical centers, imaging services, clinical laboratories, and health insurers. With respect to PBMs, the legislation requires PBMs to semi-annually provide employers with detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. ACP supports transparency of reliable and valid price information, expected out-of-pocket costs, and quality data that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. Health plans and health care facilities should clearly communicate to a consumer whether a provider or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer. In our letter of support, we recommended that payers, plans, and other health care organizations develop patient-targeted health care value decision-making tools that are written for patients at all levels of health literacy that make

price, estimated out-of-pocket cost, and quality data available to consumers. This information should be communicated in an easy-to-understand way.

ACP policy also supports transparency in the pricing, cost, and comparative value of all pharmaceutical products. Therefore, we advocate for improved transparency, standards, and guidelines for PBMs, including a ban on "gag clauses." PBMs are for-profit companies that act as intermediaries for health insurers, self-insured employers, union health plans, Medicare Part D prescription drug benefit plans, and government purchasers in the selection, purchase, and distribution of pharmaceutical products for more than half the U.S. population. ACP believes increased transparency is needed on the part of PBMs and health plans to provide greater understanding of drug prices, help patients make informed decisions and support a more sustainable health care system.

The continued lack of transparency from PBMs and insurers can hinder how patients, physicians, and others view the drug supply chain and can make it difficult to identify whether a particular entity is inappropriately driving up drug prices. This lack of transparency can also prevent viable policy solutions from being identified and further delay reforms that would help to rein in spending on prescription drugs. ACP believes health plans, PBMs, and pharmaceutical manufacturers should report the amount paid for prescription drugs, aggregate number of rebates, and nonproprietary pricing information to HHS and make it publicly available. Any disclosure mandate should be structured in a way that deidentifies negotiated rebates with specific companies and protects confidential information that could be considered trade secrets or could have the effect of increasing prices.

Support for Oversight of PBMs Mergers and Acquisitions

ACP policy urges more stringent oversight of PBM mergers and acquisitions. The consolidation of the PBM market raises concerns about potential antitrust issues and has been shown to increase prices for patients. Although many smaller regional PBMs exist, the large national PBMs that take up much of the market share continue to wield leverage with pharmaceutical companies. While approximately 60 PBMs operate in the United States, consolidation has resulted in three of them (CVS Caremark, OptumRx, and Express Scripts) representing as much as 85 percent of the market share. As the market continues to consolidate, companies like Amazon are becoming market disrupters by selling prescription drugs and medical devices directly to consumers, in the belief that eliminating the middleman will result in cost savings. Some insurance companies have decided to end their relationship with PBMs indefinitely and create their own in-house PBMs. For example, Anthem ended its relationship with Express Scripts and developed its own pharmacy benefit management arm, called IngenioRx.

In the U.S. pharmaceutical market, where competition and consumer choice should be cornerstones of a healthy market system, consolidation that limits these factors can create scenarios in which PBMs are not motivated to bargain with manufacturers to keep drug costs down. In addition, PBMs have been criticized for "clawbacks," which occur when patient copayments or coinsurance are set at a rate that is higher than the acquisition cost of the drug for the insurer. A study published by JAMA showed that in 2013, patients overpaid for their prescriptions by at least $2.00 twenty-three percent of the time,

with an average overpayment of $7.69 and total overpayments of $135 million. With the increased visibility and criticism of PBMs, lawsuits, including class action lawsuits, have been filed against PBMs claiming illegal pricing schemes, violations of anti-kickback statutes, and other misconduct. As consolidation continues, agreements between PBMs, insurers and other entities should undergo strict review for both antitrust implications and effects on other aspects of the drug supply chain, such as generic and biosimilar market entry.

Support for The Modernizing and Ensuring PBM Accountability (MEPA) Act

ACP supports the Modernizing and Ensuring PBM Accountability (MEPA) Act, which would set out new requirements for PBMs to annually report drug prices and other information to Part D plan sponsors and to the Secretary of HHS. The legislation would require PBMs to include information related to several categories, such as information related to covered Part D drugs, drug dispensing, drug costs and pricing, generic and biosimilar formulary placement, PBM affiliates, financial arrangements with consultants, and potential PBM conflicts of interest.

The MEPA Act would require PBMs or their affiliates to provide Part D plans with a written explanation of contracts or arrangements with a drug manufacturer (or affiliate) that makes rebates, discounts, payments, or other financial incentives related the drug manufacturer's drug(s) contingent upon coverage, formulary placement, or utilization management conditions on other prescription drugs. ACP supports the availability of accurate, understandable, and actionable information on the price of prescription medication. We urge health plans to make this information available to physicians and patients at the point of prescribing to facilitate informed decision making about clinically appropriate and cost-conscious care.

Further, we favor measures to increase transparency and data collection regarding vertical integration and consolidation in the health care industry. Importantly, the MEPA Act requires the HHS Office of Inspector General (OIG) to investigate the effect of vertical integration between Part D plans, PBMs, and pharmacies including effects on beneficiary out-of-pocket costs and Medicare spending under the Part D program. The OIG would be required to submit a report with its findings to Congress within a specified timeframe.

Conclusion

ACP commends the Energy and Commerce Health Subcommittee for its commitment to driving down the costs of prescription drugs in this country. We urge you to continue to work together in a bipartisan manner to advance reforms to improve transparency, increase accountability and market competition in the PBM industry in order to lower prescription drug costs. If you have any further questions or if you need additional information from ACP, please contact Vy Oxman at [redacted].

AARP
STATEMENT FOR THE RECORD
for the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITEE ON HEALTH
on

AN EXAMINATION OF HOW REINING IN PBMS WILL DRIVE COMPETITION AND LOWER COSTS FOR PATIENTS

February 26, 2025
Washington, DC

For further information contact:
Gidget Benitez
Health Access and Affordability
Government Affairs
[redacted]

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the opportunity to submit this statement for the record for the hearing of the House Energy and Commerce Subcommittee on Health, "An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients." We value the Subcommittee's bipartisan efforts to address practices in the prescription drug market that can contribute to high prices for consumers and taxpayers.

Support for PBM Reform

AARP supports bipartisan, comprehensive reform to bring much-needed transparency, accountability, and competition to the prescription drug market. That includes tackling both the role of pharmacy benefit managers (PBMs) and the pricing decisions of drug manufacturers. Drug companies set the launch and list prices of medications, while PBMs control access, negotiate rebates, and determine how much patients actually pay out of pocket. Both entities have contributed to a system where patients – especially older Americans on fixed incomes – struggle to afford the medications they need.

On average, Medicare beneficiaries take between four and five prescriptions per month. Meanwhile, most people on Medicare have relatively modest financial resources. The median annual income is just over $35,000, and one in ten have no savings or are in debt. They simply do not have the resources to continue to absorb the costs associated with high and growing prescription drug prices. Without meaningful, comprehensive reform, seniors will continue to face higher costs and reduced access to life-sustaining medications. Congress has an opportunity to confirm PBMs serve their intended purpose – ensuring patients have appropriate access to needed medications at the lowest cost possible – and do not prioritize their own bottom line at the expense of consumers.

The Need for PBM Reform: Addressing Market Failures

PBMs were originally designed to lower drug prices and manage pharmacy benefits for patients. However, there are concerns that they have evolved into dominant, profit-driven intermediaries that leverage their control over formularies and reimbursement rates to extract billions from the system – often without passing those savings on to consumers. These business practices are contrary to PBMs' intended purpose and should not be allowed to continue.

Key PBM practices that should be addressed include:

- Spread pricing: Some PBMs charge health plans and payers more for a prescription drug than what they reimburse pharmacies, then pocket the difference. This drives up costs for patients and taxpayers alike. Prohibiting spread pricing would increase accountability in the prescription drug supply chain.
- Opaque contracts: PBM contracts are highly complex and can prevent employers and payers from fully understanding their drug costs or negotiating fairer terms for consumers. This lack of transparency also inhibits competition in the market, hurting consumers and taxpayers.

- Misaligned incentives: Currently, some PBM fees are linked to drug prices, which could incentivize PBMs to cover high-priced drugs instead of lower-priced alternatives. Congress should require Part D plans to compensate PBMs with flat-dollar service fees instead of basing payments on a percentage of drug prices, which should eliminate misaligned incentives and reduce costs for Medicare Part D enrollees.
- NADAC Survey Participation: Ensuring that PBMs and payers rely on accurate, market-based drug pricing benchmarks is essential. Requiring pharmacies to respond to the National Average Drug Acquisition Costs (NADAC) survey would improve transparency and accountability.

Support for Bipartisan Legislative Solutions

Ensuring that consumers – especially seniors – benefit from lower drug prices requires policies that eliminate perverse incentives, increase transparency, and strengthen market competition. Prescription drugs do not work if people cannot afford to take them. And American taxpayers cannot afford to continue paying the highest prices in the world for our drugs.

We commend this Subcommittee for holding today's hearing and for its ongoing bipartisan work to rein in harmful PBM practices that increase costs for consumers. We look forward to continuing to work with Congress to advance meaningful PBM reforms that put patients first and drive real savings for older Americans.

Statement for the Record: National Community Pharmacists Association

United States House Energy and Commerce Health Subcommittee Hearing:

"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients."

February 26th, 2025

Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Carter, Vice Chairman Dunn, Ranking Member DeGette and Members of the Committee:

On behalf of the National Community Pharmacists Association, thank you for holding this hearing regarding pharmacy benefit managers (PBMs) and their effect on the prescription drug market. NCPA represents America's community pharmacists, including 18,900 independent community pharmacies across the country, and together our members employ 205,000 individuals, and provide an expanding set of health care services to millions of patients every day. Our members are small business owners who are among America's most accessible health care providers. We commend your bipartisan leadership on this issue and thank you for prioritizing PBM reform in the 119th Congress.

PBMs are largely unrecognized by most patients and misunderstood by many employers and payers (including governmental entities and taxpayers), but they profoundly influence U.S. health care decision-making and drug spending. They have the power to determine which drugs patients may have, which pharmacies patients may use, and, through their affiliations with or ownership of pharmacies, control how much their competitors can be reimbursed for prescription drugs and other pharmacy services. They also determine the drug price patients pay at the counter. They use this influence to increase their outlandish profits at the expense of taxpayers, patients, and local, independently run pharmacies. Due to vertical integration, the three largest PBMs (representing over 80 percent of covered lives in this country) are owned by or own the three largest health insurance companies and they each have their own pharmacy, whether it is mail order or retail. PBMs' anticompetitive practices, opaque reimbursement models, and restrictive contract terms have created an environment in which they can use their overwhelming market power to steer patients away from their competitors to their own pharmacies and pay themselves higher prescription reimbursement rates. They also limit access to the marketplace similar to major tech firms that run app stores.

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A recent Federal Trade Commission (FTC) interim report found that the top three PBMs generated more than $7.3 billion in revenue from patients by steering "specialty drugs" to their affiliated pharmacies.[1] Such practices not only limit independent pharmacies' reimbursements but also inhibit patients' ability to pay for critical medications. These and other PBM abuses have led to the net loss of over 450 independent community pharmacies since June 2023, and we are on track to continuing losing one a day.[2] The closures of these irreplaceable community pharmacies harm tens of thousands of patients, many of whom rely on their local pharmacy for first-line medical care, particularly those who live in rural or medically underserved areas.

In addition, pharmacists have recently been subject to financial burden in several forms, including: the Change Healthcare cybersecurity attack, Express Scripts' (ESI) violation of the recent direct and indirect remuneration (DIR) rule for their own profit, as described in more detail below, and lower reimbursement overall for prescriptions. The cyberattack on Change Healthcare affected roughly a third of the country and led to pharmacies dispensing patients' medications in good faith after the system went down.[3] However, reimbursements for those medications were delayed by months, severely cutting into pharmacies' already low bottom line. In the aftermath of Hurricane Helene in September 2024, pharmacies had to operate without access to their records or electricity, and when they acted in good faith to serve patients, PBMs hit them with audits in the middle of the crisis. PBMs skirt the rules and play games all too frequently. In January 2024, the Medicare Part D rule on DIR fees went into effect and pharmacists immediately noticed overall lower reimbursement on medications, as well as new fees from PBMs. Those new fees and games took the form of ESI's "bonus pool" where fees were not being calculated at the point of sale and thus violated the restriction on retroactive DIR fees. NCPA notified the Centers for Medicare & Medicaid Services (CMS) of the violation on January 8. We sent a letter in April to ESI calling out their stifling business practices, including the unlawful bonus pool program[4] We followed up with CMS in May with a letter and with a meeting the following week between CMS and NCPA's Regional Chain Advisory Group, which represents over 700 pharmacies in 20 different states. CMS informed us that ESI was violating the rule[5] and by June 10, ESI announced they would be discontinuing[6]

These practices should not be a surprise. In June 2024, 3 Axis Advisors released a report detailing spread pricing in employer-based health plans in the state of Washington.[7] The results show that many mail-order pharmacies' prescriptions cost significantly more than brick-and-mortar pharmacies, with the price of generics three times higher, and brand-name drugs three to six times more expensive at a PBM-affiliated mail-order pharmacy than a chain and **35 times more expensive** than at independent pharmacies.[8] During the four-year period of the study, plan sponsor costs went up by 30 percent, and pharmacy reimbursements decreased by three percent.

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[1] FTC Releases Second Interim Staff Report on Prescription Dug Middlemen
[2] Local Pharmacies on the Brink, New Survey Reveals | NCPA
[3] NCPA Timeline of Change Healthcare Cyberattack and Response
[4] NCPA Letter to ESI, April 2024
[5] ESI Fees Violate Federal Policy; NCPA Pushes CMS for Clarity, Accountability
[6] ESI blinked and vows to accelerate reimbursement for bonus pool fees
[7] 3AxisAdvisors Report - Understanding Drug Pricing from Divergent Perspectives
[8] WSPA PBM Study Results Released

We often hear that PBMs claim they save money for state-funded health plans like Medicaid managed care programs, yet numerous reports have found that this is not the case. Instead, you can see that excessive amounts of taxpayer dollars have been funneled to PBMs. Here are a few examples:

- West Virginia and North Dakota both eliminated spread pricing and moved to a transparent cost-based reimbursement system, saving their Medicaid programs $54.4 million and $17 million respectively.[9]
- Kentucky identified $123 million of spread pricing annually, precipitating wholesale changes to their Medicaid pharmacy model.
- The auditor general in Ohio identified more than $224 million of spread pricing.
- Illinois found $220 million in spread pricing waste in its Medicaid program.
- The Commonwealth of Virginia and Maryland have found smaller yet still egregious sums of spread pricing.

Further, according to an NCPA survey of our members in January 2025, over 80 percent of respondents said the financial health of their business declined in 2024, and 20 percent are considering closing their doors this year.[10] Half of all respondents stated that Medicare Part D makes up over 40 percent of their business by prescription volume, and we found that community pharmacies are being under-reimbursed on 75 percent of the Part D prescriptions they fill, when taking into consideration the cost to acquire and dispense a medication.[11] If pharmacies continue to face challenges like these, more and more will shut their doors. In the last four years we have lost almost 2,700 retail pharmacies (chain, mass merchants and independents) — an overall 4.7 percent decrease of pharmacy choices for patients — and that pattern of pharmacy closures is increasing. Independent pharmacy net closures continue at approximately one store per day.

It is for these reasons that Congress must enact the bipartisan, bicameral legislation that was negotiated and agreed to at the end of last year to address these issues and hold PBMs accountable. The Congressional Budget Office (CBO) scored the PBM reform policies included in the legislation as saving taxpayers nearly $5 billion, as can be seen in the chart below. Included in the legislative measures are policies that would enhance transparency and eliminate spread pricing in Medicaid managed care programs, as well as requirements of CMS to define and enforce reasonable and relevant contract terms in Medicare Part D, improving patient access to medications.

[9] NCPA Explainer – State Medicaid Managed Care Reform
[10] Report for January 2025 Survey of Independent Pharmacy Owners/Managers
[11] Report for February 2024 Survey of Independent Pharmacy Owners/Managers

Provision	Latest Public CBO Score
NADAC	$2.046B in savings (CBO)
Medicaid spread	$306M in savings (CBO)
Commercial PBM transparency	$1.872B in savings (CBO)
Part D delinking/transparency	$719M in savings (CBO)
TOTAL	**$4.943B in savings**[12,13]

Furthermore, we believe the recent push to improve efficiency in government and save taxpayers money is a natural fit for these reforms and the above-mentioned savings that would follow. As we outlined in a December 2024 letter to the incoming administration,[14] the PBMs' blatantly anticompetitive behaviors prevent the overall health care market from operating efficiently for consumers, resulting in higher drug costs. The increasing dominance of PBMs poses a significant threat to consumers' convenient access to prescription medications, while at the same time raising costs for government programs like Medicare Part D, Medicaid, Tricare, and the Federal Employees Health Benefit Plan.

This can be seen in a recent report from the Government Accountability Office, which called for additional oversight of the Department of Defense's (DOD) Tricare program.[15] The DOD's Defense Health Agency (DHA) oversees the Tricare contract, and oversight plans within the contract call for audits of the program. However, since 2009 when ESI took over the contract, DHA has never implemented an audit, instead relying on monthly reports from ESI, which GAO found to have inaccuracies. Specifically, there were two months of missing information on beneficiaries impacted by network changes, during which time roughly 200 pharmacies had left the network.

Additionally, the Office of Inspector General (OIG) released a report in March 2024[16] finding the PBM – once again ESI – overcharged the United States Postal Service health plan by nearly $45 million dollars. This included such acts as overcharging pharmacy claims, failing to implement pass-through transparent drug pricing, withholding drug pricing discounts when filling prescriptions with the PBM's own mail-order and specialty pharmacies, failing to return retail pharmacy transaction fees the carrier had been credited for, and failing to pass on a portion of – or outright withholding – the drug manufacturer rebates. We continue to encourage the committee to use their power of oversight and policymaking to find creative ways to save money for patients and taxpayers while ensuring independent pharmacies are reimbursed fairly.

Further delay of legislative action would be catastrophic to community pharmacies and their patients. Increased vertical and horizontal consolidation of PBMs and health plans has caused severe inequities

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[12] CBO Estimated Budget Effects of the Beter Mental Health Care, Lower-Cost Drugs and Extenders Act and Certain Provisions of the MEPA Act

[13] CBO Cost Estimate of S.1339, Pharmacy Benefit Manger Reform Act

[14] NCPA Letter to DOGE December 2024

[15] GAO Report - DOD Should Improve Monitoring of TRICARE Beneficiaries Access to Prescription Drugs

[16] OIG Report – Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021

for pharmacies and Medicare Part D beneficiaries alike. Community pharmacies are under-reimbursed on 75 percent of Part D claims, and PBM practices cause further harm to patients by impeding access to medications through limited formularies and networks, letting insurance companies – not patients and doctors – decide when a drug works for a patient. We applaud the bipartisan, bicameral efforts to address PBM reform, and we urge lawmakers on both sides to continue to work in a bipartisan manner to pass these reforms that save $5 billion. Congress must not miss this opportunity to pass comprehensive and meaningful PBM reforms, and we hope that this hearing will provide the necessary momentum to provide legislative relief in the coming days.

STATEMENT FOR THE RECORD BY

BUSINESS GROUP ON HEALTH

TO THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

"AN EXAMINATION OF HOW REINING IN PBMS WILL DRIVE COMPETITION AND LOWER COSTS FOR PATIENTS"

February 26, 2025

Chairmen Guthrie, Subcommittee Chairman Carter, Ranking Member DeGette, and Members of the subcommittee, Business Group on Health appreciates the opportunity to submit a statement for the record on behalf of our members regarding the subcommittee's February 26, 2025, hearing: "An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients." We commend the subcommittee for its focus on reforms to improve transparency and accountability within the pharmacy benefit manager (PBM) sector.

As the nation's leading voice for large employers dedicated to advancing the quality and affordability of health care, the Business Group represents a vibrant community of more than 440 of today's most forward-thinking employers and industry partners including 72 Fortune 100 companies, providing health coverage for 60 million workers, retirees and their families in 200 countries. Business Group members – innovative employer plan sponsors – are leading the way and encouraging others by providing strong health plan offerings, adopting alternative payment models, managing the total cost of care, furthering population health, and keeping people well. As large employers committed to providing sustainable, high-quality health coverage to millions of Americans, we urge Congress to adopt thoughtful, targeted reforms that respect the complexities of the pharmaceutical market and preserve plan sponsors' flexibility to design effective benefit programs.

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I. The Vital Role of Transparency in Combating High Prescription Drug Costs

Prescription drug costs continue to escalate, and employer plan sponsors face significant challenges in maintaining affordable and comprehensive prescription drug benefits for employees and their families. Our 2025 Large Employer Health Care Strategy Survey reveals that, between 2021 and 2023, the median percentage of health care dollars spent on pharmacy has jumped from 21% to 27%, suggesting that nearly all of the increased health care costs that employers are absorbing is related to pharmacy cost.[1] Therefore, it is not surprising that nearly all large employers cite patient and plan affordability as paramount concerns, with 94% specifically troubled by the unsustainable pharmacy cost trend.[2]

Rising drug costs are propelled by long-standing market structures and practices and exacerbated by the lack of transparency within PBM arrangements and a rebate-dominated contracting model that often limits plan sponsors' ability to obtain or consider clear, upfront pricing for needed medications. The lack of transparency in contracting and rebates and the opaqueness of the pharmacy supply chain are some of employers' biggest concerns relative to pharmacy benefits; Business Group on Health's 2025 Employer Health Care Strategy Survey shows that 97% of employers seek greater transparency in their vendor partnerships.[3]

Provisions requiring PBMs to provide health plans data on rebates, fees, benefit design parameters and other essential information would strengthen employers' crucial insights into drug costs and utilization that would help empower employers to better evaluate PBM performance and design more cost-effective benefits. Thus, the Business Group views transparency and accountability as vital reforms and supports increased reporting and disclosures to plan sponsors to better inform decision-making, contracting, and plan design. **For these reasons we urge Congress to enact PBM transparency requirements so that all stakeholders can have clear directives and standards for employer access to this critical information.**

II. Opposition to Civil Monetary Penalties or Excise Taxes Under ERISA, the Public Health Service Act, and/or the Internal Revenue Code

While the Business Group supports transparency and accountability in PBM arrangements, we are seriously concerned about proposals that would impose new civil monetary

[1] Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024.
[2] Ibid.
[3] Ibid.

penalties (CMPs) or other amendments to ERISA Section 502 or made otherwise applicable to employer sponsored health and welfare plan arrangements. We believe that ERISA's current requirements, including fiduciary responsibilities and enforcement provisions, are adequate and appropriate to support and ensure compliance with any new statutory provisions.

Adopting CMPs into ERISA would be a significant and negative departure from long-standing enforcement practices, harmful to employer's authority and fiduciary oversight, unnecessary and overly burdensome. ERISA's current Section 502 provisions are adequate and appropriate to handle the enforcement of any new requirements and should not be amended. Moreover, provisions that would apply CMPs (or other penalties) through the Public Health Service Act (PHSA) or the Internal Revenue Code (IRC) would misalign accountability, create confusion, increase administrative burden, and have similar deleterious effects on employer health plans as any ERISA Section 502 amendments.

We believe the imposition of CMPs would disrupt plan sponsors' ability to negotiate effectively and manage relationships with PBMs and other stakeholders. Instead of facilitating greater transparency and cost management, we believe CMPs or other penalties in this circumstance would lead to higher costs, increased litigation risks, and reduced flexibility and control for employer-sponsored plans.

For these reasons, we urge Congress to remove the previously proposed CMP and excise tax provisions from the relevant sections of any proposed amendments to ERISA, PHSA, and IRC. The proposed transparency provisions, without the disruptive penalty provisions, will be an important improvement that allows employers to work in furtherance of their fiduciary responsibilities without overreaching into counterproductive government interference or other undesirable consequences.

III. Additional Notes and the Importance of Employer Flexibility and Control

We are under the impression that Congress is generally starting this session's consideration of PBM and other transparency reforms as released in the draft Continuing Resolution (CR) from December, 2024. **Other than the CMP and excise tax elements which should be removed (discussed above), the PBM and transparency-focused reforms proposed in the December 2024 CR draft would overall be beneficial to enact.**

We note and applaud Congress's removal from the December 2024 CR of some previously proposed PBM reform provisions from earlier in the 118th Congress and stress

the importance of continuing to keep certain proposals out of any current legislation, as described:

- Congress should avoid mandating fiduciary status to certain vendors, such as PBMs. Not all parties involved in a plan's ecosystem need be or should be fiduciaries. Employer plan sponsors and the individuals acting as the named fiduciaries of the plan(s) should continue to be empowered to determine when a partner or service provider will serve as a delegated or co-fiduciary. According to the Business Group's 2025 Employer Health Care Strategy Survey, seven out of ten employers believe that control of whether a vendor partner serves as a fiduciary should remain with the employer as plan sponsor.[4]

- Previously proposed special fiduciary certifications are unnecessary, overly burdensome, and provide no meaningful value beyond existing compliance requirements for the entirety of the plan. We appreciate the removal of the burdensome certification from the December 2024 CR provisions and urge Congress to refrain from going further into such a patchwork in the future.

- While transparency around pricing structures is crucial, a broad ban on "spread pricing" as a PBM arrangement may unnecessarily limit plan sponsors' ability to manage prescription costs effectively. The final price of a prescription is determined by several market and plan design factors. For plan sponsors' flexibility, we are concerned about a one-size-fits-all ban and instead prefer the greater transparency into these arrangements that would be afforded under the proposed transparency provisions.

In all, Business Group on Health urges Congress to take a balanced approach in considering PBM and transparency legislation that strengthens accountability while preserving essential flexibility for plan sponsors to optimize their benefit designs. Congress should ensure that PBM reform efforts focus on meaningful transparency and accountability without imposing unnecessary, overreaching CMPs or excise taxes that would undermine and interfere with employer plan contracting and control of their vendors and service providers. The Business Group appreciates the subcommittee's attention to this critical issue and welcomes any questions or further discussion.

[4] Business Group on Health. 2025 Employer Health Care Strategy Survey. August 2024.

THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

Statement for the Record by
The ERISA Industry Committee (ERIC) to the
U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health Hearing:

"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"

February 26, 2025

Introduction and About The ERISA Industry Committee

Subcommittee Chairman Carter, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing, *"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients."* We appreciate the subcommittee's interest in commonsense, pro-competition reforms that will lower costs for patients and employers, while providing better access to affordable prescription drugs for workers and their families.

ERIC is a national nonprofit organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. ERIC's member companies voluntarily provide benefits that cover millions of active and retired workers and their families across the country. With member companies that are leaders in every sector of the economy, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans and to lawfully operate under ERISA's protection from a patchwork of different and conflicting state and local laws, in addition to federal law.

You are likely to engage with an ERIC member company when you drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

Contrary to some claims, employers are not satisfied with the current state of their relationships with PBMs. Spiraling drug costs are a large part of America's health care affordability problem. Because of misaligned incentives under current law, the largest PBMs reportedly engage in business practices that drive up prescription drug costs, rather than lowering costs and passing the savings on to those feeling the pressure of rising costs. Three PBMs process more than 80 percent of prescription drug claims in the U.S., giving them immense market power, often making it very challenging for employers to negotiate contract terms for affordably priced medications for workers and families. This skewed market dynamic drives up drug costs for employers, patients, and taxpayers, with real-life consequences for those relying on medications to manage their health conditions.

We urge Congress to take decisive action to finish the job begun in the last Congress, and implement transparency, accountability, and reform in the pharmacy benefit manager (PBM) industry. Since 2018, ERIC has been advocating for policies to reorient PBM practices to lower drug costs and drive value for our workers, their families, and retirees. We strongly support comprehensive transparency and accountability for PBMs, including the following policies that were nearly included in the 2024 end-of-the-year funding legislation:

- **Requiring complete and unrestricted transparency into the PBM "black box."** It is not practical for employers to reduce drug costs if we don't know what those drug costs are. Clear information on pricing, rebates, fees, and discounts is essential for employers and patients to make informed decisions and to build a functioning free market for prescription drugs. Specifically, we need to know how the PBM is making money, where it is deriving fees or other profits from, what arrangements the PBM has with drug manufacturers or other third parties, including more transparency into PBM-owned pharmacies and other entities in the supply chain under common ownership and/or control as a PBM. We must be able to rely on independent outside experts of our choosing to help us audit our PBMs, any related entities, and their contracts. While transparency is of great importance, transparency alone is not enough.

- **Banning so-called "spread pricing."** The bill included a ban on spread pricing in Medicaid, which is a good start – Congress should start there, and later consider banning all spread pricing in the PBM industry. Spread pricing arrangements allow a PBM to charge an employer-sponsored plan (or patient) more than the PBM actually pays for a drug, usually with no disclosure of how much the price has been inflated. We are not aware of any large employers who wish to maintain this type of arrangement. Most small and medium-sized employers are not familiar with PBM practices and are not aware that they have been enrolled in spread-pricing plans. This practice is especially pernicious when intertwined with PBM-owned mail-order and specialty pharmacies, with patients usually steered to these dispensing channels. Certainly, no one expects PBMs to perform their services without remuneration. However, employers engage the services of PBMs for the explicit purpose of obtaining essential, and even lifesaving, medicines at the best price possible. Yet, due to the opaqueness of the arrangement and other business practices, payors are completely unaware of the extent of the "spread."

- **Requiring 100% pass-through of rebates, discounts, fees, and other payments from drug manufacturers.** When a drug manufacturer remits these kinds of payments to a PBM, they should be considered plan assets, and should be spent only in the interests of plan beneficiaries. Instead, often times these payments are given creative names or purposes, are channeled through new intermediaries (such as "aggregators" or offshore "group purchasing organizations"), and never accrue to the benefit of patients. These reforms will effectively de-link PBM profits from high list prices for drugs so that PBMs can be profitable while helping to ensure that employers and consumers are the primary beneficiaries of the savings negotiated by PBMs.

ERIC values the work of the 118th Congress, including the Energy and Commerce Committee, and six other committees across both chambers, who voted overwhelmingly and with little opposition in favor of PBM transparency and reforms, which culminated in the bipartisan health care package that was under consideration for the Continuing Resolution in December 2024. The foundation for this crucial change has been laid, and the subcommittee deserves praise for highlighting the need to reform the PBM system once and for all.

Now is the time to finish the work and include these reforms in a March spending deal. When taken together, these measures complement and build upon important policy principles that Congress enacted under the Consolidated Appropriations Act of 2020 – commonsense solutions to reorient PBM practices and drive better access to lower-cost prescription drugs for millions of Americans. Congress must finish what it started – doing so will have a meaningful impact on the tens of millions of Americans who these commonsense, pro-competition reforms will impact. By acting now, Congress will ensure that the health care market functions as intended, preventing companies from steering patients toward higher-priced medications and away from more affordable alternatives.

We strongly urge you to continue the fight and build even more congressional support for the bipartisan PBM transparency and accountability reforms agreed upon by leadership in December. Employers, working families, patients, and taxpayers across America are counting on Congress this March to help mitigate their ever-growing health care costs.

HIV+HEP
POLICY INSTITUTE

February 24, 2025

The Honorable Brett Guthrie
Chair, House Energy and Commerce Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Re: Support for Pharmacy Benefit Manager (PBM) Reform

Chair Guthrie and Members of the House Energy and Commerce Health Subcommittee,

The HIV+Hepatitis Policy Institute is a leading national HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. As the Subcommittee examines how reining in pharmacy benefit managers (PBMs) will drive competition and lower costs for patients, we urge Congress to pass meaningful reforms that will ensure patient access to life-saving medications and address the harmful, profit-driven practices of PBMs.

For too long, pharmacy benefit managers have profited at the expense of patients living with chronic conditions. These middlemen, who now control 80% of prescription drug claims dictate, with little transparency or oversight, which medications insurers cover, how much patients pay and which administrative hoops patients and providers must jump through to access prescribed treatments.[i] PBMs exploit their dominant market position to extract profits at the expense of patients, particularly those managing chronic conditions such as cancer, diabetes, and HIV. Chronic conditions affect more than 130 million Americans and as of 2022, approximately 1.2 million people were living with HIV nationwide.[ii]

A troubling example of these exploitative practices is how PBMs manipulate medication list prices and rebates to maximize their own revenue. Since PBM revenue is directly tied to the list price of medicines, they earn more the higher the list price. These misaligned incentives sometimes lead to patients footing expensive bills tied to a cost higher than what their own health plan paid for a medication. This misalignment not only increases patient out-of-pocket costs but also increases the likelihood that patients will discontinue treatment, switch to less effective alternatives, or face serious health complications. A recent report from the Federal Trade Commission (FTC) underscores these concerns, revealing that PBMs have marked up the price of generic PrEP, a critical HIV prevention medication, by an astonishing 1000%, further illustrating how their profiteering directly undermines patient access to essential treatments.[iii]

To address these abuses, we strongly support the following PBM reforms and urge Congress to pass them now:

- **Full PBM Transparency:** Require disclosure of PBM business arrangements and financial incentives
- **Ban Spread Pricing:** Prohibit PBMs from charging more for drugs than they pay pharmacies
- **100% Pass-Through of Savings:** Ensure all rebates, discounts, fees, and other payments from drug manufacturers go directly to plan sponsors
- **De-Link PBM Profits from Drug Prices:** Prevent PBMs from profiting based on higher drug list prices

Beyond manipulating drug pricing, PBMs have devised and exploited schemes such as accumulator adjustment programs (AAPs), which systematically divert patient assistance funds away from those who need them most. In 2023, an estimated 49% of commercially insured beneficiaries were enrolled in plans with AAPs, nearly doubling from 28% in 2018. [iv] Rather than easing the financial burden on patients, PBMs and insurers absorbed approximately $5 billion in manufacturer assistance that year, effectively shifting costs onto patients. [v] Alarmingly, nearly half of all manufacturer-provided cost-sharing assistance was captured by PBMs, insurers, or third-party vendors, rather than directly benefiting patients as intended. [vi] These predatory practices hit the most vulnerable patients the hardest, making it even more difficult for them to afford the medications they rely on.

We also urge Congress to enact measures such as the bipartisan *Help Ensure Lower Patient (HELP) Copays Act*, which would require health plans to count patient assistance toward cost-sharing obligations, effectively prohibiting the use of AAPs in non-grandfathered commercial health plans. The bill builds on action taken by 22 states, DC, and Puerto Rico that have already passed AAP bans in their state-regulated markets.[vii]

Continued inaction on PBM reform will only exacerbate the financial and health challenges that millions of Americans face daily. Congress must act now to ensure that patients, not PBMs, are at the center of our health care system. We appreciate your leadership on this critical issue and urge the Subcommittee to advance comprehensive PBM reforms that restore fairness, transparency, and affordability to the prescription drug marketplace.

If you have any questions or need any additional information, please do not hesitate to reach out via phone at [redacted] or email at [redacted].

Sincerely,

Carl E. Schmid II
Executive Director

Cc: Members of the House Energy and Commerce Health Subcommittee

[i] https://www.ftc.gov/news-events/news/press-releases/2024/07/ftc-releases-interim-staff-report-prescription-drug-middlemen

[ii] https://www.cdc.gov/hiv-data/nhss/estimated-hiv-incidence-and-prevalence.html

[iii] https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf

[iv] Fein A. The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. *Drug Channels Institute,* March 2024.

[v] IQVIA. 2023 Update: Six Years of Deductible Accumulators and Copay Maximizers. 2024. https://www.iqvia.com/locations/united-states/blogs/2024/03/2023-update-six-years-of-deductible-accumulators-and-copay-maximizers

[vi] Fein A. The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers. *Drug Channels Institute,* March 2024.

[vii] Avalere. Cort Ruling Will Limit Accumulators. October 2023. https://avalere.com/insights/court-ruling-will-limit-accumulators

Division [X] — Health

TITLE I—MEDICAID

Sec. 101. Streamlined Enrollment Process for Eligible Out-Of-State Providers Under Medicaid and CHIP. For purposes of improving access to necessary out-of-state care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP), this section requires States to establish a process through which qualifying pediatric out-of-state providers may enroll as participating providers without undergoing additional screening requirements.

Sec. 102. Making Certain Adjustments to Coverage of Home or Community-Based Services Under Medicaid. This section authorizes a 3-year, 5-state demonstration program to authorize selected States to cover home and community-based services (HCBS) for individuals who need such services but do not meet the current-law requirement of having an "institutional level of care" under section 1915(c) of the Social Security Act. In addition, this section codifies State reporting requirements on waiting lists for HCBS and directs the Centers for Medicare and Medicaid Services (CMS) to issue guidance on interim plans of care for HCBS.

Sec. 103. Removing Certain Age Restrictions on Medicaid Eligibility for Working Adults with Disabilities. This section removes the current age limit of 65 from the Medicaid "Ticket to Work" eligibility groups, which allows States to cover working individuals with disabilities who, but for earned income, would be eligible for Medicaid.

Sec. 104. Medicaid State Plan Requirement for Determining Residency and Coverage for Military Families. This section allows active duty military service members and their dependents to retain their coverage of Medicaid HCBS services if the service member or their dependent is relocated to another State for their military service. This section also applies to the individual or dependent's place on a State's waitlist for HCBS.

Sec. 105. Ensuring the Reliability of Address Information Provided Under the Medicaid Program. This section requires States to establish processes to regularly obtain beneficiary address information from reliable data sources, including by requiring State Medicaid programs to collect address information provided by beneficiaries to managed care entities (where applicable).

Sec. 106. Codifying Certain Medicaid Provider Screening Requirements Related to Deceased Providers. This section codifies the requirement that State Medicaid programs check, as part of the provider enrollment and re-enrollment process and on a quarterly basis thereafter, whether providers are deceased through the Social Security Administration's Death Master File.

Sec. 107. Modifying Certain State Requirements for Ensuring Deceased Individuals Do Not Remain Enrolled. This section requires State Medicaid programs to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased.

Sec. 108. One-Year Delay of Medicaid and CHIP Requirements for Health Screenings, Referrals, and Case Management Services for Eligible Juveniles in Public Institutions; State Interim Work Plans. This section delays by 12 months CMS' enforcement of the requirements in Section 5121 of the Consolidated Appropriations Act, 2023 (P.L. 117-328, CAA, 2023) to require State Medicaid and CHIP programs to provide screenings, diagnostic services, and targeted case management services for eligible juveniles within 30 days of their scheduled date of release from a public institution following adjudication. This provision also clarifies that Section 5121 and Section 5122 of the CAA, 2023 do not require States to provide these services to individuals in Federal custody, including inmates in a Federal prison, and requires that States submit an interim work plan on their progress in meeting these requirements by June 1, 2025.

Sec. 109. State Studies and HHS Report on Costs of Providing Maternity, Labor, and Delivery Services. This section requires State Medicaid programs to conduct studies on the costs of providing maternity, labor, and delivery services in rural hospitals and hospitals that serve a high proportion of Medicaid beneficiaries, and submit a report detailing the results of this study to the Department of Health and Human Services (HHS).

Sec. 110. Modifying Certain Disproportionate Share Hospital Payment Allotments. This section eliminates the Medicaid Disproportionate Share Hospital (DSH) allotment reductions for FY 2025 and delays the effective date of the two remaining years of Medicaid DSH allotment reductions until January 1, 2027. This section also authorizes Tennessee to make Medicaid DSH payments until January 1, 2027 (Tennessee's DSH allotments would otherwise expire at the end of FY 2025).

Sec. 111. Modifying Certain Limitations on Disproportionate Share Hospital Payment Adjustments Under the Medicaid Program. For purposes of calculating the Medicaid hospital-specific DSH limit, this section alters the definition of Medicaid shortfall to include costs and payments for patients whose primary source of coverage is Medicaid and for patients who are dually eligible for Medicare and Medicaid.

Sec. 112. Ensuring Accurate Payments to Pharmacies Under Medicaid. This section requires participation by retail and applicable non-retail pharmacies in the National Average Drug Acquisition Cost (NADAC) survey. The NADAC survey measures pharmacy acquisition costs and is often used in the Medicaid program to inform reimbursement to pharmacies.

Sec. 113. Preventing the Use of Abusive Spread Pricing in Medicaid. This section bans "spread pricing" in the Medicaid program, which occurs when pharmacy benefit managers retain a portion of the amount paid to them (a "spread") for prescription drugs.

TITLE II—MEDICARE

Sec. 201. Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals. This section extends the Medicare low-volume hospital payment adjustment through December 31, 2025.

Sec. 202. Extension of the Medicare-Dependent Hospital (MDH) Program. This section extends the Medicare-dependent Hospital (MDH) program through December 31, 2025.

Sec. 203. Extension of Add-On Payments for Ambulance Services. This section extends Medicare ground ambulance add-on payments through December 31, 2026.

Sec. 204. Extending Incentive Payments for Participation in Eligible Alternative Payment Models. This section extends incentive payments for qualifying participants (QPs) in advanced alternative payment models (APMs) through payment year 2027 based on performance year 2025, at an adjusted amount of 3.53 percent, and extends QP eligibility thresholds in effect for performance year 2023 through payment year 2027.

Sec. 205. Temporary Payment Increase under the Medicare Physician Fee Schedule to Account for Exceptional Circumstances. This section adds a supplementary boost to the Medicare Physician Fee Schedule (PFS) conversion factor of 2.5 percent for 2025.

Sec. 206. Extension of Funding for Quality Measure Endorsement, Input, and Selection. This section provides $5 million in funding to the Centers for Medicare and Medicaid Services (CMS) for quality measure selection and to contract with a consensus-based entity to carry out duties related to quality measure endorsement, input, and selection activities through December 31, 2025.

Sec. 207. Extension of Funding Outreach and Assistance for Low-Income Programs. This section provides $100 million for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and a contract with an entity to inform older Americans about benefits available under Federal and State programs through December 31, 2026.

Sec. 208. Extension of the Work Geographic Index Floor. This section extends the 1.0 work geographic practice cost index (GPCI) floor used in the calculation of payments under the Medicare physician fee schedule through December 31, 2025.

Sec. 209. Extension of Certain Telehealth Flexibilities. This section extends Medicare telehealth flexibilities that were extended in the Consolidated Appropriations Act, 2023, through December 31, 2026, establishes a special payment rule for telehealth services provided by Federally Qualified Health Centers and Rural Health Clinics, and imposes certain modifiers on telehealth services furnished incident to other services and telehealth visits furnished via contracts with certain virtual platforms.

Sec. 210. Requiring Modifier for Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care. This section instructs CMS to create a new Medicare claims form modifier in order to track when a hospice face-to-face recertification encounter occurs through telehealth.

Sec. 211. Extending Acute Hospital Care at Home Waiver Flexibilities. This section extends the Acute Hospital Care at Home initiative, as currently authorized under CMS waivers and flexibilities, through December 31, 2029. This section also establishes the parameters for a new interim study and report on the Acute Hospital Care at Home initiative and officially names the initiative after Senators Thomas R. Carper and Tim Scott as well as Representatives Brad R. Wenstrup, D.P.M. and Earl Blumenauer in recognition of their leadership.

Sec. 212. Enhancing Certain Program Integrity Requirements for DME Under Medicare. This section enacts certain oversight measures aimed at improving program integrity, such as with respect to aberrant billing practices and sources of waste, fraud, and abuse. This section also orders the Inspector General of the Department of Health and Human Services to conduct a study examining clinical lab tests at high risk of fraud.

Sec. 213. Guidance on Furnishing Services via Telehealth to Individuals with Limited English Proficiency. This section enacts the SPEAK Act, facilitating guidance and access to best practices on providing telehealth services accessibly.

Sec. 214. In-Home Cardiopulmonary Rehabilitation Flexibilities. This section would allow cardiopulmonary rehabilitation services to be furnished via telehealth at a beneficiary's home under Medicare in 2025 and 2026.

Sec. 215. Inclusion of Virtual Diabetes Prevention Program Suppliers in MDPP Expanded Model. This section expands participation in the Medicare Diabetes Prevention Program (MDPP) Expanded Model to virtual until 2030 and allows beneficiaries to participate virtually and in-person.

Sec. 216. Medication-Induced Movement Disorder Outreach and Education. This section directs HHS to conduct outreach and education to relevant providers on screening for medication-induced movement disorders among at-risk beneficiaries via telehealth.

Sec. 217. Report on Wearable Medical Devices. This section directs GAO to conduct a technology assessment and issue a report on wearable medical devices.

Sec. 218. Extension of Temporary Inclusion of Authorized Oral Antiviral Drugs as Covered Part D Drugs. This section extends Medicare Part D coverage of certain oral antiviral drugs through December 31, 2025.

Sec. 219. Extension of Adjustment to Calculation of Hospice Cap Amount. This section extends, for one additional year, the change to the annual updates to the hospice aggregate cap. Specifically, this section applies the hospice payment update percentage, rather than the medical expenditure component of the Consumer Price Index for Urban Consumers (CPI–U), to the hospice aggregate cap through FY 2034.

Sec. 220. Multiyear Contracting Authority for MedPAC and MACPAC. This section grants the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) the authority to enter into multiyear contracts, consistent with authorities granted to other legislative branch agencies.

Sec. 221. Contracting Parity for MedPAC and MACPAC. This section simplifies the process for MedPAC or MACPAC to enter into contracts for goods and services that include indemnification and governing law clauses, consistent with authorities granted to the Congressional Budget Office and other legislative branch agencies.

Sec. 222. Adjustment to Medicare Part D Cost-Sharing Reductions for Low-Income Individuals. This section prohibits cost sharing for generic drugs for Part D beneficiaries who are eligible for the low-income subsidy.

Sec. 223. Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act. This section requires Medicare Advantage plans to maintain accurate provider directories on a public website beginning in plan year (PY) 2027. Additionally, this section requires plans to report on the accuracy of their directories and provide cost-sharing protections.

Sec. 224. Medicare Coverage of Multi-Cancer Early Detection Screen Tests. This section adds multi-cancer early detection (MCED) screening tests as a covered benefit under the Medicare program, effective January 1, 2029, subject to certain parameters.

Sec. 225. Medicare Coverage of External Infusion Pumps and Non-Self-Administrable Home Infusion Drugs. This section would codify the Joe Fiandra Access to Home Infusion Act, enabling beneficiaries to receive certain infusion treatments in the home under Medicare.

Sec. 226. Assuring Pharmacy Access and Choice for Medicare Beneficiaries. This section codifies existing requirements that plan sponsors contract with any willing pharmacy that meets their standard contract terms and conditions, which must be reasonable and relevant.

Sec. 227. Modernizing and Ensuring PBM Accountability. This section:

- Prohibits PBMs and their affiliates from deriving remuneration for covered Part D drugs based on the price of a drug;
- Requires PBMs to define and apply drug and drug pricing terms in contracts with Part D plan sponsors transparently and consistently;
- Sets out annual requirements for PBMs to report on drug price and other information to Part D plan sponsor clients; and
- Empowers Part D plan sponsors with new audit rights with respect to PBMs.

Sec. 228. Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department of a Provider. This section requires each off-campus outpatient department of a hospital to obtain and bill for services under a unique national provider identifier, subject to HHS Office of the Inspector General (OIG) compliance review.

Sec. 229. Medicare Sequestration. This section extends current law mandatory 2 percent Medicare payment reductions under sequestration for the last 4 months of FY 2032 and the first 2 months of FY 2033.

Sec. 230. Medicare Improvement Fund. This section reduces the amount of funding in the Medicare Improvement Fund from $3.197 billion to $1.8915 billion.

Title III—HUMAN SERVICES

Subtitle A—Reauthorize Child Welfare Services and Strengthen State and Tribal Child Support Program

Part 1 reauthorizes discretionary funding under Subparts 1 and 2 of Title IV-B of the Social Security Act, and provides mandatory funding for Subpart 2 at the current funding level for FY 2025 and at $420 million for FY 2026 through FY 2029. A detailed section-by-section of the child welfare reauthorization provisions contained within this Part may be found at the House Ways and Means Committee's website.

Part 2 modifies Section 6103 of the Internal Revenue Code and Section 464 of the Social Security Act to allow the Secretary of the Treasury to disclose appropriate tax information to Tribal and local child support agencies, as they do States, and to require those entities to keep information confidential. The Part also allows State and Tribal child support agencies to confidentiality redisclose the information to agents under contract for purposes of collecting child support. The part also allows Tribal child support programs to seek federal reimbursement for related administrative costs.

Subtitle B—Other Matters

Sec. 341. Sexual Risk Avoidance Education Extension. This section extends the Sexual Risk Avoidance Education (SRAE) program under Title V of the Social Security Act through December 31, 2025.

Sec. 342. Personal Responsibility Education Extension. This section extends the Personal Responsibility Education Program (PREP) under Title V of the Social Security Act through December 31, 2025.

Sec. 343. Extension of Funding for Family-to-Family Health Information Centers. This section extends the Family-to-Family Health Information Centers Program under Title V of the Social Security Act through December 31, 2025.

TITLE IV—PUBLIC HEALTH EXTENDERS

Subtitle A—Extensions

Sec. 401. Extension for Community Health Centers, National Health Service Corps, and Teaching Health Centers That Operate GME Programs. This section reauthorizes the Community Health Center Fund and the National Health Service Corps through FY 2026 and reauthorizes the Teaching Health Center Graduate Medical Education program through FY 2029.

Sec. 402. Extension of Special Diabetes Programs. This section reauthorizes the Special Diabetes Program for Type I Diabetes and the Special Diabetes Program for Indians through FY 2026.

Subtitle B—World Trade Center Health Program

Sec. 411. 9/11 Responder and Survivor Health Funding Corrections. This section updates the funding formula for the World Trade Center Health Program for FY 2026 through 2040, and requires a report to Congress from the Secretary of HHS that assesses the anticipated budgetary needs of the Program.

TITLE V—SUPPORT ACT REAUTHORIZATION

Sec. 501. Short Title. This title may be cited as the "SUPPORT for Patients and Communities Reauthorization Act of 2024."

Subtitle A—Prevention

Sec. 511. Prenatal and Postnatal Health. This section reauthorizes section 317L of the Public Health Service Act for FY 2025 through 2029 to continue activities to address neonatal abstinence syndrome and prenatal substance use and misuse, as well as to continue efforts to understand the outcomes of treating opioid use disorder during pregnancy.

Sec. 512. Monitoring and Education Regarding Infections Associated with Illicit Drug Use and Other Risk Factors. This section reauthorizes section 317N of the Public Health Service Act for FY 2025 through 2029 to continue efforts to prevent and respond to infections commonly associated with illicit drug use.

Sec. 513. Preventing Overdoses of Controlled Substances. This section reauthorizes section 392A of the Public Health Service Act for FY 2025 through 2029 to continue support for State efforts to enhance overdose data collection and improve prescription drug monitoring programs (PDMP), including other innovative, evidence-based projects, such as wastewater surveillance.

Sec. 514. Support for Individuals and Families Impacted by Fetal Alcohol Spectrum Disorder. This section reauthorizes federal fetal alcohol spectrum disorders programs under the Department of Health and Human Services (HHS) that support prevention, identification, intervention, and research for FY 2025 through 2029.

Sec. 515. Promoting State Choice in PDMP Systems. This section clarifies that HHS cannot require States to use a specific vendor or interoperability connection in PDMP systems.

Sec. 516. First Responder Training Program. This section reauthorizes section 546 of the Public Health Service Act for FY 2025 through 2029. This program helps support first responders and other key community members to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

Sec. 517. Donald J. Cohen National Child Traumatic Stress Initiative. This section reauthorizes section 582 of the Public Health Service Act for FY 2025 through 2029. This program supports training initiatives focused on mental, behavioral, and biological aspects of psychological trauma response, prevention of long-term consequences of child trauma, and early intervention services to address long-term impacts of child trauma.

Sec. 518. Protecting Suicide Prevention Lifeline from Cybersecurity Incidents. This section requires internal coordination within HHS and improved reporting mechanisms to protect the 9-8-8 Suicide & Crisis Lifeline from cybersecurity incidents. This also requires a study of cybersecurity vulnerabilities of the Lifeline to be sent to Congress.

Sec. 519. Bruce's Law. This section allows HHS to develop a public education and awareness campaign focused on drug overdose prevention, detection of early warning signs of addiction among youth, and dangers of drugs that could be contaminated with fentanyl. In addition, this section allows the Secretary of HHS to begin a Federal Interagency Working Group on Fentanyl Contamination of illegal drugs within an existing interdepartmental coordination group.

Sec. 520. Guidance on At-Home Drug Disposal Systems. This section directs the Food and Drug Administration (FDA), in consultation with the Drug Enforcement Administration (DEA), to issue guidance on how at-home drug disposal systems should meet relevant requirements and include recommendations regarding the use of such systems.

Sec. 521. Assessment of Opioid Drugs and Actions. This section requires the Secretary of HHS to publish a report outlining a plan for assessing approved opioid analgesic drugs. This section requires that HHS provide an opportunity for public input on the public health effects of opioid analgesic drugs as part of the FDA's existing benefit-risk assessment framework.

Sec. 522. Grant Program for State and Tribal Response to Opioid Use Disorders. This section clarifies that the Substance Abuse and Mental Health Services Administration's (SAMHSA's) State and Tribal opioid response grants may be used for fentanyl or xylazine test strips in States where they are legal.

Subtitle B—Treatment

Sec. 531. Residential Treatment Program for Pregnant and Postpartum Women. This section reauthorizes section 508 of the Public Health Service Act through FY 2029. This program helps support residential treatment recovery services for pregnant and postpartum women with substance use disorder.

Sec. 532. Improving Access to Addiction Medicine Providers. This section adds addiction medicine specialists to the covered fields under the Minority Fellowship Program.

Sec. 533. Mental and Behavioral Health Education and Training Grants. This section reauthorizes section 756 of the Public Health Service Act through FY 2029. This program helps recruit and educate students to pursue careers in the fields of behavioral and mental health, including substance use disorder treatment.

Sec. 534. Loan Repayment Program for Substance Use Disorder Treatment Workforce. This section reauthorizes section 781 of the Public Health Service Act through FY 2029. This program, known as the STAR Loan Repayment Program, helps recruit and retain substance use disorder professionals.

Sec. 535. Development and Dissemination of Model Training Programs for Substance Use Disorder Patient Records. This section strikes the authorization of appropriations for this program.

Sec. 536. Task Force on Best Practices for Trauma-Informed Identification, Referral, and Support. This section extends the authority for section 7132 of the SUPPORT Act, known as the Interagency Task Force on Trauma-Informed Care, to identify, evaluate, and make recommendations on best practices with respect to children and youth who may experience trauma.

Sec. 537. Grants to Enhance Access to Substance Use Disorder Treatment. This section strikes the authorization of appropriations for this program.

Sec. 538. State Guidance Related to Individuals with Serious Mental Illness and Children with Serious Emotional Disturbance. This section requires SAMHSA to review State uses of funding for activities to identify and address early serious mental illness and children with a serious emotional disturbance under the Community Mental Health Services Block Grant program. This also requires the Secretary to publish a report to Congress and update related guidance to States based on its findings to improve the quality of care provided through Block Grant funds.

Sec. 539. Reviewing the Scheduling of Approved Products Containing a Combination of Buprenorphine and Naloxone. This section requires the Secretary of HHS and the DEA to review the scheduling of buprenorphine-naloxone combination products under the Controlled Substances Act.

Subtitle C—Recovery

Sec. 541. Building Communities of Recovery. This section reauthorizes section 547 of the Public Health Service Act through FY 2029. This program helps support recovery community organizations to develop, expand, and enhance recovery services.

Sec. 542. Peer Support Technical Assistance Center. This section reauthorizes the National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support, which supports recovery community organizations and peer support networks that provide substance use disorder peer support services. Additionally, this pilots a regional approach to providing this technical assistance.

Sec. 543. Comprehensive Opioid Recovery Centers. This section reauthorizes section 552 of the Public Health Service Act through FY 2029. This program supports the operation of comprehensive opioid recovery centers that provide a full spectrum of treatment and recovery support services for individuals with substance use disorder.

Sec. 544. Youth Prevention and Recovery. This section reauthorizes section 7102 of the SUPPORT Act through FY 2029. This program provides support for prevention, treatment, and recovery for children, adolescents, and young adults suffering from substance use disorder.

Sec. 545. CAREER Act. This section reauthorizes grants for substance use disorder treatment programs that help individuals in recovery re-enter the workforce, including support for recovery housing.

Sec. 546. Addressing Economic and Workforce Impacts of the Opioid Crisis. This section reauthorizes section 8041 of the SUPPORT Act for FY 2025 through 2029 to continue resources to address various economic impacts associated with a high rate of substance use disorder in a given area.

Subtitle D—Miscellaneous Matters

Sec. 551. Delivery of a Controlled Substance by a Pharmacy to a Prescribing Practitioner. This section clarifies that pharmacies may deliver a Schedule III, IV, or V controlled substance to an administering practitioner if the product is administered intranasally with post-administration monitoring.

Sec. 552. Technical Correction on Controlled Substances Dispensing. This section corrects a technical issue where a section was misplaced in the Consolidated Appropriations Act, 2023.

Sec. 553. Required Training for Prescribers of Controlled Substances. This section makes technical changes to training requirements for prescribers of opioids by including additional professional societies and accrediting bodies.

Sec. 554. Extension of Temporary Order for Fentanyl-related Substances. This section extends the temporary scheduling of all fentanyl-related substances through FY 2026.

TITLE VI—PANDEMIC AND ALL-HAZARDS PREPAREDNESS AND RESPONSE

Sec. 601. Short Title. This title may be cited as the "Pandemic and All-Hazards Preparedness and Response Act."

Subtitle A—State and Local Readiness and Response

Sec. 611. Temporary Reassignment of State and Local Personnel During a Public Health Emergency. This section updates existing authority to allow State and Tribal Health Officials to request temporary assistance for emergency responses through calendar year (CY) 2026.

Sec. 612. Public Health Emergency Preparedness Program. This section reauthorizes and makes improvements to the Public Health Emergency Preparedness cooperative agreement through CY 2026.

Sec. 613. Hospital Preparedness Program. This section reauthorizes the Hospital Preparedness Program cooperative agreement through CY 2026, and improves the coordination of day-to-day and surge regional medical operations within and among health care coalitions.

Sec. 614. Facilities and Capacities of the Centers for Disease Control and Prevention to Combat Public Health Security Threats. This section reauthorizes authorizations of appropriations for facilities, detection, and situational awareness capabilities through CY 2026.

Sec. 615. Pilot Program to Support State Medical Stockpiles. This section reauthorizes and makes improvements to the state medical stockpile pilot program administered by the Office of the Assistant Secretary for Preparedness and Response (ASPR) through FY 2026.

Sec. 616. Enhancing Domestic Wastewater Surveillance for Pathogen Detection. This section codifies activities to detect the circulation of infectious diseases through wastewater

testing through CY 2026, and directs the Secretary of HHS to continue to support research to improve these activities in the future.

Sec. 617. Reauthorization of Mosquito Abatement for Safety and Health Program. This section reauthorizes the Mosquito Abatement for Safety and Health program through CY 2026, and directs the Secretary of HHS to consider the use of innovative and novel technology for mosquito control.

Subtitle B—Federal Planning and Coordination

Sec. 621. All-Hazards Emergency Preparedness and Response. This section codifies the Assistant Secretary for Preparedness and Response's role in leading the development of requirements for countermeasures and amends existing language to clarify that planning for medical product and supply needs during a response includes raw materials and critical components. This section makes changes to current law related to the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Multi-Year Budget and Strategy and Implementation Plan.

Sec. 622. National Health Security Strategy. This section updates the National Health Security Strategy to improve preparedness related to medical readiness, settings that pose an increased risk for the transmission of infectious diseases during a public health emergency, natural disasters, and cybersecurity.

Sec. 623. Improving Development and Distribution of Diagnostic Tests. This section requires the Secretary of HHS to develop a strategic plan to support domestic capacity and capabilities related to diagnostic testing to improve future responses.

Sec. 624. Combating Antimicrobial Resistance. This section updates current law to account for the current activities of the Combating Antibiotic-Resistant Bacteria Task Force and the President's Advisory Council on Combating Antibiotic-Resistant Bacteria and codifies the related National Action Plan.

Sec. 625. Strategic National Stockpile and Material Threats. This section updates the Annual Threat-Based Review for the Strategic National Stockpile (SNS) and amends procedures for administering the Stockpile to ensure that the Secretary is utilizing best practices and processes, including deployment and distribution tools, as well as appropriate communication regarding contract changes. Additionally, this section reauthorizes the SNS through FY 2026 and Project BioShield through FY 2034.

Sec. 626. Medical Countermeasures for Viral Threats with Pandemic Potential. This section encourages the Biomedical Advanced Research and Development Authority (BARDA) to prepare for "Disease X" by supporting innovative medical countermeasures to address priority virus families with significant pandemic potential, and ensures appropriate communication and notification regarding contract changes. Additionally, this section reauthorizes BARDA through FY 2026.

Sec. 627. Public Health Emergency Medical Countermeasures Enterprise. This section requires that the Secretary share information with stakeholders related to recommendations made and strategies developed by the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) and strengthens consultation between PHEMCE and public health officials.

Sec. 628. Fellowship and Training Programs. This section allows the Secretary of HHS to convert individuals who complete an epidemiology, surveillance, or laboratory fellowship or training program to a career-conditional appointment following completion of their fellowships.

Sec. 629. Regional Biocontainment Research Laboratories. This section codifies the Regional Biocontainment Laboratories to support preparedness and provide surge capacity for responding to biological agents, through CY 2026.

Sec. 629A. Limitation Related to Countries of Concern Conducting Certain Research. This section updates language from the PREVENT Pandemics Act (Public Law 117-328, Division FF, Title II) to extend the moratorium through CY 2026 related to funding research involving certain pathogens in countries of concern.

Subtitle C—Addressing the Needs of All Individuals

Sec. 631. Improving Access to Certain Programs. This section updates a program that provides compensation associated with medical products.

Sec. 632. Supporting At-Risk Individuals During Emergency Responses. This section directs the Secretary of HHS to provide technical assistance to assist localities with planning for the needs of older adults, individuals with disabilities, pregnant women, and children during a public health emergency. This section also requires the Secretary to issue guidance to States and localities related to the development of crisis standards of care for use during a public health emergency or major disaster.

Sec. 633. National Advisory Committees. This section extends three National Advisory Committees that provide advice to the federal government on preparedness and response planning related to children, seniors, and individuals with disabilities, and makes changes to the composition of the Committees.

Sec. 634. National Academies Study on Prizes. This section directs the National Academies to study alternative models and strategies to promote drug development in comparison to current practices in the United States.

Subtitle D—Additional Reauthorizations

Sec. 641. Medical Countermeasure Priority Review Voucher. This section reauthorizes through CY 2026.

Sec. 642. Epidemic Intelligence Service. This section reauthorizes through CY 2026.

Sec. 643. Monitoring and Distribution of Certain Medical Countermeasures. This section reauthorizes through CY 2026.

Sec. 644. Regional Health Care Emergency Preparedness and Response Systems. This section reauthorizes through CY 2026.

Sec. 645. Emergency System for Advance Registration of Volunteer Health Professional. This section reauthorizes through CY 2026.

Sec. 646. Ensuring Collaboration and Coordination in Medical Countermeasure Development. This section reauthorizes through CY 2026.

Sec. 647. Military and Civilian Partnership for Trauma Readiness. This section reauthorizes through CY 2026.

Sec. 648. National Disaster Medical System. This section reauthorizes through CY 2026.

Sec. 649. Volunteer Medical Reserve Corps. This section reauthorizes through CY 2026.

Sec. 649A. Epidemiology-Laboratory Capacity. This section reauthorizes through CY 2026.

TITLE VII—PUBLIC HEALTH PROGRAMS

Sec. 701. Action for Dental Health. This section reauthorizes grants for innovative dental workforce programs at the Health Resources and Services Administration (HRSA) through FY 2029.

Sec. 702. PREEMIE. This section reauthorizes public health and prevention activities related to preterm birth through FY 2029. Additionally, this directs the Secretary of HHS to establish a working group to coordinate federal activities related to preterm birth, infant mortality, and other adverse birth outcomes. Lastly, it directs the National Academies of Sciences, Engineering, and Medicine (NASEM) to conduct a study and issue a report on the costs of preterm birth and the factors and gaps in public health programs that contribute to preterm birth.

Sec. 703. Preventing Maternal Deaths. This section reauthorizes support for State-based maternal mortality review committees through FY 2029. Additionally, this section directs HHS to disseminate best practices on maternal mortality prevention to hospitals, State-based professional societies, and perinatal quality collaboratives.

Sec. 704. Sickle Cell Disease Prevention and Treatment. This section reauthorizes through FY 2029 and otherwise modifies a program related to improving the treatment of sickle cell disease and the prevention and treatment of complications from the disease in populations with a high proportion of individuals with sickle cell disease.

Sec. 705. Traumatic Brain Injuries. This section reauthorizes the Centers for Disease Control and Prevention's (CDC) traumatic brain injury (TBI) program through FY 2029, and names the program in honor of the late Representative Bill Pascrell, Jr. Additionally, it emphasizes identifying and addressing the needs of populations at higher risk for TBI and causes, and risk factors for, TBI. This section also reauthorizes competitive awards administered by the Administration for Community Living for projects to improve access to rehabilitation and other TBI services. Additionally, it directs the State Advisory Boards for such projects to take into consideration populations that may be at higher risk for TBI. Furthermore, it requires a report to Congress that provides an overview of populations who may be at higher risk for TBI, an outline of existing CDC surveys and activities on TBIs and any steps the agency has taken to address gaps related to the populations identified, as well as an overview of any outreach or education efforts to reach populations who may be at higher risk. Lastly, it directs the Secretary to conduct a study, or enter into a contract to conduct such study, to examine the long-term symptoms or conditions related to TBI, and identify any gaps in such research.

Sec. 706. Lifespan Respite Care. This section reauthorizes the Lifespan Respite Care program through FY 2029 and clarifies the definition of "family caregiver" to include individuals under age 18.

Sec. 707. Dr. Lorna Breen Health Care Provider Protection. This section updates a requirement for the Secretary of HHS to release best practices for suicide prevention and improving mental health and resiliency among health care professionals. This section also reauthorizes an education and awareness initiative to promote the use of mental health and substance use services by health care providers through FY 2029. This section also reauthorizes through FY 2029 grant programs to promote mental health within the health care workforce by improving awareness of and access to mental health services and training.

Sec. 708. Gabriella Miller Kids First Research. This section reauthorizes the Pediatric Research Initiative through FY 2031. This section also directs the National Institutes of Health (NIH) to coordinate pediatric research and prioritize such research that does not duplicate already existing research activities. Furthermore, this section requires the Secretary of HHS to submit a report to Congress on the pediatric research projects receiving funding through the program and a summary of the advancements made in pediatric research with such funds.

Sec. 709. SCREENS for Cancer. This section reauthorizes and makes improvements to the program through FY 2029. This section also directs the Comptroller General to conduct a study on the program and provide an estimate on the number of individuals eligible for the program and a summary of the trends of the number of individuals served.

Sec. 710. DeOndra Dixon INCLUDE Project. This section directs the Director of the NIH to carry out a program of research, training, and investigation related to Down syndrome.

Sec. 711. IMPROVE Initiative. This section directs the Director of the NIH to carry out a research program focused on reducing maternal mortality and morbidity, as well as improving health outcomes for pregnant and postpartum women.

Sec. 712. Organ Procurement and Transplantation Network. This section authorizes the Secretary of HHS to collect registration fees from any member of the Organ Procurement and Transplantation Network (OPTN) for each transplant candidate such member places on the list and to distribute these fees to support the operation of the OPTN.

Sec. 713. Honor Our Living Donors (HOLD). This section amends current law to prohibit the consideration of the organ recipient's income when determining whether a living donor is eligible for qualified reimbursements for living organ donation. This section also removes language that indicates an organ recipient's ability to pay for a donor's expenses cannot be a factor in considering a donor's eligibility for reimbursement, and requires an annual report to Congress to examine the sufficiency of funding of this program.

Sec. 714. Program for Pediatric Studies of Drugs. This section makes a technical correction to the existing authorization of appropriations for the NIH to fund studies of drugs in children.

Title VIII — FOOD AND DRUG ADMINISTRATION

Subtitle A—Give Kids A Chance

Sec. 801. Research into Pediatric Uses of Drugs; Additional Authorities of Food and Drug Administration regarding Molecularly Targeted Cancer Drugs. This section provides the FDA the authority to require pediatric cancer trials for new drugs that are used in combination with active ingredients that meet the standard of care for targeting pediatric cancer or have been approved to treat adult cancer and are directed at molecular targets for pediatric cancer.

Sec. 802. Ensuring Completion of Pediatric Study Requirements. This section provides the FDA additional authority to enforce against companies that fail to meet pediatric study requirements. The Secretary of the Department of HHS shall perform due diligence before concluding failure to meet requirements.

Sec. 803. FDA Report on PREA Enforcement. This section requires the FDA to report on enforcement of the Pediatric Research Equity Act (PREA).

Sec. 804. Extension of Authority to Issue Priority Review Vouchers to Encourage Treatments for Rare Pediatric Diseases. This section extends the FDA priority review voucher (PRV) program through FY 2029, to incentivize the development of drugs for rare pediatric diseases. It also requires a study from the GAO on the effectiveness of the pediatric PRV program.

Sec. 805. Limitations on Exclusive Approval or Licensure of Orphan Drugs. This section clarifies that orphan drug exclusivity applies to the approved indication, rather than the potentially broader designation.

Subtitle B—United States-Abraham Accords Cooperation and Security

Sec. 811. Establishment of Abraham Accords Office Within Food and Drug Administration. This section requires the FDA to establish an office in an Abraham Accords country to enhance facilitation with the agency and require the Secretary of HHS to submit a report to Congress 3 years after the date of enactment of this Act to evaluate the office's progress.

Title IX — LOWERING PRESCRIPTION DRUG COSTS

Sec. 901. Oversight of Pharmacy Benefit Management Services. This section promotes price transparency for prescription drugs purchased by employer health plans by ensuring Pharmacy Benefit Managers (PBMs) provide group health plans and issuers with detailed data on prescription drug spending at least semi-annually. Such data includes gross and net drug spending, drug rebates, spread pricing arrangements, formulary placement rationale, and information about benefit designs that encourage the use of pharmacies affiliated with PBMs. The section also ensures that health plans and individuals can receive a summary document regarding information about the plan's prescription drug spending.

Sec. 902. Full Rebate Pass Through to Plan; Exception or Innocent Plan Fiduciaries. This section requires that PBMs fully pass through 100 percent of drug rebates and discounts, excluding bona fide service fees, to the employer or health plan regulated under the Employee Retirement Income Security Act of 1974 (ERISA) for new contracts, extensions, or renewals entered into for plan years beginning 30 months after the date of enactment. This section also clarifies the meaning of "covered service provider" under ERISA.

Sec. 903. Increasing Transparency in Generic Drug Applications. This section requires FDA to disclose to certain new generic drug applicants what ingredients, if any, cause a drug to be quantitatively or qualitatively different from the listed drug for purposes of establishing sameness in formulation, and the specific amount of the difference.

Sec. 904. Title 35 amendments. This section curbs so-called "patent thickets" by limiting, in certain instances, the number of patents that a reference biological product manufacturer can assert in a patent infringement lawsuit against a company seeking to sell a biosimilar version.

TITLE X—MISCELLANEOUS

Sec. 1001. Two-year Extension of Safe Harbor for Absence of Deductible for Telehealth. This section extends through CY 2026 the flexibility to exempt telehealth services from the deductible in high-deductible health plans (HDHPs) that can be paired with a Health Savings Account (HSA).

What Can House Republicans Cut Instead of Medicaid? Not Much.

The math of the G.O.P.'s goals makes the move almost unavoidable.


By Margot Sanger-Katz and Alicia Parlapiano
Reporting from Washington

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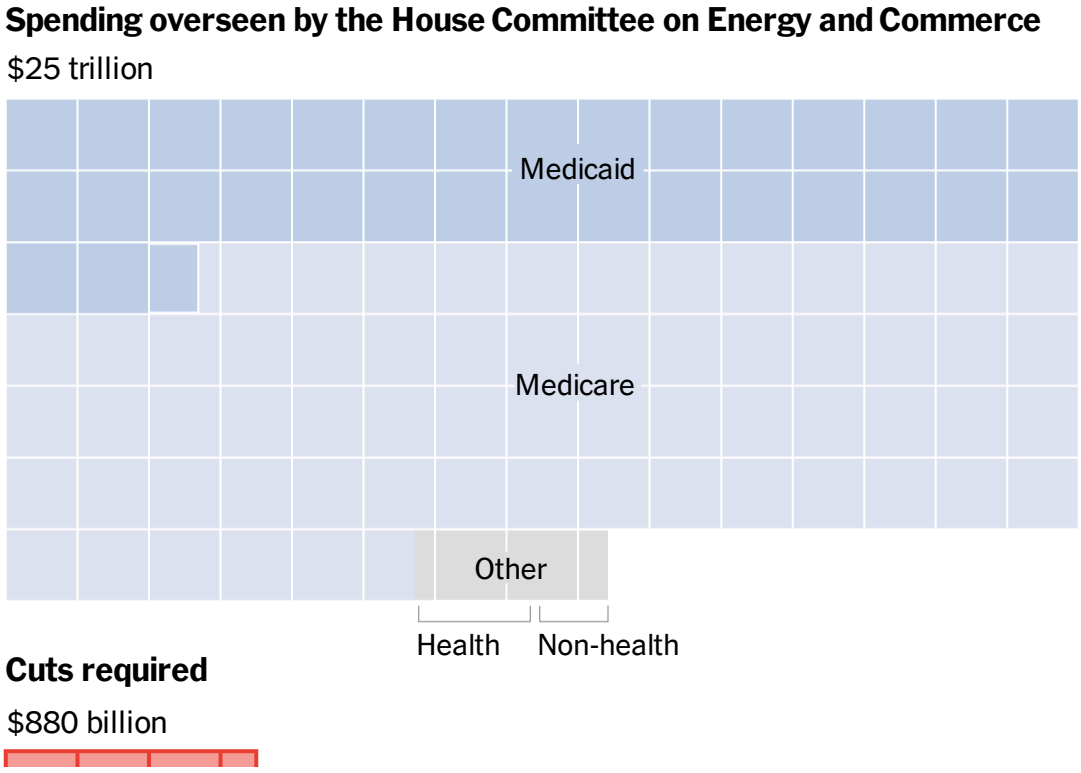
The House passed a budget resolution Tuesday night after Speaker Mike Johnson persuaded several Republican lawmakers, including those who have expressed reservations about possible Medicaid cuts, to support the bill.

In theory, the budget, which kicks off the process of passing an extension of tax cuts enacted in 2017 and up to $2 trillion in spending cuts meant to partly offset them, could become law without significant cuts to Medicaid. But it won't be easy.



Each square represents $250 billion in 10-year gross mandatory spending. • By The New York Times

That process has a few more steps: For one, the Senate has to adopt this budget resolution. Then both houses of Congress will also need to write and pass legislation that follows its instructions.

The budget resolution itself is silent on whether Congress cuts Medicaid, which provides health coverage to 72 million poor and disabled Americans. But it instructs the House Energy and Commerce Committee, which has jurisdiction over the program, to cut spending by $880 billion over the next decade. If the committee can't save at least that much, the entire effort could be imperiled because of the special process Congress is using to avoid a Senate filibuster. Ten other committees have their own instructions to follow, though none have been assigned with cutting nearly as much.

It's not so simple as finding the cuts elsewhere. The special process, known as budget reconciliation, means Republicans will have to find all $880 billion from within the Energy and Commerce Committee's jurisdiction. That leaves them with fewer options than one might think.

Below, a list of those options. (These numbers are not exact; they are informal or outdated estimates. Before a reconciliation bill passes, they would all get an official evaluation from the Congressional Budget Office, Congress's scorekeeper.)

Option 1: Cut Medicare instead

If Republicans want to avoid major cuts to Medicaid, the largest pot of available money is in the other big government health insurance program: Medicare.

But Republicans face an even tighter political bind when it comes to Medicare than they do with Medicaid. President Trump has said repeatedly that he does not wish to cut Medicare. And most House Republicans have made a similar pledge.

"Social Security and Medicare is off the books now," President Joseph R. Biden Jr. said during last year's State of the Union address, drawing a standing ovation from nearly every Republican present.

Mr. Trump said last week in a Fox News interview that Medicaid wouldn't be "touched" either. But his record shows he has been much more open to Medicaid cuts than to Medicare reductions.

Option 2: Cut everything else the committee oversees

Even if the committee cuts everything that's not health care to $0, it will still be more than $600 billion short.

The committee could also save around $200 billion by eliminating the Children's Health Insurance Program, but that option has not been raised by the budget committee or anyone in House leadership.

Option 3: Consider options that aren't exactly cuts, even if they don't add up to $880 billion

There are some creative options that would allow the committee to find budget savings without having to cut spending it oversees. A document circulated earlier this year by the budget committee included a few such ideas.

- **Overturn regulations that require carmakers to raise fuel efficiency standards and reduce automobile emissions (~$110 billion).** Repealing this rule would save the government money without making direct budget cuts by reducing spending on tax credits for people who buy electric cars and increasing gas tax revenue.
- **Auction portions of the airwaves to telecommunications companies (~$70 billion).** The committee periodically passes legislation to sell the rights to transmit signals over specific bands of the electromagnetic spectrum, but the Defense Department tends to object to selling too much.
- **Speed up permitting for energy extraction (~$7 billion).**

Some of these options might run afoul of the special budget process rules. A staff member for the Senate, known as the parliamentarian, would have to rule on their suitability if the final legislation comes up for a vote there.

Option 4: Cut Medicaid after all

Even if all of these cuts, revenues and rule cancellations from outside health care can pass muster, the committee will still be left with hundreds of billions of dollars to cut to hit its goal. Mathematically, the budget committee's instructions mean the committee would need to make major cuts to either Medicare, Medicaid or both.

Congressional leadership has been signaling that Medicaid has been the main focus.

"$880 billion is a lot of money, and even if only $600 billion is coming from health care, you have to go beyond tiny tinkering on the margins," said Marc Goldwein, a senior policy director at the Committee for a Responsible Federal Budget, a group that supports deficit reduction.

And several experts advising the committee say Medicaid policy changes are wise. "There's more than enough in wasteful, inappropriate spending to get meaningful savings from the program," said Brian Blase, the president of the right-leaning Paragon Health Institute, who was a White House economics official in the first Trump administration.

Some leading options for Medicaid cuts are below. The first few may be less politically fraught for vulnerable lawmakers, but would save less money. The last two would save more, but would have a much larger impact on the program as a result.

(Because of the way various Medicaid policies intersect with one another, it's best not to add them together. Adopting all of them will reduce spending by less than the sum of each pursued alone.)

- **Establish a national work requirement for adults without disabilities and without young children (~$100 billion).** Many Republicans, even the ones who are worried about the politics of Medicaid cuts, are comfortable with this approach. But that change is estimated to save only around $100 billion.
- **Reverse a Biden-era policy that limits how often states can check the eligibility of beneficiaries (~$160 billion).** The change would allow states to check people's incomes more often and require them to fill out more paperwork to stay enrolled.
- **Limit the ability of states to tax hospitals to help pay their share of Medicaid bills (~$175 billion).** This would squeeze state budgets, and has been often described as reducing abuse of the program. Because of the formulas used to fund Medicaid, these taxes result in higher medical bills to the state — and thus more funding from the federal government.
- **Squeeze the share of government spending on working-class adults who were part of the program's expansion under the Affordable Care Act (~$560 billion).** This would save hundreds of billions by paying less in the 41 states that have expanded Medicaid under Obamacare but would do so by abruptly reducing federal funding for the program. Some states would probably immediately eliminate their Medicaid expansions, leading to large increases in the number of working-class adults who lack health insurance. Other states would have to find funding by other means — like cutting education or raising taxes.
- **Fundamentally change the structure of Medicaid (~$900 billion)**, from one in which the federal government pays a percentage of beneficiaries' medical bills to one where it gives states a flat fee per person each year.

Conclusion: Health care is where the dollars are

The committee just doesn't have enough other places to find the money. If the budget resolution is going to become public policy, it will require legislation that cuts health programs. Almost a trillion dollars is a lot of money, even in federal budget terms, and health care is where the money is.

If the committee can't find $880 billion, the entire reconciliation process — including the extension of tax cuts — will collapse.

"The instructions they have given necessitate huge cuts to health care — full stop," said Bobby Kogan, a senior director of federal budget policy at the Center for American Progress, and a former Senate and White House budget official. "There is a mathematical requirement."

Margot Sanger-Katz is a reporter covering health care policy and public health for the Upshot section of The Times. More about Margot Sanger-Katz

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National Patient
Advocate Foundation

February 24, 2025

US House of Representatives
Washington, DC 20515
VIA E-Mail

Re: Urgent Request from Patients: Protect Medicaid from Proposed Cuts

Dear Members of the United States House of Representatives:

National Patient Advocate Foundation (NPAF) is writing with urgency to ask that you protect Medicaid from proposed cuts on behalf of patients and families experiencing complex and chronic conditions across the United States.

We are deeply concerned about the staggering cuts to Medicaid now being considered by the US House of Representatives as part of budget resolution discourse. Medicaid coverage is a lifeline to health and long-term care for 83 million adults and children in the United States. It improves health outcomes, helps keeps adults working and kids learning in school, and provides financial protection from medical debt for low-income populations and under-resourced communities across the country. Medicaid is also a vital economic driver in these communities. The cuts proposed would cause health coverage loss for tens of millions of people across the country and create catastrophic consequences for enrollees, care providers, state budgets and communities.

NPAF relies on insights, lived experiences and real-world perspectives of our nationwide patient and caregiver network and the patients served by our sister organization, Patient Advocate Foundation (PAF) to guide policies we pursue. We've prioritized protecting Medicaid because patients from all walks of life and every corner of the country have made clear that access to needed care, along with financial and social stability is a top concern directly linked to physical, mental and behavioral health outcomes. Medicaid provides access to healthcare and practical help for limited-resourced patients and families coping with social issues, emotional ones, medical debt, household financial hardships, and other financial and social constraints that contribute to poorer health.

We know the importance of Medicaid's vitality firsthand because NPAF's patient services counterpart, PAF, delivers skilled needs navigation and direct financial assistance to patients and families in all 50 states. Needs navigation provides hands-on support to enable access to needed healthcare and address healthcare costs concerns. Since 1996, PAF has helped people find and use Medicaid and other safety net services and supports necessary for making ends meet and maintaining financial health while contending with hardships because of their medical and mental or behavioral health conditions. In 2023, PAF distributed more than $450 million in financial support and provided direct support,

including sustained needs navigation and direct financial assistance to more than 185,000 patients from all 50 states and representing 93% of all US counties.

Here we are sharing just a few examples from among many testimonials NPAF is continuing to capture that speak to the high stakes harms of the proposed cuts for enrollees and communities:

1) **Parent in Pasadena, Texas**: My child and others living with a rare form of epilepsy called Dravet Syndrome rely on Medicaid to cover medical supplies and services that private insurance won't cover. My family still sat on a waitlist for 8 years before being approved for a Medicaid waiver in my state. During those 8 years, our family went into debt paying for medication, treatments, therapies and supplies.

   Now that my child is 12, her coverage is vital to keeping her alive and our family able to keep our home and keep working to feed our family. Decreasing her coverage, which is limited already, would have lasting impacts. She will need assistance and support for the rest of her life. Getting rid of those supports also means she will have to live in an institution after I am gone. Not to mention her loss of supports in her education.

2) **Patient in Quincy, Illinois:** In 2014, I was diagnosed with endometrial and ovarian cancer. At the time, I didn't have health insurance. Despite that, my doctor agreed to treat me. I spoke with a navigator and learned I qualified for health insurance through the Affordable Care Act. Illinois was one of a handful of states that had extended Medicaid coverage to cover all low-income individuals, and I qualified. Medicaid covered my entire treatment cost, including my prescriptions. I didn't see one bill. *Without it, I wouldn't have been able to afford treatment, and I would have likely died*.

   It's 11 years later. I'm now 61 and I have multiple health issues, including kidney cancer, an aortic root dilation, congestive heart failure and osteoarthritis in my left hip. I haven't worked since 2022 and was homeless. Medicaid continues to pay for my medical costs. Without it, I don't know what I'd do. I can't afford to lose my Medicaid coverage. I have no income, and no one will hire me. I've applied for disability and was denied. Without Medicaid, I'll die... Congress will basically be signing my death warrant if that happens. I'm terrified. It's my life on the line.

3) **Patient in Lincolnton, North Carolina**: It provided health insurance for my children, but NC took too long to expand Medicaid, and my husband was not insured. *He did not want to seek medical help and put his family in even more financial danger. He ultimately died from an extremely curable disease*. I practically begged him to go much sooner than he did; he responded, 'we can't afford it'. That was in Feb. of 2020.

4) **County Health Department employee, Marysville, Ohio:** Medicaid is a highly utilized and needed resource for many individuals who live in our community. There are a lot of people who go years without healthcare due to employment issues, lack of adequate income, or lack of services available in their area. *Medicaid allows more people to get the assistance they need, even in the short term*.

5) **Patient and caregiver in Richmond, Kentucky**: [Medicaid] brings healthcare to those in financial need in rural Appalachia who would otherwise not be able to afford doctors.

National Patient Advocate Foundation Urges Congress to Protect Medicaid

Medicaid is a critical cornerstone of healthcare and a vital asset to communities across the country. Funding cuts would destabilize hospitals and health systems, particularly devastating sustainability of safety-net hospitals in rural and underserved areas already most susceptible to funding fluctuation. NPAF expresses its most strident opposition to Medicaid cuts, including reductions to the Federal Medical Assistance Percentage (FMAP) for the expansion population, implementation of per capita caps, and work reporting requirements. These measures would fundamentally alter Medicaid's financing structure, shift significant costs to states, and jeopardize the health for millions of adults and children covering every single state and county.

We urge that you instead support policies to strengthen and expand Medicaid to make the health system work for all of us. Please contact me at [redacted] if NPAF can provide further information.

Respectfully submitted,

Rebecca A. Kirch
Executive Vice President, Policy and Programs

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Statement for Hearing on
"An Examination of How Reining in PBMs Will Drive Competition and Lower Costs for Patients"

House Energy & Commerce Committee
Subcommittee on Health

February 26, 2025

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for over 300 million Americans through employer-sponsored insurance, the individual insurance market, and public programs such as Medicare and Medicaid.

While drugmakers engage in anticompetitive practices and lavishly fund marketing campaigns to induce demand for the highest cost brand medicines, health plans and pharmacy benefit managers (PBMs) negotiate savings for millions of patients every day. Health plans and their partners are securing savings for patients, promoting safety, and providing an important check on drug manufacturers' pricing power. Drug manufacturers set and raise the prices for their drugs and often deploy anti-competitive tactics to delay generic competition and protect monopoly pricing. Health plans and PBMs are essential negotiators for lowering drug costs and protecting patients from out-of-control prices.

We appreciate the Subcommittee's interest in lowering the cost of prescription drugs for Americans. The most impactful and efficient way to accomplish this goal is by addressing the driver of increasing drug costs: drug manufacturers' anticompetitive practices, which are designed to extend monopolies and block patients from accessing more affordable alternatives while increasing list prices.

Drug Manufacturers Continue to Increase Prices on Americans

More than 24 cents of every dollar spent on health insurance premiums goes to pay for prescription drugs.[1] Solutions to make prescription drugs more affordable must start with the root causes of high drug prices: drug manufacturers often hold monopoly power over medicines and continue to prevent and undermine competition in order to keep their prices as high as possible at the expense of American patients. For their first 250 price increases of the year, drug manufacturers raised their prices by a median increase of 4.5%,[2] significantly exceeding the 2.7% rate of inflation.[3] Despite drugmaker claims that price increases on American consumers are needed to fund innovations, the largest drugmakers in the United States spend just 22 cents out of every dollar on R&D.[4] In fact, a study from JAMA Network found "no relationship" between the price brand name drugmakers set and the amount those companies invest in R&D.[5]

Health Plans Are Committed to Meaningful Transparency

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[2] https://www.reuters.com/business/healthcare-pharmaceuticals/drugmakers-raise-us-prices-over-250-medicines-starting-jan-1-2024-12-31/
[3] https://tradingeconomics.com/united-states/inflation-cpi
[4] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796669

Health plans have demonstrated their commitment to providing Americans with actionable health care information and market competition through increased price transparency. Examples include implementing innovative solutions such as new copay plans capping out-of-pocket copays on prescription drugs, providing fully transparent price models, and enhancing disclosure practices.[6] Other plan initiatives include increasing the interoperability between systems so that PBMs can proactively and transparently share patient benefit information with prescribers to ensure continuity of care and show out-of-pocket costs for prescription medications.[7] In Medicare Part D, Part D sponsors and PBMs provide detailed, real-time formulary and benefit information, including enrollee cost-sharing information, through prescriber and beneficiary real-time benefit tools. Part D enrollees and prescribers can also use Medicare Plan Finder to access plan-level formulary and benefit information, including cost-sharing information, and to determine which pharmacies are in-network. Health insurance plans currently report substantial data on health care and drug spending to the federal government through the Prescription Drug Data Collection (RxDC). Extensive reporting of claims data also occurs under both Medicare Part D and Medicaid.

Market-based solutions are essential to reducing the overall cost of health care, including the cost of prescription drugs. Providing employers with consistent, standardized information on their prescription drug costs promotes competition across issuers and PBMs, reducing prescription drug spending. While PBMs and issuers typically report much of this data to their members and plan sponsors through existing requirements and contractual arrangements, to promote even greater competition in the employer PBM market, AHIP supports additional disclosure measures to health plan sponsors to ensure that employers have further information to make the right coverage decision for their employees:[8] Those measures include:

- Gross spending on prescription drugs at the drug level
- Net spending on prescription drugs after manufacturer rebates at the drug level
- Total drug utilization
- Fees and compensation paid to brokers and consultants

Transparency Should Be Consistent Across the Drug Supply Chain

Efforts to boost transparency should extend to the rest of the drug supply chain, including manufacturers and wholesalers. Consumers and taxpayers should have access to information on drug manufacturing and research and development costs, net profits, and marketing and advertising costs for expensive medications. AHIP urges Congress to consider policies that would require drugmakers to publicly justify high prices and report pricing information. To this end, Congress should advance policies from the 118th Congress's *Fair Accountability and Innovative Research (FAIR) Drug Pricing Act*[9] – which are in Energy & Commerce's jurisdiction – to apply basic transparency to drug pricing and require drug manufacturers to justify their price increases. Additionally, Congress should pass legislation requiring pharmaceutical manufacturers to disclose list prices in Direct-to-Consumer advertising, as was proposed by the Trump Administration in 2018 and the bipartisan *Drug-price Transparency for Consumers Act* from the previous Congress.

Certain Reporting Requirements Would Facilitate Drug Manufacturer Collusion

[6] https://newsroom.thecignagroup.com/express-scripts-further-advances-transparency-and-affordability
[7] https://payorsolutions.cvshealth.com/insights/strategic-initiative-to-create-greater-transparency-and-access
[8] AHIP also has supported additional disclosure measures from PBMs to Part D sponsors.
[9] https://www.congress.gov/bill/118th-congress/senate-bill/935

AHIP supports transparency initiatives that empower consumers and employers to make informed choices. However, we are deeply concerned that Congress is considering requiring the public disclosure of all confidential net drug prices to competing drug manufacturers via machine-readable files. These disclosures would allow drug manufacturers to collusively raise their prices, engage in "shadow pricing," and limit negotiation. The Congressional Budget Office (CBO) has repeatedly found that disclosing these prices would "set in place conditions for tacit collusion" and that even disclosure of average net prices at the therapeutic class level "could result in tacit collusion among competing manufacturers."[10]

Employers and PBMs Work Together to Create the Best Contracts for Employees

Health plans use contract flexibility to lower prescription drug spending for Americans and employers to help insulate them from shouldering the full burden of drug manufacturers' exorbitant price increases. Contracting flexibility is a critical tool that allows employers to select the plan that is best for their employees, best fits their budget, and best aligns with their tolerance for assuming financial risk. Contracting flexibility also encourages private-sector innovation that drives lower prescription drug spending and benefits employer clients.

Mandates that limit contract flexibility leave businesses with fewer tools with which to help lower the cost of their employees' coverage. Bank of America's 2023 annual PBM survey[11] found substantial variation in employers' preference for a prescription benefit contract: 34% want a shared savings model, 22% want a variable fee model incorporating rebates and spread pricing, and 14% want a fixed fee model incorporating rebates – all models that would be prohibited under previously proposed legislation. Only 24% of employers wanted a fixed fee model per prescription with no spread pricing or rebates – the only model available if Congress bans spread pricing and mandates full rebate pass-throughs. In other words, more than three-quarters of U.S. employers favor models that would be banned under proposals recently considered by Congress.

Patent Gaming Is a Root Cause of High Drug Costs in the U.S.

Instead of placing restrictions on popular contracting options between private entities, Congress should consider bipartisan proposals to reduce patent abuses by drugmakers. The American people are paying the cost of drugmakers' patent thickets, product hopping, pay-for-delay, and other anticompetitive practices. For example, a 2023 analysis found that "anticompetitive patent abuse tactics used by big pharmaceutical companies cost U.S. consumers an additional $40.7 billion in prescription drug expenses in one year alone."[12] In fact, according to the analysis "patent thickets on just five drugs cost U.S. consumers over $16 billion in lost savings" in 2023."[13]

To begin the process of reining in drugmakers' anticompetitive practices, AHIP recommends that Congress consider and pass the 118th Congress' *Affordable Prescriptions for Patients Act*.[14] This bipartisan legislation, advanced by unanimous consent in the Senate last Congress, would boost

[10] https://www.cbo.gov/system/files/2024-12/s1339.pdf

[11] Survey of 50 employers covering at least 1,000 lives and having more than $1M in annual prescription drug spend. Together, these employers represented $4.2B in 2022 drug spend. Reprinted by permission. Copyright © 2023 Bank of America Corporation ("BAC"). The use of the above in no way implies that BAC or any of its affiliates endorses the views or interpretation or the use of such information or acts as any endorsement of the use of such information. The information is provided "as is" and none of BAC or any of its affiliates warrants the accuracy or completeness of the information.

[12] http://www.economicliberties.us/wp-content/uploads/2023/05/AELP_052023_PharmaCheats_Report_FINAL.pdf

[13] https://getmga.com/wp-content/uploads/2023/01/Patent_Thickets_Jan_2023.pdf

[14] https://www.congress.gov/bill/118th-congress/senate-bill/150

competition by limiting manufacturers' ability to manipulate the patent litigation process. The legislation also saves the federal government $1.8 billion. In addition, AHIP supports the reintroduction and passage of several other bipartisan bills that would make the pharmaceutical market more competitive by limiting patent gaming:

- The *Interagency Patent Coordination and Improvement Act*[15] would establish a cooperative task force between the U.S. Patent and Trademark Office (USPTO) and the Food and Drug Administration (FDA) in order for the two agencies to be more collaborative in their patent-related functions. This legislation would create a more competitive drug market and lower costs for consumers.
- By restraining anticompetitive "pay-for-delay" deals that delay and prevent the introduction of more affordable follow-on developments and generic versions of branded drugs, the *Preserve Access to Affordable Generics and Biosimilars Act*[16] would reduce the cost of drugs and reduce the growing cost burden on patients and our health care system.
- The *Stop STALLING Act*[17] would authorize the Federal Trade Commission (FTC) to take action against pharmaceutical companies when they game the patent system by filing frivolous petitions with the FDA. The bill would allow more generics and biosimilar alternatives to go through the approval process and enter the market, bolstering competition and leading to lower prices.

Conclusion

AHIP looks forward to working with the Subcommittee and Congress to lower the prices of prescription drugs for Americans. However, without the freedom to negotiate contract terms with shared savings broadly preferred by employers and plan sponsors, those same employers are left with fewer tools to combat rising costs. This limits their ability to utilize PBMs to negotiate lower drug prices—exactly the outcome that drugmakers are seeking. Alternatively, Congress should seek bipartisan policy solutions, such as patent reforms, to promote competition and reduce the root cause of high and rising drug prices: drugmakers themselves.

[15] https://www.congress.gov/bill/118th-congress/senate-bill/79
[16] https://www.congress.gov/bill/118th-congress/senate-bill/142
[17] https://www.congress.gov/bill/118th-congress/senate-bill/148

February 25, 2025

The Honorable John Thune
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Chuck Schumer
Democratic Leader
United States Senate
Washington, D.C. 20510

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader Thune, Democratic Leader Schumer, Speaker Johnson, and Leader Jeffries:

The undersigned childhood cancer organizations are members of the Alliance for Childhood Cancer, which consists of patient advocacy groups, healthcare professionals, and scientific organizations representing Americans who care deeply about childhood cancer. We write to express concern about potential changes to Medicaid that would impede access and threaten needed health coverage for children with cancer and other diseases.

Cancer remains the most common cause of death by disease among children in the United States. Unfortunately, 1 in 5 children diagnosed with cancer in the U.S. will not survive, and for the ones who do, the battle is never over. By the age of 50, more than 99% of survivors have a chronic health problem, and 96% have experienced a severe or life-threatening condition caused by the toxicity of the treatment that initially saved their life, including: brain damage, loss of hearing and sight, heart disease, secondary cancers, learning disabilities, infertility and more. By the time a child in treatment for cancer today reaches the age of 50, we want these statistics to be far less grim.

Medicaid and the Children's Health Insurance Program (CHIP) provide quality, affordable healthcare coverage for nearly 80 million people, including over 37 million children, or roughly half of all children in the US.[1] For children with cancer, Medicaid plays an especially critical role as a safety net. In many states, a child is eligible for Medicaid and CHIP coverage upon receiving a childhood cancer diagnosis, emphasizing the need for timely access to quality, uninterrupted care.

Many children with complex medical needs like childhood cancer are only able to receive the specialty care and supportive services they need due to the Medicaid program, even children with private insurance as their primary payer. Research has shown that pediatric patients who experience disruptions in their Medicaid coverage are more likely to have advanced-stage

[1] KFF. "Monthly Child Enrollment in Medicaid and CHIP." Accessed February 12, 2025. https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment/.

disease and worse survival rates than patients without disruptions.[2] Compared to adolescent and young adult patients continuously enrolled in Medicaid, those with newly gained Medicaid or other Medicaid enrollment patterns were 54% and 18%, respectively, more likely to present with stage IV lymphoma.[3] This research shows that Medicaid coverage plays a key role in catching and treating cancers in children early. [4].

We are deeply concerned by policy proposals and comments in the media about plans to make severe cuts to the Medicaid program. Any changes to Medicaid's financing structure – including but not limited to block grants and per capita caps – or other policies that shift costs to states, like cuts to the federal medical assistance percentage (FMAP) – would not only impact children enrolled in Medicaid but would also threaten the financial viability of the pediatric healthcare system overall. Children's hospitals, which provide the vast majority of childhood cancer care, rely on Medicaid financing as a large proportion of their budgets.[5]

Further, cuts to eligibility and benefits and the addition of any barriers to coverage, such as work reporting requirements, would add needless red tape to enrollment and would severely harm children with cancer and their families. For example, when Arkansas implemented work requirements for its Medicaid program in 2018, more than 18,000 beneficiaries lost coverage in just 10 months – nearly a quarter of those subject to the requirement[6]. Research is clear that children are more likely to be enrolled in health coverage if their parents are as well,[7] meaning that any coverage losses for parents will have a disproportionate impact on children.

Work requirements may also impact caregivers of children with cancer who are unable to work due to the demands of cancer treatment or young adults with cancer who may not yet be eligible for insurance via their employer or may not be able to work due to their diagnosis. Many young adults rely on Medicaid, especially the Medicaid expansion, for coverage, and research shows a clear increase in survival for young adults with cancer in Medicaid expansion states.[8]

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[2] Xin Hu et al., Association Between Medicaid Coverage Continuity and Survival in Patients With Newly Diagnosed Pediatric and Adolescent Cancers. JCO Oncol Pract 0, OP.24.00268 DOI:10.1200/OP.24.00268

[3] Zhang, Xinyue Elyse, Sharon M. Castellino, K. Robin Yabroff, Wendy Stock, Patricia Cornwell, Shasha Bai, Ann C. Mertens, Joseph Lipscomb, and Xu Ji. "Medicaid Coverage Continuity Is Associated with Lymphoma Stage among Children and Adolescents/Young Adults." *Blood Advances* 9, no. 2 (January 16, 2025): 280–90. https://doi.org/10.1182/bloodadvances.2024013532.

[4] Barnes JM, Neff C, Han X, Kruchko C, Barnholtz-Sloan JS, Ostrom QT, Johnson KJ. The association of Medicaid expansion and pediatric cancer overall survival. J Natl Cancer Inst. 2023 Jun 8;115(6):749-752. doi: 10.1093/jnci/djad024. PMID: 36782354; PMCID: PMC10248835.

[5] Heller, Richard E., Aparna Joshi, Robin Sircar, and Shireen Hayatghaibi. "Medicaid and the Children's Health Insurance Program: An Overview for the Pediatric Radiologist." *Pediatric Radiology* 53, no. 6 (2023): 1179–87. https://doi.org/10.1007/s00247-023-05640-7.

[6] Sommers BD, Chen L, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. Health Aff (Millwood). 2020 Sep;39(9):1522-1530. doi: 10.1377/hlthaff.2020.00538. PMID: 32897784; PMCID: PMC7497731.

[7] Jennifer E. DeVoe, et al. "The Association Between Medicaid Coverage for Children and Parents Persists: 2002-2010." *Maternal and Child Health Journal* 19, no. 8 (2015): 1766-74. https://pubmed.ncbi.nlm.nih.gov/25874876/.

[8] Xu Ji, et al. "Survival in Young Adults With Cancer Is Associated With Medicaid Expansion Through the Affordable Care Act." Journal of Clinical Oncology 41, no. 10 (2023): 1909-1920. https://pubmed.ncbi.nlm.nih.gov/36525612/.

Our organizations strongly oppose changes to the Medicaid program that would restrict access, cut needed funding to states, create burdensome red tape, or reduce the quality or availability of services for children or their families.

Thank you for your leadership on behalf of children with cancer. We look forward to working with you to improve the lives of childhood cancer patients, survivors, and families. Should you have any questions or need additional information, please contact Rosalie Abbott, Co-Chair of the Alliance for Childhood Cancer, at [redacted], or Dr. Michael Link, Co-Chair of the Alliance for Childhood Cancer, at [redacted].

Sincerely,

The Alliance for Childhood Cancer

American Academy of Pediatrics
American Cancer Society Cancer Action Network
American Childhood Cancer Organization
American Society of Pediatric Hematology/Oncology
The Andrew McDonough B+ Foundation
Association for Clinical Oncology
Association of Pediatric Oncology Social Workers
Children's Brain Tumor Foundation
Children's Cancer Cause
Dana-Farber Cancer Institute
The Leukemia & Lymphoma Society
MIB Agents Osteosarcoma
National Brain Tumor Society
Pediatric Brain Tumor Foundation
Rally Foundation for Childhood Cancer Research
St. Baldrick's Foundation
St. Jude Children's Research Hospital

February 25, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
H-204, The Capitol
Washington, D.C. 20515

Dear Speaker Johnson and Minority Leader Jeffries:

On behalf of the undersigned chapters of the **American Academy of Family Physicians (AAFP)** , representing over 130,000 family physicians and medical students across the country, we write to convey our deep concerns regarding proposals to reduce Medicaid funding or implement further eligibility restrictions. We strongly urge you and your colleagues to reject any reforms that have the potential to impede access to essential care for millions of Americans who rely upon Medicaid, including our nation's most vulnerable populations.

Family physicians are at the forefront of health care delivery, caring for individuals and families across the lifespan, and we witness firsthand the positive impact that Medicaid has on our patients' lives. Medicaid is a lifeline for more than 72 million low-income individuals and families, children, pregnant women, elderly adults, and individuals with disabilities. It ensures access to necessary medical care, preventive services, and long-term services and support that many would otherwise be unable to afford.

Medicaid is both wide-reaching and favorably viewed by most Americans. Data from January shows that two-thirds of adults say that they or someone close to them has direct experience with Medicaid and more than three-quarters have a favorable view of Medicaid, including the majority of Democrats, Independents, and Republicans.[i] Reducing funding or further restricting eligibility for Medicaid would not only limit access to care but also exacerbate existing health disparities, leading to poorer health outcomes and increased healthcare costs in the long term. Preventive care and early intervention, which are cornerstones of family medicine, would be significantly compromised, resulting in more severe and costly health issues down the line.

Medicaid coverage has been consistently shown to improve health outcomes at the individual, family, and community levels both in the short- and long-term. Studies have shown that greater exposure to Medicaid eligibility in childhood is associated

with a significant improvement in health in adulthood, and Medicaid coverage is associated with reduced mortality in both childhood and adulthood.[ii]

Medicaid coverage also yields notable economic benefits. Eligibility for Medicaid early in life leads to higher rates of employment, higher earnings, lower rates of disability, decreased likelihood of incarceration, and lower rates of public assistance usage.[iii] Expanded Medicaid eligibility for pregnant women has been shown to increase their children's economic opportunity in adulthood through increased educational attainment and higher incomes.[iv] Children covered by Medicaid also pay more in cumulative taxes by age 28 compared to their peers who are not Medicaid-enrolled.[v]

Further, many state-specific analyses have found that, between cost offsets and increased tax revenue, Medicaid expansion more than paid for itself.[vi] In some states, Medicaid expansion appears to have generated potential cost savings as health care spending per person is lower.[vii] This is likely because individuals who would otherwise be uninsured and unable to afford care are connecting with primary care physicians and utilizing preventive care, rather than delaying treatment and relying upon more expensive care settings like emergency departments. The literature supports this assumption, with several studies finding that Medicaid expansion led to significant improvements in rates of self-reported access to and utilization of care, including primary and preventive care, mental health care, and prescription drugs.[viii]

Given the above findings and robust support by the American people, we respectfully urge you to reject any proposed Medicaid reforms that would impede access to care and instead focus on strengthening and expanding this crucial program. Investing in Medicaid is an investment in the health and future of our nation. The AAFP stands ready to collaborate with you and other stakeholders to identify sustainable solutions that ensure all Americans have access to high-quality, affordable health care.

Thank you for your attention to this urgent matter. We look forward to your support in preserving and enhancing Medicaid for the benefit of all Americans.

Sincerely,

Alabama Academy of Family Physicians
Alaska Academy of Family Physicians
Arizona Academy of Family Physicians
Arkansas Academy of Family Physicians
California Academy of Family Physicians
Colorado Academy of Family Physicians
Connecticut Academy of Family Physicians
Delaware Academy of Family Physicians
District of Columbia Academy of Family Physicians

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Hawaii Academy of Family Physicians
Idaho Academy of Family Physicians
Illinois Academy of Family Physicians
Indiana Academy of Family Physicians
Iowa Academy of Family Physicians
Kansas Academy of Family Physicians
Kentucky Academy of Family Physicians
Louisiana Academy of Family Physicians
Maine Academy of Family Physicians
Maryland Academy of Family Physicians
Massachusetts Academy of Family Physicians
Michigan Academy of Family Physicians
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Montana Academy of Family Physicians
Nebraska Academy of Family Physicians
Nevada Academy of Family Physicians
New Hampshire Academy of Family Physicians
New Jersey Academy of Family Physicians
New Mexico Academy of Family Physicians
New York Academy of Family Physicians
North Carolina Academy of Family Physicians
North Dakota Academy of Family Physicians
Ohio Academy of Family Physicians
Oklahoma Academy of Family Physicians
Oregon Academy of Family Physicians
Pennsylvania Academy of Family Physicians
Rhode Island Academy of Family Physicians
South Carolina Academy of Family Physicians
South Dakota Academy of Family Physicians
Tennessee Academy of Family Physicians
Texas Academy of Family Physicians
Utah Academy of Family Physicians
Vermont Academy of Family Physicians
Virginia Academy of Family Physicians
Washington Academy of Family Physicians
West Virginia Academy of Family Physicians
Wisconsin Academy of Family Physicians
Wyoming Academy of Family Physicians

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cc: Members of the House Energy and Commerce Committee

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[i] Kaiser Family Foundation. (2023, March 30). Updated January 17, 2025. *5 charts about public opinion on Medicaid*. Kaiser Family Foundation. https://www.kff.org/medicaid/poll-finding/5-charts-about-public-opinion-on-medicaid/.

[ii] Chu, R. C., Peters, C., & Buchmueller, T. (2024, September*). Medicaid: The health and economic benefits of expanding eligibility* (Issue Brief HP-2024-18). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/effbde36dd9852a49d10e66e4a4ee333/medicaid-health-economic-benefits.pdf.

[iii] Ibid.

[iv] Kaiser Family Foundation. (2022, December 13). *Medicaid spending growth compared to other payers*. Kaiser Family Foundation. Retrieved February 8, 2025, from https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/.

[v] Ibid.

[vi] Chu, R. C., Peters, C., & Buchmueller, T.

[vii] Johnson, E. (2023, April 13). *The true cost of the great Medicaid "unwinding"*. Institute for Health Metrics and Evaluation. https://www.healthdata.org/news-events/insights-blog/acting-data/true-cost-great-medicaid-unwinding.

[viii] Chu, R. C., Peters, C., & Buchmueller, T.

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

News Release

AAP Statement on House Budget Resolution

By: Susan Kressly, MD, FAAP, President, American Academy of Pediatrics

For Release:

2/24/2025

Media Contact:

Devin Mazziotti

[redacted]

"The American Academy of Pediatrics urges lawmakers to reject the budget resolution before the U.S. House of Representatives and to protect programs that are vital to the health and well-being of children. We oppose the proposed funding cuts to programs like Medicaid and the Children's Health Insurance Program (CHIP) – which cover nearly half of all U.S. children—as well as the Supplemental Nutrition Assistance Program (SNAP). These cuts would have devastating consequences for children and families.

"Medicaid and CHIP were designed with children's unique health needs in mind, providing health care coverage for over 37 million children – including children from low-income families and children with disabilities or chronic health conditions. Nutrition assistance programs like SNAP work to support families experiencing food insecurity, helping them to put food on the table and supporting children's lifelong health.

"Protecting these programs invests in the health and well-being of America's children, which is directly related to our future healthy workforce and economic prosperity.

"We call on lawmakers to vote no on the House budget resolution and oppose cuts to programs like Medicaid, CHIP and SNAP. Investing in children helps our communities, our economy and entire country prosper."

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The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

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%20Stand%20up%20for%20Cancer%20Pat ents%20and%20 he r%20Fam es%20by%20Protect ng%20Med ca d%20and%20Oppos ng%20Budget%20Reso ut on)

All Press Releases (/landing pages/press room)

ACS CAN Urges House Members to Stand up for Cancer Patients and Their Families by Protecting Medicaid and Opposing Budget Resolution

February 25, 2025

WASHINGTON, D.C. h s week, the U S House of Representat ves s expected to cons der a budget reso ut on that cou d ead to devastat ng cuts to Med ca d Ahead of the vote, the Amer can Cancer Soc ety Cancer Act on Network (ACS CAN) s urg ng House members to oppose cuts to Med ca d he fo ow ng s a statement from L sa Lacasse, pres dent of ACS CAN

" t s cr t ca that members of the House oppose th s b because t wou d detr menta y mpact access to Med ca d for many peop e Research cons stent y shows that access to hea th nsurance coverage through Med ca d ncreases cancer screen ngs rates, ear y stage cancer d agnoses, and mproves access to t me y cancer treatment and surv va rates

"One out of ten adu ts w th a h story of cancer re ed on Med ca d for the r hea th care n 2023, accord ng to data ana yzed by the Amer can Cancer Soc ety, underscor ng the cr t ca ro e Med ca d p ays n he p ng cancer pat ents nav gate the r d agnos s and surv ve th s d sease n add t on, Med ca d protects nd v dua s and fam es from devastat ng med ca debt, he ps keep rura hosp ta doors open, creates jobs n our commun t es, and he ps our nat on become hea th er and more prosperous

"ACS CAN opposes cuts that w ncrease the number of un nsured nat onw de by sever ng the fe ne Med ca d prov des for cancer pat ents and those at r sk for cancer t s mperat ve for cancer pat ents and m ons more at r sk that th s va uab e hea th nsurance program be protected For decades, ACS CAN has advocated n support of Med ca d and w cont nue to advocate at the federa and state eve s n support of expans on of access to the program and aga nst po c es that jeopard ze nd v dua s' access to fesav ng hea th nsurance coverage "

MORE PRESS RELEASES ABOUT

Health Insurance Affordability (/press room/priority/Health Insurance Affordability), Remove Hurdles to Cancer Care (/press room/priority/Remove Hurdles to Cancer Care), Access to Health Care (/press room/priority/Access to Health Care), National (/states/National/press releases)

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FEBRUARY 25, 2025

American Hospital Association™
Advancing Health in America

Fact Sheet: Medicaid

The Issue

The Medicaid program is the largest single source of health care coverage in the United States, covering nearly half of all children, over 40% of births (including nearly 50% of births in rural communities), many low-income elderly and disabled individuals, and working adults in low-wage jobs that do not offer affordable coverage. Congress is currently considering policy options that could collectively reduce federal spending for the Medicaid program by trillions of dollars over the next 10 years. These options include proposals to directly reduce federal spending on the program and limit states' ability to generate funding for the state share of the costs.

AHA Take

Even a small portion of the proposed reductions could have wide-ranging negative consequences for the health and well-being of both Medicaid enrollees and the broader health care system. **AHA urges Congress to reject reductions to the Medicaid program that would not only strip access to health care from some of the most vulnerable populations but also destabilize hospitals and health systems, leading to a loss of services that would impact patients and communities nationwide.**

Why?

- Medicaid provides critical health coverage to a wide variety of people in every community across the nation. This coverage helps ensure patients can receive the medical services needed to live healthier and more productive lives.
- Medicaid covers over 40% of births in the U.S., including nearly 50% of births in rural communities.[1] It is also a vital source of prenatal and postpartum care for women across the country.
- State Medicaid programs pay hospitals less than the cost hospitals incur to provide care to Medicaid patients. In 2023, the difference between Medicaid payments and costs, known as "Medicaid shortfall," was $27.5 billion.[2]
- Medicaid is an important source of support for the health care system. The impact of cuts to Medicaid would not be limited to just Medicaid beneficiaries. It would stress the availability of health care services for everyone. Today, hospitals that serve disproportionately high rates of Medicaid and other public-payer patients routinely operate with negative margins and are often forced to terminate service lines or close entirely. Reductions in federal support for Medicaid would exacerbate these pressures, which could strip essential health care services for an entire community.
- Medicaid is one of the most cost-efficient forms of coverage. It has lower total and per capita costs than all other major health programs, including Medicare and private health insurance.
- Most of the spending on Medicaid is for disabled and elderly individuals. States could not absorb the magnitude of the proposed cuts by solely reducing enrollment or services for working-age adults — the disabled and elderly populations would also be negatively impacted.

American Hospital Association™
Advancing Health in America

Background

Medicaid is a joint federal-state program that covers primary and acute care services, as well as long-term care services and supports, for low-income populations, including children and their families, seniors, disabled individuals and adults, many of whom work. Medicaid provides health care coverage to one in five Americans — more than 70 million people — including 40% of all children and 60% of all nursing home residents.[3]

The federal and state governments jointly finance Medicaid. The federal government sets the basic framework for covering certain mandatory populations and benefits, as well as regulates the delivery of health care services and reimbursement. The federal government also pays a share of states' Medicaid expenses based on the state's federal medical assistance percentage (FMAP), which varies from a federal floor of 50% up to 76% depending on a state's per capita income relative to the national average. States, in turn, have latitude in the design and administration of their programs. In addition, states can use waiver and demonstration authorities approved by the Centers for Medicare & Medicaid Services (CMS) to test opportunities for innovation by operating their Medicaid programs outside of certain federal rules.

Who Is Covered Through Medicaid

The federal government sets the minimum eligibility standards, and states may expand eligibility within federal limits. Medicaid eligibility is generally determined based on an individual's age, health condition and income level (including, in some cases, an asset test). Approximately 42% of Medicaid beneficiaries are adults, 36% are children, 10% are disabled, and 10% are age 65 or older.[4] Individuals who are eligible based on disability or age make up a small share of beneficiaries overall but account for over half of all Medicaid spending.

Selected Examples of Mandatory and Optional Medicaid Eligibility Categories

States are required to cover certain populations, while others are classified as optional. Despite being eligible for coverage at state option, many of these populations are among the most vulnerable. Yet, when states face budget shortfalls, they often look to optional groups for benefit reductions.

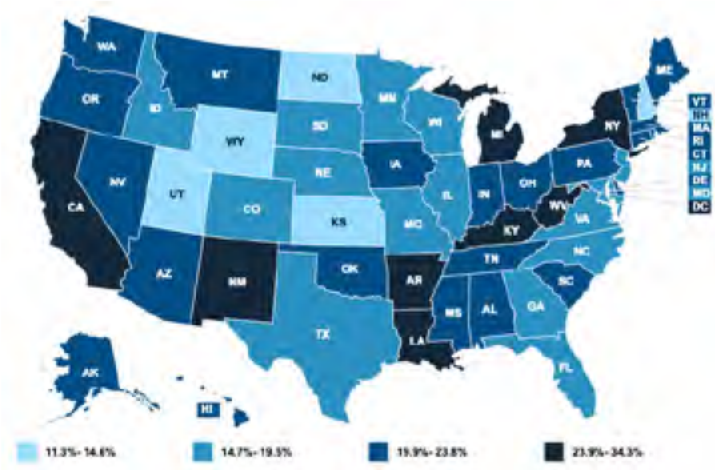
Mandatory	Optional
» Children through age 18 in families with incomes at or below 133% Federal Poverty Level (FPL)	» Infants in families with incomes above 185% FPL » Children receiving certain state adoption assistance
» Pregnant women with incomes at or below 133% FPL	» Pregnant women between 133-185% FPL
» Certain parents or caretakers with very low incomes	» Adults (parents or childless) with incomes at or below 133% FPL
» Most seniors and people with disabilities who receive cash assistance through Supplemental Security Income	» Seniors with incomes above 135% FPL » Nursing home residents with incomes above 200% FPL » Home and Community Based Services Waiver Enrollees

Note: FPL is defined as $15,060 for an individual in 2024.

Selected Examples of Mandatory and Optional Medicaid Eligibility Categories (continued)

Medicaid covers millions of people across the U.S., reaching individuals in all regions, from rural communities to urban centers. In addition to children, pregnant women, and low-income elderly and disabled individuals, Medicaid covers working adults in low-wage jobs. This opportunity for health care coverage provides a valuable resource for businesses that employ low-wage workers.

Health Insurance Coverage of the Total Population: Medicaid, 2023



Source: KFF's State Health Facts

What Services Medicaid Covers

States are required to provide coverage for certain benefits and have the option of covering additional services. This results in significant variation across states in terms of what care Medicaid covers. In addition, Medicaid is statutorily prohibited from paying for services in an institute for mental disease for adults aged 21 through 64, and federal law prohibits the use of federal funds to pay for abortion services.

Mandatory	Optional
» Inpatient hospital services	» Prescription drug coverage
» Outpatient hospital services	» Dental services
» Physician services	» Physical and occupational therapy
» Lab and x-ray services	» Speech and hearing services
» Rural and federally qualified health clinic ser-vices	» Eyeglasses
» Nurse midwife services	» Prosthetics
» Nursing facility services	» Clinic services
» Home health care services for people qualified for nursing facility services	» Hospice
» Smoking cessation services for pregnant women	» Inpatient psychiatric services for people under 21 years old
» Free-standing birth center services	-
» Family planning services	-

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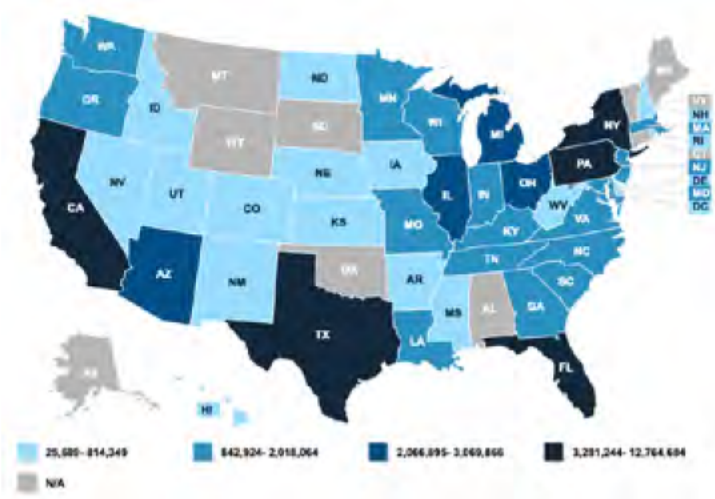
Payment

States have broad authority to design reimbursement methods for providers, subject to federal approval. State Medicaid agencies pay providers for services and may make additional supplemental payments. Medicaid payment rates are low relative to other payers.

Many states choose to provide Medicaid coverage by contracting with private Medicaid managed care organizations (MCOs). Medicaid MCOs are often paid on a capitated basis, and states must submit capitation payment rates annually for federal approval. About 74% of Medicaid beneficiaries are enrolled in Medicaid managed care.

Total Medicaid MCO Enrollment: Comprehensive Risk-Based Managed Care Enrollees, 2022



Source: KFF's State Health Facts

1 AHA analysis of Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), Natality data on the CDC WONDER Online Database (2023).

2 AHA analysis.

3 www.aha.org/medicaid

4 https://www.macpac.gov/publication/medicaid-enrollment-by-state-eligibility-group-and-dually-eligible-status/

American Hospital Association™
Advancing Health in America

AHA STATEMENT ON CONGRESSIONAL BUDGET RESOLUTION DELIBERATIONS

Rick Pollack
President and CEO
American Hospital Association
February 12, 2025

As the Senate and House Budget Committees begin deliberations on their Fiscal Year 2025 budget resolutions, the American Hospital Association urges Congress to take seriously the impact of reductions in health care programs, particularly Medicaid.

While some have suggested dramatic reductions in the Medicaid program as part of a reconciliation vehicle, we would urge Congress to reject that approach. Medicaid provides health care to many of our most vulnerable populations, including pregnant women, children, the elderly, disabled and many of our working class.

American Lung Association: House Budget Resolution Would Result in Massive Cuts that Would Irreparably Harm Nation's Lung Health

WASHINGTON, DC | February 12, 2025

For more information, contact:

Jill Dale

[redacted]

Today, the U.S. House of Representatives released its budget resolution. The budget resolution calls for dramatic, gutting reductions in federal spending that could only be achieved by making devastating cuts to the Medicaid program. American Lung Association President and CEO Harold Wimmer issued the following statement regarding this announcement:

"The House of Representative's budget resolution would devastate health coverage for tens of millions of people, including the elderly, children, people with disabilities, and workers who do not get insurance from their jobs. The proposed cuts would take away coverage, increase medical debt for patients, increase costs to states and harm the lung health of millions.

"If these cuts happen, it will result in fewer kids getting well-visit check-ups or seeing their doctor when they're sick. People living in

nursing homes will be forced to leave long-term care, pregnant women will lose access to prenatal services that ensure healthy pregnancies and babies, and people living with lung disease will have to delay necessary healthcare and may have severe asthma or COPD flare-ups that otherwise could have been prevented. There is no way to cut Medicaid spending without harming these groups.

"Medicaid is a program that ensures families are healthy enough to go to work and that kids are healthy enough to go to school. The American Lung Association calls on Congress to keep everyone's lungs healthy by protecting Medicaid coverage.

"Given the size of the cuts called for in the House's proposed budget resolution, it would almost certainly harm efforts to clean our air. We call on Congress to protect programs that invest in air pollution cleanup in communities. Current tax credits and programs invest in protecting people from asthma attacks, lifelong lung damage and other harms from pollution from vehicles and power plants. Members have signaled intention to cut these programs during this same budget reconciliation process, which would lead to health harms that should have been prevented."

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About the American Lung Association
The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research. The work of the American Lung Association is focused on four strategic imperatives: to defeat lung cancer; to champion clean air for all; to improve the quality of life for those with lung disease and their families; and to create a tobacco-free future. For more information about the American Lung Association, which has a 4-star rating from Charity Navigator and is a Platinum-Level GuideStar Member, call 1-800-LUNGUSA (1-800-586-4872) or visit: Lung.org. (http://lung.org./) To

support the work of the American Lung Association, find a local event at Lung.org/events. (https://www.lung.org/get-involved/events)

AMERICA'S ESSENTIAL HOSPITALS

FEBRUARY 19, 2025

The Honorable Brett Guthrie
Chair
Committee on Energy and Commerce
United States House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Buddy Carter
Chair
Energy and Commerce Subcommittee on Health
United States House of Representatives
2432 Rayburn House Office Building
Washington, DC 20515

The Honorable Dianna DeGette
Ranking Member
Energy and Commerce Subcommittee on Health
United States House of Representatives
2111 Rayburn House Office Building
Washington, DC 20515

RE: Medicaid Proposals in Budget Reconciliation Negotiations

Dear Chair Guthrie, Ranking Member Pallone, Chair Carter, and Ranking Member DeGette,

Members of America's Essential Hospitals—and hospitals like them—play an indispensable role in keeping all Americans healthy and form the fabric of our nation's health care safety net. They share a mission to care for all, including those facing severe financial challenges. As a result, essential hospitals serve a high share of individuals enrolled in Medicaid, our nation's safety net health insurance program for low-income children, adults, and people with disabilities. The Medicaid program is a lifeline to our nation's most under-resourced communities. In 2024, 79 million people were enrolled in Medicaid, with more than seven million enrolled in the Children's Health Insurance Program.[1] The importance of the Medicaid program for all cannot be understated.

Medicaid payments allow essential hospitals to keep their doors open and provide care for everyone in the community. In many areas, essential hospitals are the only hospitals in a region that offer trauma or burn care, and as other hospitals decide to limit or close maternity care units, we are increasingly becoming the primary labor and delivery care options in many communities. Essential hospitals are also major employers in the communities they serve. Medicaid is crucial to sustain our mission of providing care for all people.

[1] *October 2024 Medicaid & CHIP Enrollment Data Highlights*. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html#:~:text=79%2C308%2C002%20people%20were%20enrolled%20in,people%20were%20enrolled%20in%20CHIP. Accessed Jan. 31, 2025.

AMERICA'S ESSENTIAL HOSPITALS
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As the House moves forward with budget reconciliation, America's Essential Hospitals is deeply concerned about policies that would dramatically change the Medicaid program in a manner that could hurt essential health care providers and patients nationwide. Specifically, we are concerned that the House budget resolution's instructions to the Energy and Commerce Committee to identify $880 billion in savings would largely come from substantial cuts to Medicaid. State Medicaid programs will not be able to sustain cuts of this magnitude without significant changes to their programs that will reduce access and threaten the ability of many essential hospitals and other safety net providers to stay open. Cuts to Medicaid of this magnitude are also contrary to President Trump's commitment to "love and cherish" Medicaid, and his promise that "none of [Medicaid] is going to be touched."

Reducing Payment

To sustain their mission of providing care for all people, essential hospitals rely on a patchwork of support from the federal, state, and local governments. Some of the largest sources of support for essential hospitals include Medicaid state directed payments (SDPs), which help to close gaps in payment rates between Medicaid and other payers, and Medicaid disproportionate share hospital (DSH) payments, which help offset uncompensated care for Medicaid and uninsured patients. In 2022, essential hospitals reported a total of $10.4 billion in Medicaid shortfall, even after accounting for Medicaid DSH and other supplement payments intended to support essential hospitals.[2] While the Medicaid program provides coverage to many, it still offers the lowest reimbursement rates among payers by far, and structural barriers to financing Medicaid payments have often limited the ability of states to value care for Medicaid patients at the same rate as that for patients covered by other payers.[3] Because most Medicaid beneficiaries now are enrolled in managed care, states have had to develop processes to support safety net providers, including essential hospitals, in the absence of direct payments for services. SDPs help to overcome these challenges by permitting states to direct managed care organizations (MCOs) to pay providers according to specific rates or methods, closing the payment gap for essential hospitals and improving access to essential services for Medicaid beneficiaries. For example, several states use directed payments to increase the Medicaid payment rates for pediatric specialty care, thereby ensuring that there are pediatric specialists available to treat kids who have Medicaid coverage.

SDPs have played an important role in expanding access to high quality care, particularly in rural areas where access to specialized services is already more challenging, as these payments allow states to direct MCOs to enhance provider payments and ensure that essential hospitals receive adequate compensation for the care they provide to Medicaid enrollees. Importantly, state directed payments are used to close the gap from Medicaid rates up to the average commercial rates (ACR). This important policy was developed during the first Trump administration, when the administration recognized that it was critical to expand access to care in rural areas. In most cases, using the ACR as a benchmark for cost of care for Medicaid beneficiaries is the most accurate measurement, especially when looking at maternity or trauma care. Additionally, CMS has set rules for states on how directed payments may be used, and

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[2] Miu R, Kelly K, Nelb R. *Essential Data 2024: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2022 Annual Member Characteristics Survey*. America's Essential Hospitals. December 2024. essentialdata.info. Jan. 31, 2025.

[3] Zuckerman S, Skopec L, Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. *Health Affairs*. 2021;40(2):343–348. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00611. Accessed Jan. 31, 2025.

states are required to receive CMS approval for every directed payment that they want to implement. This ensures transparency for every SDP over where and why that additional support is needed.

Policies that impose limits on SDPs would jeopardize safety net providers' ability to provide access to care for patients in low-income communities, and the association is opposed to any cuts to payments that would harm the ability of providers to serve their patients and communities.

Reducing Coverage

America's Essential Hospitals is concerned with proposals related to work requirements and increasing administrative burden by repealing the Medicaid eligibility rule. Both create more bureaucracy while reducing access to care and increasing uncompensated costs for essential hospitals. Experience shows that Medicaid work requirements are very difficult to implement given the nature of the population served and the complexity of complying with such requirements. Most adults on Medicaid are already working or are caregivers. Many individuals who meet the work requirements nonetheless have their coverage taken away for procedural reasons. In short, they get caught up in the red tape. America's Essential Hospitals is concerned with any proposals or policies that would create barriers to care and reduce health care coverage for eligible patients.

FMAP Changes

Proposals changing federal medical assistance percentage (FMAP) rates threaten access to care and essential services, including policies that would reduce the FMAP rates for Medicaid expansion populations and those that would lower the FMAP floor in certain states. By shifting these costs to cash-strapped states, those states will likely be forced to reduce eligibility, coverage, or provider payments, which increases uncompensated care at essential hospitals. Ultimately resulting in significant barriers to care for vulnerable populations.

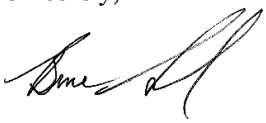
Changing Financial Structure

Proposed per capita caps on federal Medicaid funding would harm patients and providers. A per capita cap approach would result in unreliable federal funding and progressively larger Medicaid cuts over time. These caps would shift significant costs and risks to states, which would cause states to reduce Medicaid availability, benefits, and provider payments.

We ask that you keep these concerns in mind as you continue your work on the budget resolution, and we urge you to reject Medicaid policy changes that would reduce beneficiary access and curtail essential hospitals' ability to meet their mission and serve their communities.

If you have any questions, or would like to learn more about these issues, please contact Jason Pray, vice president of legislative affairs, at [redacted].

Sincerely,



Bruce Siegel, MD, MPH
President and CEO

02.24.2025 / Statement

The Health And Economic Security Of Millions Of Americans Will Be Imperiled If The House Budget Resolution Is Passed

The health and economic security of millions of Americans will be imperiled if the House budget resolution is passed. Every Member of Congress should vote against it.

As the House of Representatives prepares to vote on a budget package that would slash hundreds of billions of dollars from Medicaid and the Child Health Insurance Program (CHIP), five leading health organizations (Association for Community Affiliated Plans, Community Catalyst, Families USA, First Focus Campaign for Children, and the National Alliance on Mental Illness) urge Representatives to vote against any budget deal that would starve a health program that serves families and communities across America. These health organizations include diverse stakeholders representing providers, plans, hospitals, consumers, and communities all committed to protecting access and quality in the Medicaid and CHIP programs.

Medicaid and CHIP's foundational role in the health of our neighbors and local communities cannot be overstated. The program provides insurance for 37 million children, nearly 10 million people with disabilities and 30 million expectant mothers, parents, and adults without kids at home. They cover more than 40 percent of all births in the country and pay 61 percent of the nation's long-term care costs. Furthermore, Medicaid is a critically important source of financial support that keeps rural hospitals open to serve the health needs of their communities and is the single largest funder of mental health and substance use disorder services in the country. Already a lean program, the scale of the cuts required by the budget

resolution would force the loss of coverage for millions, and drastic cuts would have cascading effects on patients, hospitals, community clinics, nursing homes and state budgets – delaying care and driving up costs for Americans.

Americans sent their representatives to Washington with the clear message to lower costs, but the proposed cuts to Medicaid will have the opposite effect, shifting costs on to families already living paycheck to paycheck, and on to hospitals and clinics already struggling to keep their doors open. They will lead to worse health and financial outcomes as families are forced to delay care and accrue more medical debt.

We urge Members of Congress to consider the harm to their constituents and communities in the wake of indiscriminate cuts and urge them to vote against the House Budget Resolution.

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

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Association of
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T 202 828 0400
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February 21, 2025

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mike Johnson
Speaker
United States House of Representatives
Washington, DC 20515

Dear Majority Leader Thune and Speaker Johnson:

As Congress works to extend and expand the Tax Cuts and Jobs Act (TCJA, P.L. 115-97) and address health, immigration, and energy policies, the Association of American Medical Colleges (AAMC) urges you to prioritize policies that ensure access to life-saving health care and improve the health of patients and communities through strategic investments in the nation's health care, research, and public health infrastructure. We urge you to avoid policies that harm the nation's health, particularly cuts to the Medicare and Medicaid programs.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 14 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 201,000 full-time faculty members, 97,000 medical students, 158,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

AAMC-member teaching health systems and hospitals play a vital and unique role in our nation's health care infrastructure and economy. These institutions train the next generation of physicians and other health care professionals, provide a wide range of high-quality health care services, and pioneer cutting-edge research, including new and more effective diagnostics, treatments, and cures. Only in academic medicine do these missions of education, patient care, and research coalesce for the benefit of the American public. Through these missions, AAMC-member institutions enhance both the health and economic vitality of our nation's communities. Teaching health systems and hospitals are anchor institutions, delivering essential health care

and emergency services while also driving employment and economic growth. A 2022 report found that AAMC-member teaching hospitals and medical schools contributed over $728 billion to the U.S. economy, supporting more than 7 million jobs.[1]

Building on these vital contributions to the nation's health care and economy, we urge Congress to protect and strengthen key programs that directly impact our members' ability to serve patients and communities. We urge Congress to:

- Protect Medicaid and the health care safety net
- Maintain hospital tax-exempt status
- Ensure access to care for Medicare patients
- Strengthen and enhance the physician workforce
- Preserve access to coverage and care
- Safeguard access to high-quality medical education
- Support legal immigration for health care workers

PROTECT MEDICAID AND THE HEALTH CARE SAFETY NET

Medicaid is a vital source of coverage and care for over 70 million Americans, including infants, children, the frail elderly, people with disabilities, and working adults in all 50 states. The Medicaid financing structure has garnered criticism from some stakeholders, who allege that federal Medicaid spending is growing at an unsustainable rate. Despite these claims, it is worth noting that Medicaid is a relatively efficient program, with a 2023 growth rate of 7.9%, as compared to 8.1% for Medicare and 11.5% for private insurance.[2] As policymakers contemplate changes to Medicaid's financing structure, the AAMC would like to emphasize that reducing federal Medicaid funding could have devastating, wide-ranging consequences for our health care delivery system and economy, resulting in higher uncompensated care costs for providers and a sicker, less productive workforce.

AAMC-member institutions play an outsized role in caring for the Medicaid population, providing Medicaid enrollees with access to a wide range of primary care and specialty services, including labor and delivery, inpatient psychiatric care, transplant services, and burn treatment, among others. Although AAMC-member teaching hospitals comprise just 5% of hospitals

[1] https://www.aamc.org/data-reports/teaching-hospitals/data/economic-impact-aamc-medical-schools-and-teaching-hospitals
[2] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202023%3A&text=Medicare%20spending%20grew%208.1%25%20to,18%20percent%20of%20total%20NHE.

nationwide, they account for 26% of Medicaid hospitalizations.[3] This demonstrates our members' ongoing commitment to providing high-quality care, regardless of a patient's ability to pay, and the vital role they play in the Medicaid program.

The AAMC strongly supports efforts to ensure that Medicaid enrollees have access to timely, comprehensive care and opposes policies that threaten access for this population. For this reason, the AAMC urges Congress to abide by the following principles when implementing changes to the Medicaid program:

1) Ensure Medicaid enrollees can access quality care by reimbursing providers sufficiently to ensure robust provider networks.
2) Preserve targeted financial support for safety-net providers that care for many Medicaid enrollees.
3) Uphold the federal government's commitment to match state spending on Medicaid, without reducing federal matching rates or implementing block grants or per-capita caps.

State-Directed Payments (SDPs)

While Medicaid plays an important role in our nation's health care system, it is not without problems. Medicaid reimburses hospitals at lower rates than the cost of providing care, creating financial challenges for providers who care for this population. According to data from the American Hospital Association, hospitals received only 88 cents for every dollar spent caring for Medicaid patients in 2020.[4] To ensure that providers have the resources they need to care for Medicaid enrollees, policymakers have leveraged a variety of targeted supplemental payments, including Medicaid state-directed payments (SDPs). Since 2016, states have used these payments to strengthen Medicaid provider network adequacy and ensure access to care for Medicaid enrollees. Under this approach, states are given latitude to direct Medicaid managed care plans to provide additional payments to a given provider or class of providers, depending on the needs of the state. One key strength of Medicaid SDPs is that they provide states with the flexibility to tailor investments in their Medicaid program to meet the unique health care needs of their enrollees. In recent years, states have leveraged SDPs to recruit and retain a sufficient number and mix of providers in their Medicaid programs, expanding enrollees' access to essential services.

[3] AAMC analysis of FY2022 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute's Office of Cancer Centers, 2022. AAMC membership data, December 2023.
[4] https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf

We urge you to protect SDPs as an option for states to enhance provider network adequacy and meet the unique health care needs of their Medicaid population. In particular, we are concerned with proposals to restrict SDPs, such as by reducing the ceiling for these payments from the average commercial rate to the Medicare rate. Lowering the allowable payment limit for SDPs would limit access to care and destabilize teaching hospitals that care for many Medicaid patients. These types of restrictions on SDPs could have wide-ranging consequences, threatening hospital closure, limiting provider network adequacy, and undermining access to care for the Medicaid population. Rather than pursuing a top-down mandate, we encourage you to engage with state leaders to understand how they have leveraged these flexibilities to ensure access to care for Medicaid patients.

Consistent with federal law, states are permitted to finance their share of SDPs through a variety of permissible sources, including state general funds, intergovernmental transfers from local governments, and provider-based funding sources, such as provider taxes. Provider taxes, including those imposed on hospitals, play a crucial role in allowing states to implement SDPs, helping states stretch their scarce financial resources to ensure access to care for enrollees. In light of the growing fiscal pressures facing state governments, provider taxes have emerged as a critical source of funding for SDPs, and therefore, we urge you to avoid additional restrictions on states' use of provider-based funding sources. We encourage you to engage with state leaders regarding the importance of these Medicaid financing flexibilities, and allow states to leverage provider-based funding sources as they see fit to ensure access to care for patients in their Medicaid program.

Block Grants and Per-Capita Caps

Block grants and per-capita allotments ("caps") are two proposals under consideration by lawmakers to help reduce Medicaid spending. While these two proposals have different features, both would fundamentally restructure the way Medicaid is financed, limiting the federal government's commitment to the program while shifting costs and financial risks to the states, Medicaid enrollees, and providers. This type of approach would render states vulnerable to unexpected shocks in health care spending – whether due to rising enrollment during an economic downturn, a public health emergency, the high cost of a breakthrough treatment or medication, or other unforeseen factors beyond the state's control. Under these circumstances, fixed federal funding could negatively impact provider reimbursement or enrollee benefits.

Although block grants and per-capita caps both represent a significant departure from Medicaid's current funding structure, these proposals differ in detail. Under a block grant approach, states would receive a fixed amount of federal funding to administer their Medicaid program, irrespective of program enrollment. By comparison, under a per-capita cap approach, states

would receive a fixed amount of federal funding *per Medicaid enrollee*, leaving states responsible for the remaining costs. This per-enrollee amount would be annually adjusted according to a specified trend rate, such as the state's historical Medicaid spending, the medical component of the Consumer Price Index, or another benchmark. Proponents of block grants and per-capita caps argue that these policies would provide states with greater flexibility to administer their Medicaid programs, while accounting for program growth and reasonable increases in health care costs. Given the inherent unpredictability of health care costs, the AAMC remains concerned that block grants and per-capita caps will not keep pace with states' Medicaid expenses, thereby imposing undue financial strain on state Medicaid budgets. One of the stated goals of these types of policies is to reduce federal spending on the Medicaid program, which, by definition, will shift costs to states. Reducing federal funding for Medicaid could force states to limit program eligibility, further cut already inadequate provider reimbursement rates, or restrict enrollees' access to care. These trade-offs would have serious consequences for our member teaching health systems and hospitals, and their affiliated physician faculty practices, increasing Medicaid shortfalls and uncompensated care costs at a time when providers are struggling to stay afloat in an increasingly inflationary environment.

Changes to the Federal Medical Assistance Percentage (FMAP)

Medicaid is a federal-state partnership, jointly funded by the states and the federal government. The federal government's share of Medicaid expenditures, referred to as the Federal Medical Assistance Percentage (FMAP), varies by states and is inversely associated with a state's per-capita income, allowing lower-income states to receive greater federal funding. As you contemplate changes to Medicaid, the AAMC urges to uphold the federal government's commitment to Medicaid and reject reductions to the FMAP. Reducing the federal funding available to states could result in widespread consequences, including cuts to provider reimbursement, reduced enrollment, and restricted access to care.

The 340B Drug Pricing Program

Established in 1992, the 340B Drug Pricing Program allows certain safety-net health care providers, referred to as "covered entities," to purchase covered outpatient drugs at a discount from manufacturers. The program supports our health care safety net at no cost to the taxpayer – the savings come directly from pharmaceutical companies. The AAMC opposes policies that reduce reimbursement for drugs acquired through the 340B program, which would erode the savings available to covered entities and ultimately harm the patients and communities they serve.

MAINTAIN HOSPITAL TAX-EXEMPT STATUS

AAMC-member teaching health systems and hospitals play an outsized and unique role in our nation's health care infrastructure, providing specialized care, training future physicians, and leveraging cutting-edge technology, research, and expertise to care for the nation's most vulnerable patients. These institutions provide highly specialized health care services that are often unavailable in other settings, including oncology services, transplant surgery, trauma care, and treatment for rare and complex conditions. Although they account for just 5% of all hospitals nationwide, AAMC members comprise 100% of National Cancer Institute (NCI)-designated comprehensive cancer centers, 72% of all burn unit beds, and 61% of all level one trauma centers.[5] In addition to the unique services they provide, AAMC members serve a more medically and socially complex patient population than their non-teaching counterparts, making them critical to our health care safety net.

Any attempt to restrict or eliminate the tax-exempt status of nonprofit teaching health systems and hospitals would undermine their ability to sustain their mission-oriented work. The interconnected nature of AAMC members' patient care, education, research, and community efforts means that weakening one area inevitably harms the others. As Congress debates revisions to federal tax policy, we urge you to work with stakeholders to consider targeted revisions to the Internal Revenue Service Form 990, Schedule H, incorporate the more comprehensive definition of community benefit, and reject the elimination or restriction of the tax-exempt status of non-profit hospitals.

ENSURE ACCESS TO CARE FOR MEDICARE PATIENTS

AAMC-member teaching health systems and hospitals and their affiliated physician faculty practices continue to face profound financial challenges that seriously endanger their ability to care for patients, train the next generation of physicians, drive medical innovation, and foster economic growth. Historic workforce shortages, unprecedented capacity constraints, insufficient reimbursement from payers, supply chain disruptions, and a growth in expenses, all contribute to the acute financial pressures currently facing academic medicine. According to the Medicare Payment Advisory Commission, hospitals' overall fee-for-service Medicare margins dropped to a record low -11.6% in 2022,[6] a trend that is expected to persist. This is further exacerbated by a 2.8% reduction to the Medicare Physician Fee Schedule that took effect in January. These

[5] AAMC analysis of FY2022 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute's Office of Cancer Centers, 2022. AAMC membership data, December 2023.
[6] https://www medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf

compounding challenges jeopardize access to care for Medicare patients at a time when their needs are increasing.

Shortsighted policies such as so-called "site-neutral" payment cuts, including those considered and passed by the House in the 118th Congress, would further exacerbate these financial challenges, disproportionately harming teaching health systems and hospitals, many of which are safety net providers. Despite representing just 5% of all hospitals, AAMC-member institutions would shoulder nearly half of the cuts under current proposals.[7] These cuts fail to account for the more clinically and socially complex patient population cared for in teaching health systems and hospitals' outpatient departments (HOPDs) than physician offices, while complying with greater licensing, accreditation, and regulatory requirements. Reducing Medicare payments for care provided in these settings would threaten patients' access to critical services, particularly in rural and underserved communities, and diminish the ability of our members to sustain their missions.

Congress must act to protect access to care for Medicare beneficiaries by rejecting HOPD cuts, ensuring that there are no cuts to the Medicare program, and enacting meaningful Medicare Physician Fee Schedule reform. While we understand the difficult fiscal decisions before Congress, the AAMC strongly opposes financing temporary provisions through permanent reductions to the Medicare program. Teaching health systems and hospitals cannot absorb additional cuts without dire consequences for patients, communities, and the future of the physician workforce. We urge you to preserve and strengthen Medicare's support for academic medicine to ensure that our nation's most vulnerable patients continue to receive the high-quality care they need and deserve.

STRENGTHEN AND ENHANCE THE PHYSICIAN WORKFORCE

The United States faces a projected physician shortage of up to 86,000 doctors by 2036, with demand rapidly outpacing supply.[8] To address this growing crisis, it is critical that we expand physician training through additional investment in graduate medical education (GME), the supervised hands-on training after medical school that all physicians must complete to be licensed and practice independently. While the AAMC greatly appreciates and applauds recent bipartisan investments by Congress to expand Medicare support for GME, including the 1,200 new residency positions provided in the Consolidated Appropriations Act, 2021 (P.L. 116-260) and the Consolidated Appropriations Act, 2023 (P.L. 117-328), additional investment is needed to counteract the cap imposed on GME in 1997.

[7] AAMC Analysis of 2021 100% Medicare Standard Analytic File
[8] https://www.aamc.org/media/75236/download?attachment

While representing only 5% of hospitals nationwide, AAMC members train 72% (approximately 78,000) of residents nationwide, shouldering substantial financial responsibility while receiving only Medicare's "share" of the costs to train physicians.[9] Despite the significant financial challenges our members face, they continue to train thousands of residents beyond their Medicare caps, fully funding the training of over 21,000 resident full-time equivalents or FTEs. Teaching health systems and hospitals spend approximately $24.6 billion on physician training annually, but they are reimbursed only Medicare's "share" of the costs, which is approximately $6 billion (about 24%).[10] This amounts to nearly $19 billion in direct costs not paid for by Medicare. However, misguided proposals, such as transitioning GME into a block grant program with growth tied to the medical component of the Consumer Price Index or reducing "excess GME payments to 'efficient' teaching hospitals," would place these "over the cap" positions at risk, undermine the critical mission to train more physicians, and worsen workforce shortages, particularly in rural and underserved areas. Rather than impose these harmful cuts, Congress must build on recent bipartisan GME progress and strengthen GME support to ensure a robust physician workforce for the future.

PRESERVE ACCESS TO COVERAGE AND CARE

The AAMC is committed to ensuring that all people have access to affordable, comprehensive health insurance coverage. Consistent with this commitment, the AAMC supports policies to expand coverage and reduce the number of uninsured nationwide. We are concerned with proposals that would lead to coverage losses among the Medicaid population, including work and community engagement requirements. To protect and strengthen coverage options for everyday Americans, we urge policymakers to extend enhanced premium tax credits provided by the American Rescue Plan beyond 2025, which help ensure that coverage remains affordable to middle-class families. These tax credits have enabled millions of people to gain coverage through the marketplace exchanges, increasing access to high-quality care in teaching health systems and hospitals. Absent congressional action to extend these credits, the Congressional Budget Office estimates that nearly 4 million Americans could lose coverage, jeopardizing their access to life-saving care.[11]

SAFEGUARD ACCESS TO HIGH-QUALITY MEDICAL EDUCATION

Federal student loans play a key role in supporting aspiring physicians from all backgrounds to access medical education. For example, nearly 40% of medical students rely upon the Direct

[9] AAMC's analysis of FY2022 Hospital Cost Reporting Information System (HCRIS) data, July 2024 release.
[10] AAMC Analysis of FY2022 Medicare Cost Report data, July 2024 Hospital Cost Reporting Information System (HCRIS) release**.** If FY2022 data is not available, FY2021 data is used.
[11] https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf

PLUS Loan program to finance their medical education. Direct PLUS Loans have several key features that support prospective medical students, offering flexible income-driven repayment options, allowing students the ability to borrow up to the cost of attendance, and other essential borrower protections. Without Direct PLUS as an option, many prospective students would be unable to access medical school, further exacerbating the physician workforce shortage.

We also encourage you to maintain loan repayment options as a way to recruit and retain physicians in medically underserved areas, such as the public service loan forgiveness program (PSLF). The PSLF program is a critical tool to incentivize physicians to practice in rural and urban medically underserved communities, where serious health care workforce shortages impede access to care. Absent loan repayment plan options like PSLF, our physician shortage will continue to grow to the expense of access to care for rural and underserved communities.

The medical and higher education community also encourages lawmakers to reject proposals that would limit federal loan options and repayment plans based on factors institutions cannot control. This includes proposals to limit financial aid to institutions based on tax status. Restrictions to student loan access and flexible repayment plans create barriers to train the future physician workforce and in turn, limit access to high-quality care, especially in communities that historically struggle to recruit and retain physicians.

SUPPORT LEGAL IMMIGRATION FOR HEALTH CARE WORKERS

Physicians and health care workers from other countries play a significant role in safeguarding our nation's health and well-being by alleviating workforce shortages in rural and other underserved communities. Approximately 23% of active physicians practicing in the United States are international medical graduates, many of whom are now citizens or permanent residents.[12] As policymakers consider changes to immigration policy as part of the budget reconciliation process, we encourage you to preserve the visa programs commonly used by health care workers and ensure continued access to care for rural and underserved communities who rely on these providers. Additionally, we urge policymakers to maintain work authorization for individuals with qualified Deferred Action for Childhood Arrivals (DACA) status, including tens of thousands of health care workers. Given the serious health care workforce shortages facing our nation, our health care system can ill-afford to lose valuable personnel. We urge you to preserve and fortify policies that protect legal immigration which will in turn help maintain and improve access to care for patients.

[12]Nagarajan KK, Bali A, Malayala SV, Adhikari R. Prevalence of US-trained International Medical Graduates (IMG) physicians awaiting permanent residency: a quantitative analysis. J Community Hosp Intern Med Perspect. 2020 Oct 29;10(6):537-541. doi: 10.1080/20009666.2020.1816274. PMID: 33194124; PMCID: PMC7599012.

If you have any further questions, please contact me or Len Marquez, Senior Director, AAMC Government Relations and Legislative Advocacy, at [redacted]

Sincerely,

Danielle Turnipseed, JD, MHSA, MPP
Chief Public Policy Officer
Association of American Medical Colleges

CC: David J. Skorton, MD
President and CEO
Association of American Medical Colleges

The Honorable Mike Crapo, Chair, Senate Finance Committee
The Honorable Bill Cassidy, Chair, Senate Health, Education, Labor, and Pensions Committee
The Honorable Lindsey Graham, Chair, Senate Budget Committee
The Honorable Brett Guthrie, Chair, House Energy and Commerce Committee
The Honorable Jason Smith, Chair, House Ways and Means Committee
The Honorable Tim Walberg, Chair, House Education and Workforce Committee
The Honorable Jodey Arrington, Chair, House Budget Committee

AAMC

PRESS RELEASE

AAMC Statement on the House Budget Resolution

Feb. 25, 2025

AAMC (Association of American Medical Colleges) President and CEO David J. Skorton, MD, and Chief Public Policy Officer Danielle Turnipseed, JD, MHSA, MPP, issued the following statement on the budget resolution set for consideration by the U.S. House of Representatives:

"As the House considers its fiscal year 2025 budget resolution, we urge lawmakers to protect access to care for millions of hard-working Americans by rejecting policies that could lead to significant cuts to the Medicaid program and limit access to student financial aid for aspiring physicians. AAMC-member academic health systems and teaching hospitals, medical schools, and their affiliated physician faculty plans play a vital and unique role in our nation's health care infrastructure by training the next generation of physicians and other health care professionals, providing a wide range of high-quality health care services, and serving as the health care safety-net providing care to all patients—regardless of their ability to pay.

We remain extremely concerned that the budget resolution's reconciliation instructions would result in unsustainable cuts to federal health programs, specifically Medicaid, by requiring at least $880 billion in savings from the House Energy and Commerce Committee. Cuts of this magnitude would jeopardize both access to care for millions of Medicaid enrollees and the financial stability of providers who care for them. Rather, we hope policymakers will work together to invest in the health of all people by upholding the federal government's financial commitment to federal health care programs, ensuring sufficient reimbursement for providers, safeguarding access to high quality

medical education by ensuring access to federal loan options and repayment plans, and maintaining targeted financial support for safety-net providers.

The nation's academic health systems and teaching hospitals, medical schools, and faculty practices are committed to improving the health of the American people, and federal support is critical to achieving this goal. Ensuring access to health care is a responsibility we all share. The AAMC and our members stand ready to work with all members of Congress to develop proposals that maintain access to health care in rural and urban communities across the country."

TOPIC:

Advocacy, Policy, & Legislation | Budget/Appropriations | Legislation | Legislative Branch (Congress) | Medicare/Medicaid

AAMC Association of American Medical Colleges

CALIFORNIA CHILDREN'S HOSPITAL ASSOCIATION

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916.552.7111
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February 24, 2025

The Honorable Nanette Barragán
2312 Rayburn House Office Building
United States House of Representatives
Washington, DC, 20515

SUBJECT: PROTECT MEDICAID - VOTE NO ON THE HOUSE BUDGET RESOLUTION

Dear Representative Barragán:

On behalf of the California Children's Hospital Association (CCHA) and our eight not-for-profit, free-standing children's hospitals, we urge you to VOTE NO on the House Budget Resolution, which would require devastating cuts to the Medicaid program, harming millions of children.

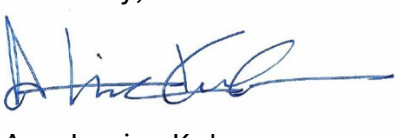
Approval of the House Budget Resolution is more than just a procedural step. It would require the House Energy and Commerce (E&C) Committee to cut the programs under its jurisdiction by $880 billion. Medicaid, a lifeline for millions of children in California and across the country, is the largest program under the jurisdiction of this Committee. There is simply no way to cut this deeply into programs overseen by E&C without harming vital resources for children. There is no credible evidence to suggest that there is $880 million in fraud, waste, and abuse in the Medicaid program, and there is no way to insulate children from the devastating impact of cuts of this magnitude.

Approximately 5.5 million children in California depend on the program, including those with the most complex, life-threatening conditions like cancer, cystic fibrosis, hemophilia, congenital heart defects, and sickle cell disease. Sizeable cuts to this program, like the ones that would be necessitated by the House Budget Resolution, would immediately impact access to care for these children, as well as children who are privately insured. This is because these cuts would require pediatric providers to reduce services that all children in the state rely on, not just children covered by Medi-Cal, the state's Medicaid program.

Today's children will eventually be responsible for supporting the U.S. economy, and as such, their health and well-being is critical to the future prosperity of our nation. We urge you to vote no on the House Budget Resolution and ensure critical programs like Medicaid are protected by whatever budget blueprint is ultimately advanced.

If you have any questions or would like additional information, please contact our Vice President of Government Affairs, Mira Morton, at [redacted] or [redacted].

Sincerely,



Ann-Louise Kuhns
President & CEO
California Children's Hospital Association

California Hospital Association

February 10, 2025

Members of the California Congressional Delegation:

Over the next few weeks, you will face consequential decisions on health care issues, the effects of which will be felt for years to come. We hope you will move quickly to protect the Californians who rely on hospitals for vital health care services by addressing several outstanding issues left unresolved by the current continuing resolution that expires March 14.

Hospitals are fragile. More than half of all hospitals in California lose money every day delivering care. Dozens more are barely above break-even. With each vote, you will have the opportunity to either offer a lifeline or deliver another cut to a health care system on the brink.

One thing is certain: With your support, hospitals can continue to provide lifesaving, life-changing care to their communities. On behalf of more than 400 hospitals and health systems serving the Californians we are all committed to help, we ask that you support a ***continuing resolution*** that would:

Protect Vulnerable Californians: Restore Payments to Disproportionate Share Hospitals

California's most vulnerable populations including children, those over the age of 65, impoverished populations, and those living with disabilities rely on programs made possible by Medicaid's disproportionate share hospital (DSH) program. More than 150 hospitals in California participate in the DSH program, which provides a lifeline that supports services such as trauma and burn care, maternal and child health, high-risk neonatal care, and more. DSH resources are also vital to deliver care to those without any health coverage at all.

Without congressional action, major cuts to this essential program are scheduled to take effect on April 1, 2025, and would reduce payments to California's hospitals by as much as $1.3 billion. Congress, understanding how essential Medicaid DSH funding is to these struggling hospitals, has repeatedly delayed the implementation of Medicaid DSH cuts with strong bipartisan support. To preserve access to vital services, Congress must act again.

Please delay cuts to this lifesaving program and ensure that hospitals can continue to serve their communities.

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1215 K Street, Suite 700, Sacramento, CA 95814 ▪ Office: (916) 443-7401 ▪ www.calhospital.org

Ensure Cost-Effective Access to Care: Extend Telehealth and Hospital-at-Home Policies

Telehealth and Hospital-At-Home programs are vital lifelines to patients who need access to care from their homes. Congress has repeatedly demonstrated bipartisan support for these essential programs, which have proven to improve quality and efficiency by facilitating patient compliance and follow-up care.

Please extend access to care for patients who rely on these cost-effective services after April 1.

Help Rural Hospitals Continue to Care for Patients: Extend Supports for Rural Hospitals

Nearly 2 million people live in California's rural communities and their access to life-saving hospital care is at risk due to significant underpayment by the Medicare and Medicaid programs. Many small and rural hospitals in California mirror a troubling national trend: on average, they have seen their operating margins drop by a frightening 8 percentage points from 2019 to 2023. Between January 2013 and February 2020, more than 100 rural hospitals nationwide closed, including two in California Corcoran District Hospital and Madera Community Hospital. When a rural hospital closes, those in poor health, seniors, and low-income Californians suffer the most.

Additional Medicare payments for ambulance services, Medicare-dependent and low-volume hospitals are set to expire at the end of March or early April.

Please extend the Ambulance Add-on, and Medicare-dependent and low-volume adjustments.

Your local hospitals desperately need your help to continue our mission of lifesaving care. Your vote on a continuing resolution to ensure access to care for Californians can help protect the communities we all serve.

Sincerely,

Carmela Coyle
President & CEO
California Hospital Association

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California Hospital Association

February 12, 2025

Members of the California Congressional Delegation:

Upcoming votes on a federal budget resolution and reconciliation package give you the power to preserve access to hospital care for 40 million Californians and help rural and other struggling hospitals stay open in our state. Today before any budget cuts are made more than half of all hospitals in California lose money providing care and dozens more barely break even.

The impact of your votes on those who need care, and the 1 million jobs California hospitals support, will be felt for decades.

Please reject budget proposals that threaten care, coverage, and California hospitals' continued viability.

Protect California: Oppose Proposals that Target California

Certain proposals reducing the Medicaid Federal Medical Assistance Percentage (FMAP), changes to Medicaid financing, and changes to the Medicare Area Wage Index (AWI) would target and gut care in California more than in other states.

- The federal share of Medicaid spending, the FMAP, varies between states. It is set at 50% for California, the lowest level allowed under current law.
- A change in the FMAP would decimate health care coverage in California and devastate the providers who care for Californians.
- States fund their share of the Medicaid program through a patchwork of financing mechanisms approved by Congress 49 states rely on provider taxes to fund a portion of their state Medicaid program.
- California is an expensive place to live and work. Medicare recognizes disparate costs of living with a payment adjustment called AWI; budget neutral changes to AWI would cut payments to ALL California hospitals, not just rural hospitals.

Please oppose proposals that will disproportionately hurt California.

Protect 15 Million Californians on Medicaid: Oppose Health Care Cuts for Seniors, Children, and More

Medicaid is an efficient insurer and vital to Californians' access to care. The facts:

- 14.9 million Californians 38% of the state's population were enrolled in Medicaid in October 2024.

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- Nearly 50% of people living in rural California counties are enrolled in Medicaid the largest source of health care coverage in rural communities.
- 5 million children 50% of all kids are covered by Medicaid.
- 40% of all births in California are covered by Medicaid.
- Three-quarters of Medicaid enrollees live in a household with someone working full- or part-time.

Adjusted for cost of living, California's per enrollee spending ranks 14th lowest in the nation.

Hospitals are paid about 80 cents for every dollar it costs to care for a Medicaid patient and these payments make up an average of 33% of hospital revenues statewide. But in some areas, they can be as much as 80% of a hospital's revenue. These resources are critical to keeping hospitals' doors open to care for everyone in their communities.

Please oppose cuts to the Medicaid program.

Ensure Patients Receive Appropriate Care: Reject Site-Neutral Payment Policies

Legislation now before Congress would reduce payments to hospitals for certain procedures provided in hospital outpatient departments, making them equivalent to payments made for services provided in physician offices. Proponents of these "site-neutral" proposals suggest that the care provided is the same, regardless of setting, and therefore the price should be the same.

This argument neglects an important fact: Patients who receive care in hospital outpatient departments typically have more complex needs and benefit from the additional clinical services provided in those settings. Hospital-based services are more expensive for important and legitimate reasons, and they have more comprehensive licensing, accreditation, and regulatory requirements than independent physician offices or ambulatory surgery centers. The additional costs support a higher level of patient care.

Cutting reimbursement for certain services would make it difficult for hospitals to continue to provide this care and because some services may not be offered elsewhere in the community, many patients would have difficulty accessing medically necessary health care.

Please oppose legislation that restricts payments based on the physical location where care is provided.

Help Hospitals Stretch Resources, Improve Patient Care: Support the 340B Drug Pricing Program

Congress created the 340B program to help stretch scarce resources, reach more patients, and provide more comprehensive services through the outpatient drug discount program. Despite having a 0.1% operating margin, California's 175 340B hospitals provided more than $7.1 billion in benefits to the communities they serve **at no additional cost to taxpayers**. Funding went to programs like medication therapy management, diabetes education and counseling, behavioral health services, opioid treatment services, and providing free or discounted drugs to those in need. Including the 340B discount, which only accounts for 3.1% of pharmaceutical company revenue, the top 10 manufacturers still had an average operating margin of more than 28%.

This program's enormous benefits are now at risk due to pressure from pharmaceutical companies seeking to bolster their bottom lines.

Please support the 340B Drug Pricing Program.

Keep Insurance Affordable: Maintain Access to Premium Support

In addition to Medicaid, more than 1.5 million Californians rely on federal support to pay for their exchange-based insurance premiums. Helping pay the premiums for hard-working Californians who could not otherwise afford coverage is vital to preserving their access to care and preventing the rise in uncompensated care for providers.

Please oppose cuts to insurance premium support.

California hospitals need your support to continue to care for the people we both serve. Your votes during the first few months of the 119 h Congress can help protect the communities we share.

Sincerely,

Carmela Coyle
President & CEO
California Hospital Association

CALIFORNIA MEDICAL ASSOCIATION

February 24, 2025

CMA Urges Congress to Protect Patient Access to Care and Oppose the Medicaid Cuts

Dear California Members of Congress:

On behalf of the more than 50,000 physicians and medical student members of the California Medical Association (CMA) and the millions of patients we serve, we urge you to reject the draconian Medicaid funding cut of nearly $880 billion in the Budget Resolution. The proposed Medicaid cuts would jeopardize the health of nearly 15 million Californians who are our patients – children, pregnant women, seniors, the disabled, veterans, and low-income working families. For decades Medicaid has been the safety net for these vulnerable patients and it must be protected. The Medicaid cuts disproportionately harm rural communities as 50% of rural Californians depend on Medicaid. The cuts threaten the economic security of low-income working families and the economic stability of rural areas. Over one-third of Californians are currently on Medicaid and as they lose coverage or benefits under this legislation, physician practices, emergency rooms, and rural hospitals will be forced to close. This bill not only threatens patient care but the viability of California's entire health care workforce and the health care delivery system.

Medicaid Matters

Medicaid provides millions of Californians with access to health care, improving their health and well-being.
It helps nearly half of California's children develop into healthy adults and helps adults stay healthy by providing access to primary and preventive care that keeps people out of already overburdened emergency rooms and hospitals. Medicaid allows disabled children to be cared for at home rather than institutionalized. It is the largest payer of nursing home care for the elderly in the nation and ensures patients have access to life-saving medications, treatment to manage chronic conditions, and care for acute illnesses. Without Medicaid, patients with cancer would be diagnosed at later stages and face higher risks of mortality. Patients with chronic conditions such as cardiovascular disease and diabetes would go untreated and have worse health outcomes. Patients suffering from mental health issues would delay or forgo the essential care they need.

Medicaid provides economic security to low-income working families, particularly in rural areas.
Many Californians do not receive health insurance from their employers, either because it is not offered, or it is unaffordable. Medicaid makes coverage affordable. It also provides access to medical care that makes it possible for people to work and attend school. Medicaid provides economic security for low-income working families struggling to pay bills and reduces medical debt and bankruptcy, particularly in rural areas.

Medicaid is an efficient, low-spending health care program.
California's Medicaid program is among the most efficient in the nation, partly because of the important role of the local Medi-Cal managed care plans. California's per enrollee spending ranks 14th lowest in the nation.

For these reasons, Medicaid is popular. Californians strongly support increased Medicaid funding.
Last November 2024, California voters overwhelmingly supported increased funding for Medi-Cal, the state's Medicaid program, through Proposition 35, the Protect Access to Health Care Act. Prop 35 enjoyed strong bipartisan support. Statewide, 68% of Californians and an average 63% of Californians in rural districts supported increased Medi-Cal funding. The promise of Prop 35 is to increase access to all providers and train the health care workforce of the future. It creates new jobs across the state. California voters were clear that we need to protect Medicaid and increase funding, not tear it down.

Americans widely support Medicaid. In a Kaiser Family Foundation poll, three-fourths of the public say they have favorable views of Medicaid, including a majority of Republicans, Independents, and Democrats. Two-thirds say they have some

connection to Medicaid, through their own coverage or a family member. The recent Hart Poll shows two-thirds of Trump voters believe Medicaid is an important source of health coverage for people who could not otherwise afford insurance.

The Medicaid cuts will have a negative impact on California physicians and the health care system.
CMA is opposed to the following proposals:
1-Reducing federal Medicaid matching funds will force California to cut coverage, benefits and physician payment, which will reduce access to care. The federal formula already discriminates against California because it is based on average income levels rather than the number of people living in poverty, which is the focus of the Medicaid program. Medicaid matching funds should be based on the numbers of people that states serve. These proposals unnecessarily discriminate against California.

2-Establishing per capita caps will end the guarantee of a national safety net and is not likely to keep pace with rising health costs and additional patient needs in economic downturns, pandemics, or natural disasters.

3-Eliminating the managed care organization and provider levies will also result in significant cuts. In California, the provider levies are almost solely dedicated to health care and the purpose of Prop 35 was to ensure that the managed care organization federal match is committed to Medicaid. Congress should ensure these levies are obligated to health care nationwide rather than eliminating the programs.

The Medicaid Cuts Shift the Economic Burden to Physicians and Hospitals which will be Forced to Close; Thousands of Health Care Jobs Will be Lost and Costs will be Shifted to All Californians.
These proposals disproportionately harm California's rural and at-risk communities that are dependent on Medicaid. Californian's health will suffer. Just as devastating, the significant loss in Medicaid coverage and the resulting increase in the uninsured will shift the burden to already overburdened physicians, hospitals and other providers. It will force the closure of physician practices, birthing centers in OB deserts, nursing homes, and rural hospitals. Such closures will result in the loss of thousands of health care related jobs in California. The economic stability of rural communities will be particularly hard hit. Moreover, Prop 35 provides funding for Graduate Medical Education to train our future health care workforce. These funds are also now in jeopardy.

Patients without health care coverage will be forced to delay or forego care which results in more difficult and costly conditions to treat in emergency rooms and hospitals. These increased costs will be passed down to all Californians. Cutting Medicaid does not save money, it just shifts costs, often to the taxpayer.

Protect the Economic and Health Care Advances California has Made
We have made great strides in California to provide affordable, efficient health care coverage and improve access to physicians and other providers. California has one of the lowest uninsured rates in its history and in the nation. Over the last 15 years, California's uninsured rate declined from 20% of the population to just over 6%.

The physicians of California urge you to protect these important advances by rejecting Medicaid cuts that threaten quality patient care, coverage, and the viability of our entire health care system. Please Protect Medicaid.
Thank you for your support of physicians and patients. We look forward to working with you to improve the Medicaid Program. Please direct any questions to Elizabeth McNeil, Federal Government Relations, CMA, [redacted].

Sincerely,

Shannon Udovic-Constant, MD
President

February 24, 2025

TO: Members of the California Congressional Delegation
RE: Protect Access to Care and Oppose Medicaid Cuts

On behalf of the undersigned organizations and the 15 million Medi-Cal (California's Medicaid program) patients we serve, we urge you to reject the severe proposed Medicaid funding cuts that would harm the care that is delivered to all Californians, not just those on Medicaid.

California's Medi-Cal program is among the most efficient and cost effective in the nation, thanks in part to the critical role of local Medi-Cal managed care plans. Adjusted for cost of living, California ranks 14th lowest in per-enrollee Medicaid spending nationwide.

Ultimately, the proposed Medicaid cuts amount to an added tax burden on all Californians, as newly uninsured patients are forced to forgo vital preventive care and instead end up in hospital emergency departments with more costly, difficult-to-treat conditions — leading to higher health care costs for everyone.

In particular, the health care of our patients – children, pregnant women, seniors, disabled individuals, veterans, and low-income working families who cannot afford insurance or are not offered it by employers will be directly impacted. Additionally, having a regular source of care that includes preventive care and treatment for chronic conditions plays an important role in family stability and productivity. Medicaid provides essential health care services, and it must be protected. Medicaid is particularly important in rural areas, where 50% of Californians would lack health care coverage without it.

With nearly 40% of Californians enrolled in Medi-Cal, California voters have made clear that we need to protect this health care coverage, and increase funding, not tear it down. In November 2024, voters overwhelmingly supported increased funding for Medi-Cal, through Proposition 35, the Protect Access to Health Care Act, which passed with 68% of the vote and strong bipartisan support.

Three-fourths of Americans have favorable views of Medicaid, including a majority of Republicans, Independents, and Democrats and a recent Hart Poll shows two-thirds of Trump voters believe Medicaid is an important source of health coverage for people who could not otherwise afford healthcare.

The proposals to reduce federal Medicaid matching funds, establish per capita caps that end the guarantee of Medicaid, and eliminate managed care organization and provider levies—

which are dedicated to health care in California—disproportionately harm California's rural and at-risk communities that rely on Medicaid. These significant cuts would shift the health care burden to physicians and other healthcare providers, may result in the closure of more hospitals and their services, along with physician/healthcare provider practices, strain community health centers that care for one third of all Medi-Cal enrollees in our state and make it more difficult for us to care for Medi-Cal patients and those who lose coverage.

California's healthcare system serves everyone. Medi-Cal, 15 million people enrolled, is a critical funding source and critical to the health and well-being of your constituents. It protects our most vulnerable by providing essential services to half of California's children. It ensures vital access to primary and preventive care, improving health outcomes and reducing overall costs by keeping people out of emergency rooms.

Medicaid cuts will hurt California disproportionately. A vote to strip funding away from California is a vote against what California voters supported when they passed Proposition 35. We urge you to protect your constituents by rejecting Medicaid cuts that threaten patient care, coverage, and California provider viability. Please protect our Medicaid program.

Catholic Health Association of the United States

We Will Empower Bold Change to Elevate Human Flourishing.℠

February 20, 2025

United States House of Representatives
Washington, DC 20515

Dear Representative:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization representing more than 2,200 Catholic hospitals, long-term care facilities, clinics, service providers, healthcare systems, and other facilities across all fifty states**, I urge you to vote "No" on the House Concurrent Budget Resolution 14 for FY25 through FY34. This budget resolution would severely impact critical health and social safety-net programs, especially the Medicaid program, that are lifelines for your constituents and the patients and communities we serve.**

We are deeply concerned that this budget resolution would force the House Energy and Commerce Committee to slash $880 billion from the Medicaid program—an essential health care program for nearly 80 million low-income Americans. Medicaid provides coverage for one in five individuals, funds 41% of all births nationwide, and is the largest payer for long-term care and behavioral health services. These cuts would have devastating consequences, particularly for those in small towns and rural communities, where Medicaid is often the primary source of health care coverage. **Medicaid is not just a health program—it is a lifeline. It provides access to care for those who need it most—poor and vulnerable children, pregnant women, elderly, adults, and disabled individuals in our nation while ensuring their dignity.**

CHA and our members firmly believe that health care is a fundamental human right that is essential to human flourishing. For decades, we have championed policies ensuring everyone has access to affordable health care. Rooted in our faith, we affirm that every individual is created in the image of God, possesses inalienable worth, and deserves care that upholds their inherent dignity. Our health ministry is especially committed to serving those most in need, recognizing that our mission is not complete until quality, affordable, and accessible health care is a reality for all.

We urge you to vote against the budget resolution when considered on the House floor and instead champion policies rooted in compassion and dignity. By protecting our most vulnerable, we create a healthier, stronger society for everyone.

Sincerely,

Sister Mary Haddad

Sr. Mary Haddad, RSM
President and CEO

1625 Eye Street NW, Ste. 550 Washington, DC 20006 *phone* 202.296.3993 *fax* 202.296.3997 **www.chausa.org**

CHILDREN'S HOSPITAL ASSOCIATION

STATEMENT

Children's Hospital Association Opposes Cuts to Medicaid, Urges Congress to Protect Patient Care

Substantial cuts to Medicaid would have a devastating impact on the 37 million children who rely on the program.

BOOKMARK

Published Feb. 25, 2025 1 min. read

WASHINGTON, D.C. – Children's Hospital Association (CHA) released a statement today urging House members to vote "no" on the budget resolution, which would likely have a major impact on the Medicaid program. Substantial cuts would have a devastating impact on the 37 million children who rely on the Medicaid program. It is vital to ensure our nation's children are healthy and able to thrive into adulthood. CHA's President and CEO Matthew Cook released the following statement:

"The House budget resolution's directive to the Energy and Commerce Committee to cut $880 billion in spending will almost certainly lead to deep reductions in Medicaid funding for children who rely on the program and destabilize the financial viability of providers caring for them."

"Slashing funding would mean fewer health care providers, fewer services, and longer wait times for patients who already face significant barriers to care. These cuts will impact the 37 million children on the Medicaid program, including nearly 50 percent of children with special health care needs, 3 million children in military-connected families, and more than 40 percent of children living in rural areas and small towns. Patients in rural communities would be hit especially hard, as hospitals and clinics in these areas rely heavily on Medicaid funding to stay open."

"We urge Congress to prevent these harmful cuts to ensure all Medicaid enrollees can get the care they need, when they need it. Now is the time to strengthen access to care, not put it at risk."

...

ACCESS TO CARE MEDICAID MEDICARE

Contact Us

About Children's Hospital Association

Children’s Hospital Association is the national voice of more than 200 children’s hospitals, advancing child health through innovation in the quality, cost, and delivery of care.

LEARN MORE

LEGAL ACTION CENTER

Coalition for Whole Health

Protect Medicaid: Oppose Funding Cuts to Health Care Coverage for Over 70 Million Americans

Coalition for Whole Health Report

Executive Summary

The Coalition for Whole Health (Coalition) urges Congress not to cut funding or otherwise undermine access to Medicaid. Medicaid is a lifeline for the more than **70 million Americans** who rely on the program for access to health care. We advocate for the nearly **40% of nonelderly adult Medicaid enrollees – 13.9 million people – with a mental health condition and/or substance use disorder** who depend on Medicaid for critical health services.
We urge Congress not to use the Medicaid program to pay for other legislative priorities.

Medicaid plays a key role in access to care for people with **MH conditions and SUD** and is vital to ongoing efforts to address the **overdose crisis**.

- Medicaid is the single largest payer of mental health (MH) and substance use disorder (SUD) care as the U.S. loses nearly 300 people a day to drug overdose and nearly 50,000 a year to suicide.
- Medicaid funds the full range of MH, SUD and integrated health care in clinics, hospitals, doctors' offices and nursing homes as well as vital home and community-based services and transportation to care.
- In 2023, about 30% of adults who needed but did not receive SUD treatment cited lack of coverage and/or unaffordability as the reason.

We urge Congress to **oppose** any changes to Medicaid's financing structure, including but not limited to:

- Block grants
- Per capita caps
- Cuts to the federal medical assistance percentage
- Cuts to eligibility and benefits
- Making Medicaid coverage less affordable
- Barriers to coverage like work requirements and other policies that add red tape to enrollment

Any of these changes would lead to:

- Coverage losses
- Reduced access to MH and SUD treatment
- Difficulty managing co-occurring chronic medical and MH/SU conditions
- Increased use of costly emergency departments
- Poorer health outcomes, including more deaths by suicide and overdose

Medicaid is a vital lifeline for people across the U.S. at critical times in their lives. Visit That'sMedicaid to see how Medicaid has impacted people in your state.

Oppose All Cuts to Medicaid!!!

Protect Medicaid: Oppose Funding Cuts to Health Care Coverage for Over 70 Million Americans

Coalition for Whole Health Report

Medicaid Provides Access to Critical Mental Health and Substance Use Services and is an Essential Tool in the U.S. Response to the Drug Overdose and Suicide Crises

The Coalition for Whole Health (Coalition) urges Congress not to cut funding or otherwise undermine access to Medicaid. Medicaid is a lifeline for the more than **70 million Americans** who rely on the program for access to health care. We advocate for the nearly **40% of nonelderly adult Medicaid enrollees with a mental health (MH) condition and/or substance use disorder (SUD)** who depend on Medicaid for critical health services.

We urge Congress not to use the Medicaid program to pay for other legislative priorities.

The Coalition is a broad alliance of over 150 national, state, and local organizations in the MH condition and SUD prevention, treatment, and recovery communities. Established in 2009 to ensure federal health care reform legislation equitably included MH and substance use-related conditions, the Coalition has worked the last several years to ensure the Affordable Care Act is working for people with MH and SUD care needs.

Medicaid provides critical access to **health care services**:

- Inpatient and outpatient hospital services
- Physician services
- Rural health clinic services and federally qualified health center services
- Lab and x-ray services
- Home and community-based services for older adults, people with disabilities, and people with MH conditions or SUD
- Nursing facility services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children
- Medication Assisted Treatment
- Transportation to medical services
- Integrating MH and SUD care with medical and specialty care

Cuts to the Medicaid program would have impacts on people across demographics, but more acute impacts on people who are already more vulnerable, including:

- Children
- Older people
- Adults and children in crisis
- People living in rural areas
- People with disabilities
- People with co-occurring medical and MH/SUD conditions
- People reentering from prisons/jails

The Case for Medicaid: The Data

- Medicaid plays a key role in access to care for people with MH and substance use conditions. Nearly 40% of the nonelderly adult Medicaid population (13.9 million enrollees) had an MH condition or SUD in 2020.
- Medicaid is playing a key role in addressing the overdose crisis as it is the single largest payer of MH and SUD care in the country. Although U.S. overdose deaths decreased in 2023 for the first time since 2018, the U.S. is still losing nearly 300 people a day to drug overdose.
- Close to 30% of people receiving coverage through the Medicaid expansion of eligibility have an MH condition and/or an SUD.
- States that expanded Medicaid eligibility saw improvements in access to medications and services for MH conditions and SUD after expansion.
- Roughly 40% of people with chronic medical illness also have MH/SU conditions. Research has shown that when people with co-occurring chronic medical and behavioral health conditions aren't able to access MH/SUD services, they have significantly poorer health outcomes at increased cost to the health care system.
- Medicaid expansion of eligibility decreased suicide mortality by increasing access to MH coverage.
- Studies show Medicaid expansion of eligibility has significantly increased outpatient and preventive care, reduced emergency department use and medication lapses due to cost, and improved self-reported health.
- In 2023, approximately 30% of adults who needed but did not receive SUD treatment cited not having coverage and/or being unable to afford the cost of care as the reason. Likewise, adults who needed but did not receive MH care most commonly cited the same reasons.

The Case for Medicaid: Advancing Innovation and Providing State Flexibility to Address Local Needs

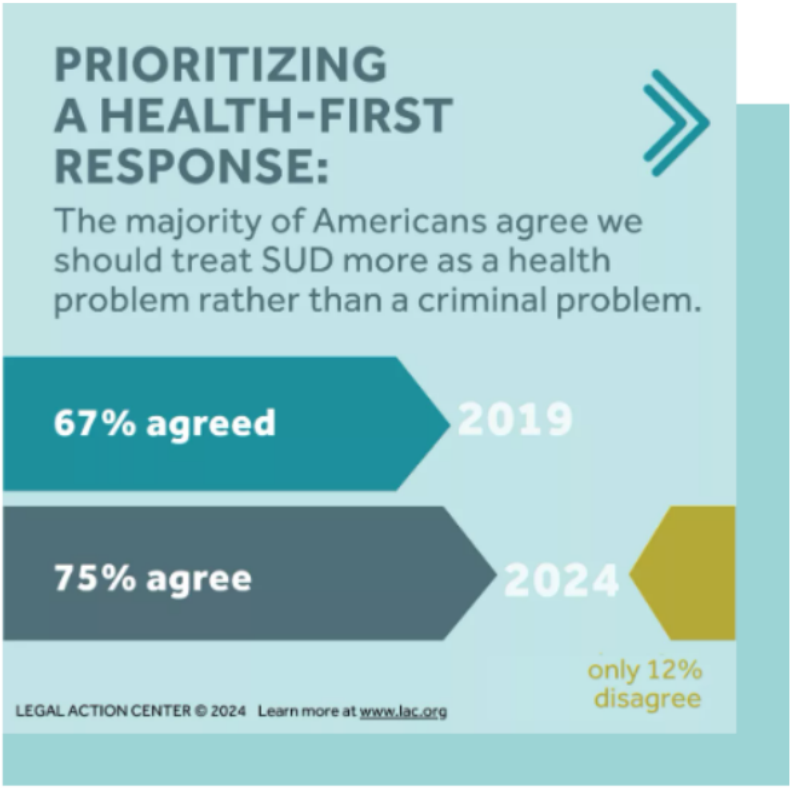
- **Medicaid Reentry:** As of January 2025, more than half of all states have developed or are developing their own Medicaid Reentry Section 1115 Demonstration Projects, with 19 states having received federal approval of their demonstration.

- **Medicaid Mobile Crisis Services:** Thirty-three states use Medicaid funding to provide mobile crisis services to people in an MH or SUD crisis when and where they are needed.

- **Addressing Needs of High-Risk Populations:** More than 30 states have either approved or pending 1115 waiver demonstration flexibilities to test new approaches to addressing the specific needs of high-risk populations, like children and adults with complex mental health needs and/or SUD conditions, to more effectively improve health outcomes, avoid suicide and overdose, and lower overall health care costs in the Medicaid programs.

The Case for Medicaid: Strong, Diverse Public Support

- Nearly two-thirds (65%) of Americans know someone who is struggling or has struggled with SUD, a dramatic increase in just four years when less than half of those polled (44%) knew someone affected by SUD.
- 80% of Americans think that SUD treatment should be readily available and accessible to all.
- Three-fourths (77%) of the public holds favorable views of Medicaid.



The Case for Medicaid: Our Stories

The following stories were pulled from the That's Medicaid website, an RWJF-led effort to share stories of people covered by Medicaid at critical points in their lives.

Robert R. / Oakhurst, New Jersey

Robert had health insurance intermittently throughout his life before a bladder infection in 2017 left him in the hospital and in need of surgery. He obtained temporary Medicaid there and eventually received full-time coverage upon being discharged.

Robert had jobs on a horse farm and at a racetrack in New Jersey, but those were often seasonal positions that did not come with benefits. The program is helping him with health issues such as addiction, depression, and high cholesterol, providing medication, doctor visits, and therapy needed for his conditions.

“Medicaid has been a godsend,” he says. “It is better than anything I ever expected.”

Stacia T. / Cottonwood, Arizona

Stacia suffered from SUD and coinciding MH symptoms for many years, which eventually caused her to lose her home, custody of her children, and almost her life. After hitting rock bottom, Stacia checked herself into a facility that treats substance use and MH issues holistically. Medicaid covered Stacia's stay as she worked to recover from years of addiction.

Stacia graduated and has stayed sober. Two years later, she was hired by the facility that helped save her life. Now the lead behavioral health worker, she helps patients through the same challenges that she overcame.

Danielle A. / Sheridan, Wyoming

Danielle had just launched her new house cleaning business when the COVID-19 pandemic began causing her business to struggle. She was now responsible for teaching her first-grade son at home while trying to pay her mortgage and childcare expenses.

A friend recommended she apply for Medicaid, and Danielle was soon accepted. As a recovering alcoholic and prone to depression, Danielle quickly sought mental health support.

Valuable case management support and a nurse practitioner have continued to help Danielle, and a mental health therapist has been by her side as she gets back on her feet.

"I really credit Medicaid for saving my life because my mental and emotional health were so poor," Danielle says. "If I wouldn't have gotten that help, I don't know where I'd be."

Cuts or Changes to Medicaid's Financing Structure Will Harm People with MH and Substance Use-Related Conditions

Any efforts to cut Medicaid, whether through restructuring Medicaid financing, making other cuts to federal funding that will shift costs to states, reduce eligibility or benefits, or add barriers to coverage such as work requirements would severely harm the people we represent by making it more difficult for them to access health coverage and essential MH/SUD and other needed health services, medications, and supports and must be rejected. The Coalition opposes any changes to Medicaid's financing structure, including but not limited to:

- Block grants
- Per capita caps
- Cuts to the federal medical assistance percentage (FMAP)
- Cuts to eligibility and benefits
- Proposals that make Medicaid coverage less affordable to patients; and
- Additional barriers to coverage like work reporting requirements and other policies that add red tape to enrollment

Any of these harmful changes would lead to:

- Coverage losses
- Reduced access to MH and SUD treatment
- Increased difficulty managing co-occurring chronic medical conditions and MH/SUD
- Increased use of costly emergency departments; and
- Poorer health outcomes, including more deaths by suicide and overdose

Making fundamental changes to how Medicaid is financed would put significant pressure on **state budgets** and force state lawmakers and Medicaid administrators to do one or more of the following:

- Raise revenue
- Eliminate coverage for certain people
- Reduce services provided
- Cut reimbursement rates for doctors, hospitals, and other providers; and/or
- Reduce payments to managed care plans, which would lower provider rates and/or employ other practices to limit access to care

Make Your Voices Heard

For more information about how to amplify the vast importance of Medicaid as a lifeline for millions of individuals and families nationwide, and in particular, those in reentry and/or who are struggling with substance use and mental health issues, visit the Legal Action Center's Website for media templates and other resources here.

Endorsements of the Coalition for Whole Health's Protect Medicaid Report

National organizations:

American Association on Health and Disability
American Association for the Treatment of Opioid Dependence
American Foundation for Suicide Prevention
American Psychiatric Association
ATOD Section/American Public Health Association
Beyond $avvy Consumers
Coalition on Human Needs
Community Catalyst
Community Oriented Correctional Health Services
Drug Policy Alliance
Faces & Voices of Recovery
Global Alliance for Behavioral Health & Social Justice
IC&RC
Inner Explorer Institute
International Society of Psychiatric Mental Health Nurses
Lakeshore Foundation
Legal Action Center
Medicare Rights Center
Mental Health America
Mental Health Section, American Public Health Association
NAADAC, the Association for Addiction Professionals
NHMH - No Health without Mental Health
National Alliance on Mental Illness
National Association of Addiction Treatment Providers
National Association of County Behavioral Health and Developmental Disability Directors
National Association for Rural Mental Health (NARMH)
National Association of Social Workers
National Behavioral Health Association of Providers
National Health Care for the Homeless Council
National Health Law Program
NETWORK Lobby for Catholic Social Justice
Overdose Prevention Initiative
Partnership to End Addiction
Technical Assistance Collaborative, Inc.
Vital Strategies
Young People in Recovery

State/local organizations:

Addiction Professionals of North Carolina
California Consortium of Addiction Programs & Professionals
Capstone Solutions Consulting Group (CA)
The First 72+ (LA)
Illinois Alliance for Reentry and Justice
Massachusetts Law Reform Institute
MD Heroin Awareness Advocates, Inc.
NCADD-Maryland
New Futures (NH)
New Jersey Citizen Action

Powell Recovery Center, Inc. (MD)
TASC (IL)
Women on the Rise GA

February 24, 2025

Re: Reconciliation Cuts to Medicaid/CHIP Would Significantly Harm Children's Health

Dear Honorable Members of the United States House of Representatives:

Children's health should be one of our nation's highest priorities. As a coalition of national organizations dedicated to promoting the health of our nation's children and pregnant women, we write to express our grave concerns over potential cuts to Medicaid and the Children's Health Insurance Program (CHIP) and the devastating consequences cuts would have for millions of children across the country. Medicaid and CHIP serve as critical lifeline programs ensuring children – especially those from families with low incomes, those in rural areas, those with disabilities, and those with chronic health conditions – have access to the physical and mental health care they need to grow, thrive, and lead healthy lives.

Cuts to Medicaid and CHIP cannot be accomplished without harming children. By reducing vital support for Medicaid and CHIP, you would not just be cutting a budget line – you would be limiting the health prospects of our children, leaving them without the care they need to grow into healthy adults. Beyond just access to services, the potential consequences of such cuts threaten to undermine children's long-term health outcomes, educational performance, and overall well-being. The House budget resolution would force Congress to cut hundreds of billions of dollars in federal funding for these vital programs. **We urge you to vote no on the budget resolution and oppose these substantial cuts.**

Together, Medicaid and CHIP cover more than 37 million children in the United States.[1] Medicaid covers over 40% of births in the country.[2] Medicaid also covers 3 million children in military-connected families, helping ensure highly specialized health care needs not fully addressed by TRICARE or commercial insurance are met.[3] Medicaid and CHIP help ensure children have access to essential health care services such as doctor visits, hospital care, medications, vision and dental care, and early intervention therapies. Medicaid improves health outcomes by reducing child mortality, emergency care utilization, and hospitalizations while promoting preventive care and early treatment of illnesses.[4]

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[1] Centers for Medicare & Medicaid Services, Medicaid and CHIP Enrollment Trend Snapshot (Oct. 2024), https://www medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index html.

[2] KFF, Births Financed by Medicaid (2023), https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] Children's Hospital Association, Medicaid: A Vital Resource for Nearly 3 Million Military-Connected Families (Nov. 2023), Prepared by FTI Consulting, https://www.childrenshospitals.org/-/media/files/public-policy/medicaid/report/medicaid-military-report.pdf

[4] Hakim RB, Boben PJ, Bonney JB. Medicaid and the health of children. *Health Care Financ Rev*. 2000;22(1):133–140; Currie J, Chorniy A. Medicaid and Child Health Insurance Program improve child health and reduce poverty but face threats. *Acad Pediatr*. 2021;21(8S Suppl):S146–S153; Boudreaux MH, Golberstein E, McAlpine DD. The long-term impacts of Medicaid exposure in early childhood: Evidence from the program's origin. *J Health Econ*. 2016;45:161-175. doi:10.1016/j.jhealeco.2015.11.001.

Medicaid and CHIP cover 47% of the more than 13 million U.S. children with special health care needs.[5] Without a robust Medicaid program, these children will not have access to the services they need. Children with life-threatening illnesses, rare diseases, and complex medical needs would face even greater barriers to care, forcing families to make impossible choices between paying for health care or meeting other basic needs such as food and housing.

Medicaid and CHIP also provide vital mental health services to children and their families, which are increasingly necessary in the midst of the current crisis in children's mental health. The numbers of students who persistently feel sad or hopeless and have seriously considered attempting suicide are increasing, and 50% of mental health disorders show their first signs before a child turns 14 years old.[6,7] Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit ensures that children receive mental health screening and services, in addition to other necessary health services. The mental and physical health of caregivers is also vital to the well-being of babies and children. Medicaid/CHIP postpartum coverage is now provided for 12 months in 48 states and DC, and Medicaid covers 23% of nonelderly adults with mental illness.[8,9] This coverage for families directly impacts children's health and well-being.

Additionally, Medicaid and CHIP support services in schools, enabling children with disabilities to receive necessary therapies and supports. With over one-third of school-age children (5-18 years old) covered by Medicaid and CHIP,[10] reducing program funding would force schools to cut these critical programs, limiting educational opportunities and making it harder for children with disabilities to participate fully in their education. School nurses and counselors rely on Medicaid and CHIP funding to provide mental health services, ensuring that children struggling with anxiety, depression, and trauma receive the care they need. Eliminating or reducing funds for these supports would not only put additional strain on families but also contribute to worsening mental health crises among students.

Further, many rural, frontier, and underserved communities rely on Medicaid and CHIP. Over 40% of children in small towns and rural areas are covered by Medicaid and CHIP.[11] In these communities, Medicaid and CHIP provide funding to sustain pediatric care, hospitals, other health

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[5] KFF, How do Medicaid/CHIP Children With Special Health Care Needs Differ From Those With Private Insurance, https://files kff.org/attachment/Issue-Brief-How-Do-Medicaid-CHIP-Children-with-Special-Health-Care-Needs-Differ-from-Those-with-Private-Insurance (last accessed 02/12/2025).
[6] Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023.* U.S. Department of Health and Human Services; 2024. https://www.cdc.gov/yrbs/dstr/index html
[7] Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Kathleen R Merikangas, Ellen E Walters. *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication.* National Center for Biotechnology Information, National Institutes of Health, 2023. https://pubmed ncbi nlm nih.gov/15939837/
[8] KFF, *Medicaid Postpartum Extension Tracker*. January 2025. https://www kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/
[9] Heather Saunders and Robin Rudowitz, *Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020*, KFF, June 2022. https://www.kff.org/mental-health/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/
[10] Georgetown University Center for Children and Families, How Medicaid Supports Student Success, https://ccf.georgetown.edu/2025/01/09/how-medicaid-supports-student-success/.
[11] Georgetown University Center for Children and Families, Medicaid's Role in Small Towns and Rural Areas, https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.

facilities, community health centers, and urgent care clinics. Any reduction in Medicaid and CHIP funding would mean that many of these providers – already operating with tight budgets – would be forced to close or scale back services, leaving many children without access to routine or emergency care. The long-term effects of such closures would be devastating, leading to increased disparities in health outcomes and widening the gap between children who receive adequate care and those who do not.

The impact of Medicaid and CHIP extends beyond immediate health care needs, as research shows that children covered by Medicaid and CHIP have better health outcomes as adults, higher school attendance, and greater academic achievement.[12] Furthermore, enrollment in Medicaid and CHIP during childhood is associated with lower high school dropout rates, increased college attendance, and higher future wages.[13] By providing this vital health care coverage, Medicaid and CHIP not only improve children's current health status but also contribute to their long-term well-being and productivity, making it an essential investment in the nation's future and global competitiveness.

By maintaining and enhancing Medicaid and CHIP, we can help ensure that every child has the opportunity to grow up strong, healthy, and prepared for the future. Please work to strengthen, protect, and make investments in Medicaid and CHIP to ensure that all children, regardless of their background or health care needs, have access to the care they deserve.

Should you have any questions about the letter or wish to discuss this issue further, please contact Abuko D. Estrada, J.D., Vice President for Medicaid and Child Health Policy, at First Focus Campaign for Children at [redacted]

Respectfully,

American Academy of Pediatrics
Children's Defense Fund
Children's Hospital Association
Family Voices National
First Focus Campaign for Children
March of Dimes
National Association of Pediatric Nurse Practitioners

[12] Georgetown University Center for Children and Families, How Medicaid Supports Student Success, https://ccf.georgetown.edu/2025/01/09/how-medicaid-supports-student-success/.
[13] *Ibid.*

February 24, 2025

Senator Michael Bennet
Senator John Hickenlooper
Representative Diana DeGette
Representative Joe Neguse
Representative Jeff Hurd
Representative Lauren Boebert
Representative Jeff Crank
Representative Jason Crow
Representative Brittany Petterson
Representative Gabe Evans

Dear Honorable Members of Colorado's Congressional Delegation,

Essential services and infrastructure investments that support families who work hard day in and day out are under attack in the 119th Congress. Deep cuts to healthcare, housing, energy efficiency, and food programs that assist low- and middle-income families are being proposed, coupled with major tax breaks that would benefit corporations and high-income households at the expense of working families. The 2017 tax cuts made it so corporations now pay a lower effective tax rate than an American worker making $45,000 a year. Corporations took the tax breaks and raised prices on consumers, outsourced jobs, purchased stock buybacks to pay off investors and collected record profits.

We, the undersigned organizations, believe every Coloradan should have the freedom to secure healthcare, housing, energy, and food, regardless of their financial situation. It's time for our Colorado leaders to unite and ensure that Coloradans can provide for their families in communities that are safe, healthy, and resilient. Congress and the president must do their part to deliver this security for every person and child. This isn't just the right thing to do—it's essential for ensuring economic stability and opportunity for all is best for our country.

The vast majority of people in Colorado, regardless of their political leanings, want an economy that makes it possible for folks to afford the cost of essential services like food, housing and healthcare. They also want the wealthy and profitable corporations to pay their fair share of taxes.

We urge you to ensure Congress does not pass budget legislation that would harm so many of your constituents and is fiscally irresponsible.

The risky and inefficient proposals under consideration in this Congress would:

- Make cuts to federal programs like Medicaid, Supplemental Nutrition Assistance Program (SNAP), the Child Tax Credit (CTC), and the Earned Income Tax Credit (EITC)

that research shows strengthen families, prevent child abuse and neglect, decrease rates of child maltreatment and build strong foundations for families to thrive.

- Slash funding for Medicaid and put the coverage of more than 1.1 million Coloradans at risk, including people living with disabilities, older adults, Coloradans needing nursing care, family caregivers, and children and families. In Colorado, where it would be fiscally impossible to continue coverage for adults on Medicaid expansion, at least 280,000 Coloradans would lose coverage and Colorado would see an estimated 29.5 billion fewer federal dollars.
- Fail to continue robust health premium tax credits that make healthcare affordable for families who purchase their plans in the Affordable Care Act (ACA) marketplace; For Colorado that would mean 225,000 Coloradans would see their out-of-pocket premiums jump an average of 50%, with rural Coloradans seeing average increases of 70%.
- Place unnecessary and overly burdensome work requirements on another 36 million Medicaid participants, putting them at risk of losing their healthcare as well; For Colorado, that would amount to 540,000 participants at risk of losing their healthcare.
- Cut SNAP benefits, which one in 10 Coloradans depend on to afford groceries. These cuts would push SNAP benefits below the minimum cost of a healthy diet, meaning a $380 million reduction in benefits over 10 years.
- Make other cuts to Temporary Assistance for Needy Families (TANF) and rental assistance that overwhelmingly benefit families with low and moderate incomes.
- Make cuts to the CTC which provides critical support to 640,000 low-wage working families with kids in Colorado—that's 21% of local tax filers.
- Repeal or reduce Colorado's Inflation Reduction Act (IRA) and Bipartisan Infrastructure Law (BIL) allocations, totaling $10 billion for critical investments in broadband access, energy efficiency, transportation safety, clean water, roads and bridges, flood and wildfire mitigation, public transportation and more. Colorado communities are relying on this funding and the IRA alone has resourced projects that employ over 1,100 Coloradans.

These severe funding reductions, combined with the big tax handouts for those who least need the government's support, won't just harm your constituents. These changes will also deliver a financial hit to state budgets, which will leave Colorado unable to pick up the extra cost of healthcare or cover other increased costs to Colorado families. The cascading effect of some of these choices could close health centers like Salud and Clinica Family Health that already face rising numbers of uninsured patients, impact 3,100 grocery retailers, slash local infrastructure jobs, and compromise energy independence in your district, delivering a serious economic blow to Colorado.

The majority of hardworking Coloradans in your district are on the brink—they cannot afford to pay more when they get sick, buy groceries, pay their energy bill, or to keep a roof over their heads. Household budgets are stretched thin, and people are already struggling to make ends meet. Cutting essential services and infrastructure investments will have unintended cascading consequences throughout the economy. For instance, research shows that every $1 invested in SNAP generates between $1.50 and $1.80 in economic activity. For every $1 million in federal funding lost for Medicaid, Colorado loses $2.25 million in GDP activity, 13,000 jobs, and

$825,000 in household earnings. Adding work requirements to access these programs not only disincentivizes work, but would also increase the burden on state systems —including the notoriously glitchy Colorado Benefits Management System (CBMS)—and the county workers who use them.

Colorado is uniquely vulnerable to these cuts, as a constitutional amendment in our state, the Taxpayer's Bill of Rights (TABOR), limits the amount the state budget can grow every year. Legislators are legally prohibited from raising revenue to backfill these cuts, should Congress choose to shift costs to the states. Current federal funds, including federal match programs, enable Colorado to stretch limited tax revenue further to better serve working families by investing in education, healthcare, and bolstering a thriving economy.

We Coloradans ask that you actively oppose these potential federal funding cuts to healthcare, food security, housing and energy efficiency programs, and other essential services and community investment. These misguided priorities would have a profound impact on our families and neighborhoods. We believe we have common ground in a vision for Colorado that supports strong families and industrious communities.

Sincerely,

Adelante Community Development
AFDC Coalition
Bell Policy Center
Black Parent Network
Boulder Food Rescue
Carin' Clinic
CEDS Finance
Centennial State Prosperity
Center for Health Progress
CF United
Changing the Narrative | Encore Roadmap
Christian Healing Network DBA Mission Medical Center
Chronic Care Collaborative
Clifton Community Leaders
Cloud City Conservation Center
Cobalt
Colorado Access
Colorado AFL-CIO
Colorado Behavioral Healthcare Council
Colorado Black Health Collaborative
Colorado Center for Aging
Colorado Center on Law and Policy
Colorado Children's Campaign

Colorado Civic Engagement Roundtable
Colorado Coalition for the Homeless
Colorado Community Health Network
Colorado Cross Disability Coalition
Colorado Developmental Disabilities
Colorado Ethiopian Community
Colorado Fiscal Institute
Colorado Foundation for Universal Health Care
Colorado Immigrant Rights Coalition
Colorado Latino Leadership, Advocacy, and Research Organization (CLLARO)
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Colorado Orgs and Individuals Responding to HIV/AIDS (CORA)
Colorado People's Alliance
Colorado Rural Health Center
Colorado Safety Net Collaborative
Colorado Working Families Party
Community Dental Health
Community Resource Center
Conservation Colorado
Denver Food Rescue
Eagle Valley Community Foundation
Food Security Advisory Council at Colorado State University
Front Range Pediatric Therapies
Good Food Collective
Grand Avenue Dental
Growing Home
Health Colorado, In.
Healthier Colorado
Healthy Air and Water Colorado
Human Services Network of Colorado
Hunger Free Colorado
Immunize Colorado
Jefferson County Food Policy Council
Kids First Health Care
La Plata Food Equity Coalition
LaQuetta's LAfTA, LLC®
Mental Health Colorado
Mountain Mamas
Mutual Aid Monday
Mutual Aid Partners
New Era Colorado
Next 100 Colorado
Northern Colorado Foodshed Project
Nourish Colorado

One Colorado
Oso Adventure Meals
Practice Innovation Program
Pueblo Food Project
Quevedo Interpretations
Regis Center for Play Therapy
RESULTS
Rising Routes
Rocky Mountain MicroFinance Institue
Rocky Mountain Multiple Sclerosis Center
Slow Food Boulder County
Small Business Majority
Small Town Project
Southwest Improvement Council
Spring Institute for Intercultural Learning
St. Thomas Episcopal Church
Startup Colorado
TARA Food Pantry
The Action Center
The Fax Partnership
The Latino Chamber of Commerce
Together Colorado
United for a New Economy
UpRoot Colorado
Viva Resource
Vivent Health
We Don't Waste
Western Colorado Alliance
Young Invincibles Rocky Mountain
Youth Healthcare Alliance

Additional information:

- Medicaid is a foundational piece of our healthcare system. The nation's most efficient health coverage system, it serves over 1.1 million Coloradans, including older adults, people living with disabilities, people in need of nursing facility or in-home care, family caregivers, 40% of all births in Colorado, and children and families. Proposed budget cuts to Medicaid will strip coverage from hundreds of thousands of Coloradans, jeopardize the health and safety of Colorado communities, destabilize our healthcare systems, and do nothing to lower or control health care costs. Colorado has led the nation in efforts to address the epidemic of medical debt and that progress will be more than reversed with these cuts. Healthcare providers are already struggling financially in the wake of the Medicaid continuous coverage unwinding process, particularly in rural areas, and will be at risk of closing if these cuts pass. Because healthcare dollars circulate in local and state economies, creating good jobs and supporting local businesses, the impact of cuts is hard to overstate. For every $1 million in federal funding lost for Medicaid, Colorado loses $2.25 million in GDP activity, 13,000 jobs, and $825,000 in household earnings. Conversely, the Medicaid expansion alone has added over $4 billion in economic activity and over 22,000 jobs in Colorado. Nor would impacts be limited to the public health system. The potential cuts to financial assistance under the Affordable Care Act at the end of 2025 will raise out-of-pocket premiums by an average of 50% for over 225,000 Coloradans, will destabilize the individual market and just add to the number of Coloradans who lose coverage.

- The Supplemental Nutrition Assistance Program (SNAP) is one of the most cost-effective tools for supporting working families, reducing poverty, and strengthening local economies. In Colorado, 1 in 10 residents—over half a million people—use SNAP, and more than 60% of recipients are families with children. Proposals to cut SNAP funding—including rolling back the 2021 Thrifty Food Plan (TFP) update, imposing harsher work requirements, and eliminating Broad-Based Categorical Eligibility (BBCE)—would have unintended economic consequences. This would not only make it harder for working families to put food on the table but would also harm local businesses that rely on SNAP dollars.
  SNAP is not just a safety net—it's an economic multiplier. When families receive benefits, they spend them at grocery stores, farmers' markets, and local retailers, directly supporting Colorado businesses and jobs. Research shows that every $1 invested in SNAP generates between $1.50 and $1.80 in economic activity. Cutting SNAP would reduce consumer spending, hurt small businesses, and slow job growth. Local grocers, food producers, and retailers depend on these dollars, and shrinking the program would have a ripple effect across the economy.
  One of the most impactful aspects of SNAP is Broad-Based Categorical Eligibility (BBCE), a policy that allows states to adjust income and asset limits so that low-income, working families can receive assistance while moving toward financial independence. Without BBCE, families risk losing all benefits the moment they earn slightly above the

income threshold. BBCE phases benefits out gradually, allowing workers to take promotions, work more hours, and increase their wages without fear of abruptly losing food assistance. It encourages savings and self-sufficiency by allowing families to build savings while still receiving assistance, helping them achieve long-term financial stability instead of staying trapped in poverty. Lastly, it reduces government bureaucracy by simplifying SNAP administration, reducing redundant paperwork and making the system more efficient. This saves taxpayer dollars by streamlining eligibility verification, ensuring benefits go to those who need them without unnecessary red tape.

- Most people who have coverage through Medicaid or receive food or housing assistance, are working, often juggling multiple jobs. For many others with disabilities, Medicaid enables participation in work. Proposed "work requirements" for any of these programs will bury hardworking people in red tape, administrative inefficiency, and result in many losing the benefits they need to stay healthy, stable and maintain their employment. Estimates show work requirements would lead to 36 million Americans losing Medicaid, including over 540,000 Coloradans, nearly half the population currently covered through Medicaid. Work requirements will make it harder for everyone to access healthcare, food, and housing supports, including people living with disabilities, older adults and seniors receiving home-based care or who are in nursing facilities, children and families, and people providing care to family members. Work requirements would also increase the burden on state systems - including the notoriously glitchy Colorado Benefits Management System (CBMS) - and the county workers who use them. Even without the additional mountain of paperwork that work requirements would generate, Colorado processing timeliness has been poor, resulting in federal corrective action for untimely SNAP processing in 2024 and state corrective action for county processing delays in Medicaid in 2025. Colorado resoundingly rejected work requirements both at the national and state level in 2017 and 2018 because they are ineffective, and have been proved to result in no change in employment rates while administrative costs soar and people lose coverage. Instead, work requirements will strip coverage and benefits from hundreds of thousands of Coloradans who are already working, caring for family, or navigating disability.

- Hardworking Coloradans get hurt the most when leaders prioritize tax breaks for the richest among us over the programs that make our middle class strong. The 2017 tax cuts made it so corporations now pay a lower effective tax rate than an American worker making $45,000 a year. Corporations took the tax breaks and raised prices on consumers, outsourced jobs, purchased stock buybacks to pay off investors and collected record profits.

- Proposed cuts to school meals would strip access for millions of children, burden families, and overwhelm schools with unnecessary bureaucracy. Cuts to the Community Eligibility Provision (CEP) would deny over 12 million children nutritious meals, reintroduce stigma, and undermine school efficiency. Taking food away from children

harms their education, stunting their potential and costing our future economy by robbing us of the leaders and innovators of tomorrow.

February 19, 2025

The Honorable John Thune
Majority Leader
United States Senate

The Honorable Mike Johnson
Speaker
United States House of Representatives

The Honorable Chuck Schumer
Minority Leader
United States Senate

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives

RE: Proposed Changes to Medicaid Financing and Requirements

Dear Majority Leader Thune, Speaker Johnson, Minority Leader Schumer, and Minority Leader Jeffries,

As a coalition of bipartisan membership organizations representing state legislatures, mayors, cities, and counties, we are committed to working collaboratively to strengthen the Medicaid program so that states and localities can continue to meet the needs of their residents effectively. We write to express concern over proposed changes to Medicaid financing and requirements that could significantly impact state and local budgets, healthcare infrastructure, and millions of Americans who rely on the program. Medicaid is a federal-state-local partnership that provides health coverage to approximately 79 million Americans, including children, seniors, people with disabilities, and low-income adults. It covers 38 million children, funds 40% of all births, supports rural hospitals, and is the largest payer of long-term care and behavioral health services. Expansion has provided additional federal funding to 41 states, increasing access to care, particularly for those with substance use disorders.

Policy changes that mandate specific eligibility requirements and alter the fiscal makeup of the program threaten Medicaid's effectiveness and reduce state flexibility in program design. Such changes have costly implications, leading to significant coverage losses for beneficiaries and increased medical debt, with unclear long-term savings. For example, reducing the 90% federal match rate for Medicaid expansion could cut federal spending by $561 billion over nine years, forcing states to either drop expansion or absorb higher costs—jeopardizing coverage for millions and harming state economies. Likewise, proposals such as per capita caps or block grants that do not account for increases in health costs or fluctuations in enrollment would shift financial risks to states and counties. The Congressional Budget Office estimates that half of those losing Medicaid coverage under such changes would become uninsured, leading to higher medical debt, uncompensated care costs, and potential hospital closures, particularly in rural areas.

Medicaid accounts for over half of all federal funds to states and is the largest source of federal funding for state budgets, making it essential to states' ability to design and administer healthcare programs that meet the unique needs of their populations. Preserving state flexibility and preventing significant funding cuts are both critical to ensuring Medicaid can be tailored to local priorities, as such cuts would severely limit this ability, forcing states to reduce services, restrict eligibility, or shift costs to local governments. These reductions would jeopardize access to affordable healthcare and long-term services and place an unsustainable financial burden on states and counties, which often serve as payers of last resort.

We look forward to continuing our work together as intergovernmental partners to enhance the Medicaid program and ensure that states and localities can effectively serve their residents.

Sincerely,

Tom Cochran
CEO & Executive Director
The United States Conference of Mayors

Clarence E. Anthony
CEO & Executive Director
National League of Cities

Matthew D. Chase
Executive Director/CEO
National Association of Counties

Tim Storey
Executive Director
National Conference of State Legislatures

David Adkins
CEO and Executive Director
The Council of State Governments

Marc Ott
CEO & Executive Director
International City/County Management Association

Cc: The United States House of Representatives
The United States Senate

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[1] ABMJ Consulting, "Economic Effects of Medicaid Expansion in Montana: 2025 Update." 2025-MedEx-Economic-Impacts_FINAL.pdf.[2] The Colorado Health Foundation. "Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY 2015-16 through FY 2034-35. Medicaid_Expansion_Full_ONLINE_.PDF

February 20, 2025

The Honorable Brett Guthrie, Chairman
House Committee on Energy and Commerce
2161 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Ranking Member
House Committee on Energy and Commerce
2107 Rayburn House Office Building
United States House of Representatives
Washington, DC, 20515

RE: Proposed Cuts to Medicaid Program

Dear Chairman Guthrie and Ranking Member Pallone,

The undersigned organizations represent the interests of the 385,000 nurse practitioners (NPs) who provide essential care for patients in nearly every health care setting across the country. NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care. NPs provide a substantial portion of the high-quality[1], cost-effective[2] care that our communities require. We are deeply concerned with the reports on the budget reconciliation process' proposed cuts to Medicaid, and the significant impact these proposed cuts would have on patients and providers across all healthcare settings.

Nurse practitioners are deeply committed to the Medicaid program as 80% of NPs provide care to Medicaid beneficiaries. NPs are also "significantly more likely….to care for people on Medicaid."[3] In fact, according to the Medicare Provider Advisory Commission (MedPAC), NPs and PAs comprise approximately one-third of the primary care workforce, and up to half in rural areas.[4]

As you know, Medicaid coverage is essential for the health and well-being of the over 70 million patients covered by the program, as well as the over 7 million children covered by the Children's Health Insurance Program (CHIP).[5] Of the patients covered by Medicaid, 37% are children, and 11% are Americans with disabilities.[6] It is important to note that "Non-elderly adults and children in small towns and rural areas are more likely than those living in metro areas to rely on Medicaid/CHIP for their health insurance."[7] Additionally, Medicaid covers over 40% of births in the United States[8] and is the primary payer for long-term supports and services.[9] Medicaid is also a lifeline for millions of older adults, including 7.2 million low-income seniors who are dually eligible for Medicare and Medicaid, and it provides critical funding for long-term care, covering more than half of nursing home residents and home- and community-based

[1] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[2] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[3] Nurse Practitioners: A Solution to America's Primary Care Crisis | American Enterprise Institute - AEI
[4] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[5] data.modernmedicaid.org/MMA/
[6] Ibid
[7] Medicaid's Role in Small Towns and Rural Areas – Center For Children and Families
[8] https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid
[9] https://www.medicaid.gov/medicaid/long-term-services-supports/index.html.

services.[10] Medicaid also provides critical coverage for patients to access behavioral health services[11] and treatment for substance use disorders.[12]

As health care providers, we are deeply concerned with the impact of these cuts on the health care system and their potential to harm our most vulnerable patients. Further, these cuts will threaten the viability of practices that treat Medicaid patients, financially destabilizing and having a disproportionate impact on those who provide care to underserved and rural communities. Given the impact of these cuts to millions of patients and communities across the country, we urge you to reconsider.

Medicaid provides critical support for vulnerable patients who are seen by our members every day for primary care, pediatrics, behavioral health, maternal health, long-term care for the elderly and more. Therefore, the undersigned organizations urge you to reconsider these cuts and instead strengthen this vital program. We would welcome further discussion on this important issue, and should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, [redacted], [redacted].

Sincerely,

American Association of Nurse Practitioners

Gerontological Advanced Practice Nurses Association

National Association of Nurse Practitioners in Women's Health

National Association of Pediatric Nurse Practitioners

National Organization of Nurse Practitioner Faculties

[10] https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html; https://www.kff.org/medicaid/issue-brief/pandemic-era-changes-to-medicaid-home-and-community-based-services-hcbs-a-closer-look-at-family-caregiver-policies/; https://www.macpac.gov/subtopic/nursing-facilities/

[11] Danielson, et. Al Journal of Attention Disorders 2024, Vol. 28(8) 1225–1235

[12] Chapter 6: Substance Use Disorder and Maternal and Infant Health

February 25, 2025

To whom it may concern:

On behalf of the adult and child survivors of domestic violence and sexual assault we serve and advocate for, we write to ask you to reject cuts to federal Medicaid funding. Survivors rely on Medicaid every day to escape abuse, rebuild their lives after violence and care for their families.

Being a victim of violence can take a serious toll on one's health. Beyond the injuries associated with physical or sexual abuse, violence and trauma contribute to lifelong health conditions like chronic pain, obesity and heart attacks. The mental and behavioral health effects of violence and abuse are well-documented.

Domestic and sexual violence can happen to all people but their impacts fall disproportionately on women and people with lower incomes and people with disabilities, who also make up a significant portion of the Medicaid-eligible population. One in 5 women in the United States is covered by Medicaid, including women receiving mental health services and approximately half of women with disabilities.

Children who have been abused or neglected or exposed to violence in childhood are also significantly more likely to have mental health or chronic health needs if they do not receive care. Children and parents getting the health care they need can be life-saving and break the often intergenerational cycles of violence, substance abuse and mental health challenges that so many families face.

Medicaid's reach makes it powerful in ensuring all Americans have access to health care, including victims and survivors of domestic and sexual violence. Medicaid covers more than 40 percent of all births in this country, and nearly half of all children in the United States get health care through Medicaid. Its benefits include screening and brief counseling for intimate partner violence, mental and behavioral health services, substance use services, prescription drugs, annual well-woman visits, and emergency room services. Medicaid also covers all the services a child needs through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, and many states' Medicaid programs cover sexual assault forensic exams and treatment for sexual assault survivors. Most states also have expanded their Medicaid program to cover mothers post-partum, helping to reduce a new mother's chance of dying after childbirth and improving her ability to care for her child.

Without Medicaid, they would not be able to get the help and services they need.

On behalf of all who have been impacted by violence and abuse we strongly request you reject the more than $800 billion in proposed cuts and protect Medicaid.

Sincerely,

Futures Without Violence
Legal Momentum
The National Alliance to End Sexual Violence
The National Domestic Violence Hotline
The National Indigenous Women's Resource Center (NIWRC)
The National Network to End Domestic Violence (NNEDV)
The National Resource Center on Domestic Violence

The National Resource Center on Domestic Violence, Trauma and Mental Health
Tahirih Justice Center
VALOR

CBHC | Colorado Behavioral Healthcare Council

February 25, 2025

The Honorable Senator Michael Bennet
The Honorable Senator John Hickenlooper
The Honorable Representative Diana DeGette
The Honorable Representative Joe Neguse
The Honorable Representative Jason Crow
The Honorable Representative Brittany Pettersen
The Honorable Representative Lauren Boebert
The Honorable Representative Jeff Hurd
The Honorable Representative Jeff Crank
The Honorable Representative Gabe Evans

Dear Members of Colorado's Congressional Delegation,

The proposed federal budget cuts to Medicaid pose an imminent and devastating threat to the health and well-being of Coloradans, demanding urgent action to protect our healthcare safety net. They have a devastating potential impact on Colorado's behavioral health system and our entire healthcare safety net. The deep cuts proposed to Medicaid, including Federal Medical Assistance Percentage (FMAP) reductions, work requirements, block grants, and per capita caps, represent a direct assault on the health and well-being of our most vulnerable citizens.

These cuts are not just numbers on a page; they are a direct threat to the lives of Coloradans.

The consequences of these cuts would be catastrophic and would result in:

- **Loss of Healthcare Coverage for Hundreds of Thousands of Coloradans:** The Kaiser Family Foundation (KFF) estimates a potential loss of coverage for 350,000 Coloradans due to FMAP reductions alone. The proposed cuts threaten the coverage of 1.4 million individuals, or more than 1 out of every 5 Coloradans. This plan would gut Medicaid for seniors, children, and people with disabilities, and could effectively end the Medicaid expansion currently covering nearly 500,000 Coloradans. The increased cost of uncompensated care will ultimately be passed on to taxpayers, further straining our state's economy.
- **Destabilization of Safety Net Behavioral Health Providers:** Safety net behavioral health providers, which rely heavily on Medicaid to provide a comprehensive continuum of care, face financial collapse if these proposed cuts are implemented. They would force drastic reductions in programs, services, and staffing, leaving thousands without access to critical mental health and substance use treatment.
- **Increased Emergency Room, Crisis, and Jail Utilization:** Untreated mental health and substance use issues will drive up emergency room visits, incarceration rates, and long-term healthcare costs, placing an unbearable burden on our state and local resources. The human toll of untreated behavioral health conditions would be far greater – disrupting and destabilizing communities and families.

- **Exacerbated Workforce Shortages:** The uncertainty surrounding Medicaid and federal funding will further deter qualified professionals from entering and remaining in the behavioral health field, limiting our ability to provide essential care. Because Medicaid constitutes a significant portion of safety net providers' budgets, drastic cuts would result in substantial layoffs, impacting service availability and access.
- **Economic Devastation:** The Colorado Hospital Association estimates that work requirements and per capita caps would reduce federal funds to Colorado by hundreds of millions of dollars. Medicaid supports nearly 1 in 5 jobs in Colorado. These cuts will not only lead to job losses in the healthcare sector but will also negatively impact local businesses that rely on the spending power of healthcare workers and Medicaid beneficiaries.

Medicaid is the backbone of our behavioral health system. It is not a discretionary expense; it is a lifeline. Gutting this program would have a cascading negative impact on our communities, our healthcare system, and our economy.

We must protect and strengthen, not dismantle, our healthcare safety net.

Therefore, we implore you to:

- **Oppose all proposed cuts to Medicaid, the ACA, and other vital social programs.**
- **Prioritize the health and well-being of Coloradans by recognizing the long-term cost of short-term cuts.** Reducing Medicaid funding will shift costs to states, and increase the cost of emergency care, incarceration, and untreated mental health crises.
- **Champion the Certified Community Behavioral Health Clinic (CCBHC) model.** These groundbreaking clinics leverage increased federal Medicaid funding to expand access to high-quality mental health and substance use disorder services within our communities. In Colorado pilot programs, CCBHCs have shown a 67% reduction in ER visits, and have proven to be an effective solution for improving access to and outcomes in behavioral health care. We must ensure their sustainable funding and expansion.

The decisions made in the next 30 days will have profound and lasting consequences for our state. We cannot afford inaction. We urge you to stand with Colorado's most vulnerable citizens and protect our healthcare safety net.

Thank you for your immediate attention to this critical matter.

Sincerely,

Kara Johnson-Hufford, CEO
Colorado Behavioral Healthcare Council

CBHC Member Organizations/Co-Signers

Dr. Kiara Kuenzler, CEO
Jefferson Center for Mental Health
CBHC Board President

Dr. Kelly Phillips-Henry, CEO
Aurora Mental Health and Recovery
CBHC Board President-Elect

Bill Henricks, CEO
AllHealth Network
CBHC Past Board President

Victoria Romero, CEO
San Luis Valley Behavioral Health Group
CBHC Board Secretary

Dante Gonzales, CEO
Centennial Mental Health Center
CBHC Board Treasurer

Jason Chippeaux, CEO
Health Solutions
CBHC Board Ex-Officio Officer

Kimberly Collins, CEO
North Range Behavioral Health
CBHC Board Ex-Officio Officer

Rudy Gonzales, CEO
Servicios de la Raza

Nicholas Torres, Interim CEO
Mind Springs Health

Cyndi Dodds, Interim CEO
SummitStone Health Partners

Simon Smith, CEO
Clinica Family Health & Wellness

James Greer, Interim CEO
WellPower

Rick Doucet, CEO
Community Reach Center

Adam Roberts, CEO
Diversus Health

Mandy Kaisner, CEO
Solvista Health

Shelly Burke, CEO
Axis Health System, Inc.

Jania Arnoldi, CEO
Valley-Wide Health System

The Diabetes Leadership Council (DLC) and Diabetes Patient Advocacy Coalition (DPAC) are deeply concerned by the budget resolution that is scheduled to be considered by the House of Representatives this week. The budget resolution will likely lead to cuts to the safety-net Medicaid program, which provides health insurance to almost 80 million low-income Americans. This action would disproportionately impact Americans most in need, including those with diabetes and other chronic conditions who rely on Medicaid to access the medications and technology they need to manage their conditions. Members of Congress should instead work to ensure access to health insurance through the Medicaid program without barriers for their most vulnerable constituents.

“Any policy that dramatically reduces federal spending on Medicaid or leads to a significant loss of Medicaid coverage would be detrimental to patients with diabetes and the country as a whole, increasing the nation’s uninsured rate and uncompensated care,” said George Huntley, CEO of DLC and DPAC. “We urge Congress to reject proposals that would put the Medicaid program at risk as part of any budget or reconciliation package.”

DIABETES LEADERSHIP COUNCIL

DIABETES PATIENT ADVOCACY COALITION

The Disability and Aging Collaborative

&

CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

February 21, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC

Dear Speaker Johnson, Leader Jeffries, and Members of the House of Representatives:

The co-chairs of the Disability and Aging Collaborative (DAC) and the Health and Long-Term Services and Supports Task Forces of the Consortium for Constituents with Disabilities (CCD) write to **urge you to reject the FY 2025 budget resolution passed out of committee**. The resolution calls for the committee that oversees Medicaid to cut a *minimum* of $880 billion, with pressure to make even deeper cuts. Any funding cut would punch multi-billion dollar holes in state budgets, shifting responsibility to state legislatures and forcing them to cut coverage and care for millions of Americans, including people with disabilities and older adults.

As the attached letter from 400+ aging, disability, and allied organizations from every state explains, at least 17 million people with disabilities and older adults, as well as family caregivers and their children, direct care workers, and other low-income individuals and families depend on Medicaid every day for their health, safety, and independence. Medicaid enables our communities to go to work and to care for our loved ones. It is our communities' lifeline, and we cannot afford for any part of it to be cut.

Medicaid is already lean and efficient. Funding cuts, caps, or changes that limit eligibility for or make it harder to enroll in or maintain coverage threaten the longstanding Medicaid guarantee for people with disabilities, older adults, and their families. Medicaid is critical not only as primary coverage for health care, but also as the primary payer for long-term services and supports (LTSS) that support people with disabilities and older adults. It pays for nearly 70% of home and community-based services and care for five out of eight nursing home residents. Furthermore, Medicaid helps 12.5 million seniors and people with disabilities with Medicare's high out-of-pocket costs and covers benefits that Medicare does not, including dental, vision, hearing, and non-emergency medical transportation. In short, cuts to Medicaid are cuts to Medicare as well.

We strongly oppose any budget resolution that calls for or leads to Medicaid cuts as well as any efforts to impose per capita caps, block grants, work requirements, restrictions on eligibility, barriers to enrollment, or any other harmful changes to the Medicaid program. Exemptions or carve-outs to Medicaid cuts meant for people with disabilities and older adults will not save them from harm.

Over 15 million Medicaid enrollees reported having a disability in 2023 through the American Community Survey (ACS), six million more people than those who qualify for Medicaid through having a disability. The number of people with disabilities on Medicaid is likely even higher as the ACS undercounts the total number of people with disabilities in the country. This discrepancy exists because Medicaid uses the most stringent definition of disability for eligibility, leaving many out. Medicaid expansion changed this, providing coverage to millions; however, that is now at risk. The bottom line is that any of these cuts and harmful changes lead to the same result: taking away coverage from people with disabilities, older adults, and others who cannot otherwise afford health care and long-term services and supports.

Access to Medicaid is a matter of life, death, and independence for millions of Americans with disabilities, older adults, and their families and communities. Medicaid is a lifeline, not a piggy bank. We will oppose cuts in every form because they will all harm people with disabilities and older adults.

If you have any questions, contact Natalie Kean, [redacted] Nicole Jorwic, [redacted]; and John Poulos [redacted].

Sincerely,

Co-Chairs of the Disability and Aging Collaborative
Nicole Jorwic, Caring Across Generations
Natalie Kean, Justice in Aging
John Poulos, Autistic Self Advocacy Network

Co-Chairs of the Consortium for Constituents with Disabilities LTSS Task Force
Elise Aguilar, American Network of Community Options and Resources (ANCOR)
Tory Cross, Caring Across Generations
Jennifer Lav, National Health Law Program
Kim Musheno, The Arc of the United States
Gelila Selassie, Justice in Aging

Co-Chairs of the Consortium for Constituents with Disabilities Health Task Force
Caroline Bergner, American Speech-Language-Hearing Association
Michael Lewis, American Association of People with Disabilities (AAPD)
David Machledt, National Health Law Program
Julie Schurman, Disability Belongs
Greg Robinson, Autistic Self Advocacy Network

02.12.2025 / Statement

Families USA Statement On House Republicans' Budget Resolution Signaling Their Intent For Major Medicaid Cuts

WASHINGTON, D.C. – Anthony Wright, executive director of Families USA, today released the following statement after House Republicans released their budget resolution. Notably, the resolution calls for the House Energy and Commerce Committee to cut nearly $900 billion in spending, a clear signal of the intent to make significant cuts to Medicaid that will devastate health benefits for millions of Americans across the country.

"This budget resolution is a five-alarm fire alert for our health care. Despite President Trump saying last week they were going to 'love and cherish' Medicare, Medicaid and Social Security, House Republicans today released their intent to make devastating cuts of nearly $900 billion — cuts that would decimate health care coverage for millions of Americans and upend the health system we all rely on. House Republican leadership put a giant bullseye on Medicaid, with the intent to strip Americans of their health care benefits to pay for tax cuts for billionaires and big corporations. The magnitude of these health cuts is on a similar scale to Republicans' previous attempts to "repeal and replace" the ACA — but this time it is even more clear that it is repeal without any replacement, leaving many Americans uninsured, living sicker and dying younger and one emergency from financial ruin.

"We don't need to know the mechanisms of how Medicaid would be cut to know the impact would be catastrophic: the sheer size of the proposed cuts means millions of Americans losing coverage, hospitals and clinics plunged into budget shortfalls, and health care services we all depend on being eliminated. The end result would be disastrous for local economies, especially in rural and working class areas. This is not what

the American people sent their representatives to Congress to do. This House budget resolution is a direct betrayal of the very people in working class, rural and other communities who voted for Republican leaders to bring lower costs. We have already heard concerns from governors, state lawmakers, and even some Republican Members of the House of Representatives that these kinds of cuts would be harmful to their constituents and should be off the table for budget legislation. These policymakers should use their power now to tell their colleagues to reject a budget that cuts the health care of their own constituents and communities to fund tax breaks for the wealthiest."

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

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FAPP
Federal AIDS Policy Partnership

HIV Health Care Access Working Group (HHCAWG)

February 3, 2025

The Honorable John Thune
U.S. Senate
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Johnson
U.S. House of Representatives
568 Cannon House Office
Washington, DC 20515

The Honorable Chuck Schumer
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Hakeem Jeffries
U.S. House of Representatives
2433 Rayburn House Office Building
Washington, DC 20515

Dear Congressional Leaders:

We are writing on behalf of 95 national, regional, and local organizations advocating for federal funding, legislation, and policy to end the HIV epidemic in the United States. **We urge Congress to reject all proposals to enact cuts to Medicaid—whether through per capita caps or block grants, reductions to the Federal Medical Assistance Percentage (FMAP), or mandatory work requirements—during reconciliation for the 2025 and 2026 fiscal year budgets**.

Cuts to Medicaid, whether accomplished through reductions in federal funding for Medicaid or imposition of work requirements, would undermine our national strategy to end the HIV epidemic. With access to regular antiretroviral treatment and care, HIV is not only a manageable health condition, but also impossible to transmit to others.[1] Since Medicaid is a crucial source of access to HIV prevention, care and treatment, robust access to Medicaid must be at the center of the federal government's ambitious plan to end the HIV epidemic by 2030.[2]

Medicaid is the most important source of health coverage and life-saving care for people living with HIV, providing coverage for more than 40% of people living with HIV and contributing 45% of all federal funding for domestic HIV care and treatment.[3] Medicaid expansion is especially critical, since it enables people with HIV who lack access to private insurance to obtain full scope health insurance without having to wait until they have become disabled due to advanced HIV to qualify for Medicaid.[4] Additionally, Medicaid expansion helps state AIDS Drug

[1] Myron Cohen, MD, Ying Q. Chen, Ph.D., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.
[2] About Ending the HIV Epidemic, Centers for Disease Control and Prevention, March 20, 2024.
[3] Lindsay Dawson, Jennifer Kates, et al., Medicaid and People with HIV, March 27, 2023.
[4] Jennifer Kates, Lindsay Dawson, Insurance Coverage Changes for People with HIV Under the ACA, February 14, 2017.

Assistance Programs (ADAPs)—payers of last resort for HIV medications for people with HIV who are lower income or under- or uninsured—to maximize their eligibility criteria and improve service offerings, since enrolling ADAP members into Medicaid helps ADAPs avoid having to pay the full cost of HIV medications.[5]

Medicaid coverage is also proven to increase access to HIV prevention, thereby reducing transmissions and furthering public health goals.[6] In particular, Medicaid expansion has been found to be associated with increased awareness of HIV status among people living with HIV and increased use of Pre-Exposure Prophylaxis (PrEP).[7] Increased use of PrEP is one of the key strategies embraced in the national plan to end the HIV epidemic in the U.S.[8]

Finally, Medicaid is a key source of coverage for other public health epidemics that intersect with and exacerbate the HIV epidemic, such as hepatitis C, sexually transmitted infections, and substance use disorder. For example, Medicaid is the single largest payer for behavioral health services in the nation,[9] and Medicaid expansion has helped states significantly impacted by the opioid epidemic to recover.[10]

A strong Medicaid program is thus critical to ending the national HIV epidemic. We therefore urge you to oppose all cuts to Medicaid in the fiscal year 2025 and 2026 reconciliation processes, including but not limited to the following proposals:

- **Block grants or per capita caps.** These proposals reduce federal funds to the states and would transfer the burden to make up the shortfall. To do so, states could enact cuts to services, make changes that would reduce eligibility, cap enrollment, and/or cover fewer services—all actions that would place additional pressure on other safety net programs and harm people with chronic conditions and disabilities. With reduced Medicaid eligibility, the state population inevitably becomes sicker, driving up costs of care, at the same time that overall health care costs continue to grow nationwide. States may achieve more flexibility with less oversight, but state dollars simply will not go as far, creating program inefficiencies. Importantly, block grants and per capita caps also result in reduced reimbursement rates to physicians, hospitals, and nursing homes —placing further pressure on rural and suburban populations experiencing massive reductions in health care facilities and providers.

  People living with HIV rely on consistent access to medication to achieve and maintain viral suppression—and keep the broader community safer. Medicaid block grants and per capita caps that force a reduction in Medicaid patient roles can place people living

[5] NASTAD, Expanding and Adapting ADAP Service Delivery in a Dynamic Healthcare Environment.
[6] Alex Hollingsworth, Shyam Raman, et al., Panel Paper: Does Providing Insurance Coverage Reduce the Spread of Infectious Disease? The Impact of Medicaid Expansions on HIV Diagnoses, Association for public Policy Analysis and Management 41st Annual Fall Research Conference, November 9, 2019.
[7] Bita Fayaz Farkhad, David R Holtgrave, and Dolores Albarracín, Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use, March 1, 2022.
[8] HIV.gov, Key EHE Strategies, June 27, 2024.
[9] Heather Saunders, A Look at Substance Use Disorders (SUD) Among Medicaid Enrollees, Feb. 17, 2023.
[10] Alexis Robles-Fradet, Why Medicaid is Important for Treating Substance Use Disorders, January 15, 2025.

with HIV who also rely on Medicaid at greater risk. Additionally, when compared to the broader Medicaid population, people living with HIV have a higher prevalence of certain co-morbidities, which may lead to higher costs, and 25% of people living with HIV are dually eligible for Medicaid and Medicare—a population with more chronic conditions requiring long-term care.[11] A loss of Medicaid eligibility could simply transfer that coverage burden to Medicare.

- **Reductions to the FMAP**. All proposals to reduce federal matching funds for Medicaid would also hinder efforts to end HIV by shifting additional costs to states. However, dramatic reductions to the current FMAP rate for the Medicaid expansion population (currently 90%) could have particularly dire repercussions for people living with or vulnerable to HIV. Medicaid expansion has been associated with increased coverage for those living with HIV, increased HIV testing (which informs people of their status and keeps communities safer), as well as increased PrEP uptake.[12] In short, Medicaid expansion is crucial to ending the HIV epidemic by increasing access to care and prevention services.

  Unfortunately, despite the benefit to people living with and at risk for HIV particularly, twelve states with Medicaid expansion have trigger laws that would likely result in immediate or eventual termination of Medicaid expansion in those states if the FMAP falls below 90%.[13] In addition, other states will likely follow suit if they simply cannot afford the billions of dollars that would be needed to maintain the expansion without the 90% FMAP rate. The result would be significant losses of coverage to people living with and vulnerable to HIV and dramatically increased pressure on the Ryan White HIV/AIDS Program to pay the full cost of HIV treatment for the newly uninsured.

- **Instituting work requirements.** Mandatory work requirements for any Medicaid population, even healthy adults in the Medicaid expansion group, would jeopardize efforts to end the HIV epidemic. Although many Medicaid beneficiaries living with HIV are already working or would likely qualify for an exemption, these individuals would still be vulnerable to interruptions in their coverage due to difficulty meeting administrative burdens associated with work requirements.[14] For people living with HIV, even temporary losses of coverage can be life-threatening, as HIV requires continuous access to treatment to achieve viral suppression and live a healthy life. And for the smaller population of Medicaid beneficiaries with HIV who may be able to work but are not yet working—possibly due to stigma and discrimination or the need to spend more time seeking medical care—continuous access to Medicaid coverage supports them to eventually work by enabling them to remain healthy.

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[11] Lindsay Dawson, Jennifer Kates, et al., Medicaid and People with HIV, March 27, 2023.
[12] Jennifer Kates, Lindsay Dawson, Insurance Coverage Changes for People with HIV Under the ACA, February 14, 2017; Bita Fayaz Farkhad, David R. Holtgrave, et al., Effect of Medicaid Expansions on HIV Diagnoses and Pre-Exposure Prophylaxis Use. Am J Prev Med. 2021 Mar; 60(3):335-342.
[13] Adam Searing, Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States, November. 27, 2024.
[14] Lindsay Dawson and Jennifer Kates, Medicaid Work Requirements and People with HIV, February 3, 2020.

We appreciate your support for ending the HIV epidemic in the U.S. and again urge you to reject all proposals to enact cuts to Medicaid during reconciliation for the 2025 and 2026 fiscal year budgets. If you would like to discuss any of these points further, please contact the Co-Chairs of the Federal AIDS Policy Partnership's HIV Healthcare Access Working Group: Liz Kaplan ([redacted]) with the Center for Health Law and Policy Innovation; Rachel Klein ([redacted]) with The AIDS Institute; and Leslie McGorman with AIDS United ([redacted]).

Sincerely,

AIDS United

Center for Health Law and Policy Innovation

The AIDS Institute

5280 Fast Track Cities

Access Support Network

Act Now: End AIDS (ANEA) Coalition

AID Upstate Inc.

AIDS Action Baltimore

AIDS Alabama

AIDS Foundation Chicago

AIDS Law Project of Pennsylvania

American Academy of HIV Medicine

Amida Care

APLA Health

AVAC

Black Women's Health Imperative

CAEAR Coalition

CAPSLO

Cares of Southwest Michigan

Cascade AIDS Project

CenterLink: The Community of LGBTQ Centers

Christie's Place

Colorado Health Network

Colorado Organizations and Individuals Responding to HIV/AIDS (CORA)

CORE Medical Clinic

CrescentCare

Delaware HIV Consortium

Equality California

Equality Federation

Equitas Health

Family Centers Inc.

Family Health Care Clinic, Inc.

Five Horizons Health Services

Georgia AIDS Coalition

Georgia Equality

GMHC

God's Love We Deliver

Health GAP

Health Partners of Western Ohio

Healthcare Across Borders

HealthHIV

HIV Dental Alliance

HIV Medicine Association

HIV/AIDS Alliance of Michigan

HIV+Hepatitis Policy Institute

Hope and Help Center of Central Florida, Inc

Housing Works, Inc.

iHealth, Inc.

International Association of Providers of AIDS Care

International Community of Women Living with HIV - North America

Kedren Community Health Center

KLowInspires, LLC

Lansing Area AIDS Network

Latino Commission on AIDS

LOTUS

Matthew 25 AIDS Services, Inc.

Metropolitan Charities, Inc.

MPact Global

NASTAD

National Alliance for HIV Education and Workforce Development

National Coalition for LGBTQ Health

National Harm Reduction Coalition

National HIV/AIDS Housing Coalition

National Working Positive Coalition

NC AIDS Action Network

NMAC

Positive Impact Health Centers

Positive People Network, Inc.

Positive Women's Network-Ohio

Positive Women's Network-USA

PrEP4All

Radiant Health Centers

Ribbon-A Center for Excellence

Ryan White Medical Providers Coalition

San Francisco AIDS Foundation

SIECUS: Sex Ed for Social Change

Silver State Equality - Nevada

Southern Black Policy and Advocacy Network

Southwest Care

Southwest Care Center

The Amistad Clinic

The Center for HIV Law and Policy

The Institute for Health Research & Policy at Whitman-Walker

The Reunion Project

The Sero Project

The TransLatin@ Coalition

The Well Project

Thrive Alabama

Treatment Action Group

US PLHIV Caucus

Vivent Health

W King Health Care Group

Waves Ahead

Wellness Services, Inc.

Whitman-Walker Health

FAH Statement on House Budget Resolution

The Federation of American Hospitals President and CEO Chip Kahn released the following statement ahead of the House budget resolution (H.Con.Res. 14):

“The President rightly made it clear that Medicaid is out of bounds for cuts when he said, 'it’s not going to be touched,' but the House budget resolution would drive a hole through that pledge.

"The proposed $880 billion in cuts assigned to the House Energy and Commerce Committee can only come at the expense of over 70 million children, seniors, and hardworking families who rely on Medicaid for their health and wellbeing. Medicaid is a federal-state partnership, and slicing hundreds of billions of dollars from federal funding will force states to cut the care children and families depend on or raise taxes on hardworking Americans to keep the care. Neither of these options will make America healthier, lower costs for families, or boost our nation’s economy. Congress should go back to the drawing board and craft a resolution that meets its agenda without cutting the care of millions of Americans and threatening access to 24/7 hospitals.”

Federation of American Hospitals

Charlene K. MacDonald

Executive Vice President, Public Affairs

C [redacted]

[redacted]

750 9th Street, NW, Suite 600 Washington, DC

20001-4524

NYS

Cuts to Medicaid would harm our most vulnerable.

These are the Faces of Medicaid.

43%

of children in NY
are covered by Medicaid.

72%

of nursing home residents in NY
are covered by Medicaid.

53%

of baby deliveries in NY
are covered by Medicaid.

37%

of ER visits, clinic visits and outpatient surgeries in NY
are covered by Medicaid.

The NY delegation must preserve their access to care.

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JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Today, House Republicans are marking up the budget resolution they released yesterday that would require Congress to dramatically cut programs to pay for trillions of dollars in tax cuts for the wealthy. In particular, they direct the House Energy and Commerce Committee, which has jurisdiction over Medicaid, to cut nearly $900 billion in federal spending, putting Medicaid funding at grave risk.

These massive cuts threaten the health care of millions of older adults who rely on Medicaid for their health and long-term care needs. Medicaid is not just a safety net; it is a lifeline for seniors. Without it, they could not afford home-based or nursing facility care and would struggle to meet high out-of-pocket costs associated with Medicare. The proposed cuts would starve Medicaid, forcing states to reduce spending by cutting access to these essential benefits, leaving older adults without health care and support they need.

And Medicaid is not the only program on the chopping block that supports older adults. **The budget resolution also includes deep cuts to SNAP benefits that would make it even harder for older adults to buy groceries.**

It is imperative for lawmakers to reject any budget that uses public programs as a piggy bank to fund tax breaks for the wealthy and corporations at the expense of the well-being of older adults. Instead, Congress should prioritize lowering the costs of health and long-term care for our aging population. We urge lawmakers to be champions for older adults and to ensure they have access to the care and supports they need.

Call your lawmakers and demand that they protect Medicaid for older adults: 866-426-2631.

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Statements

Leading Physician Groups: Medicaid Program Must Be Protected

For immediate release February 13, 2025

Media contacts:
AAFP: Julie Hirschhorn [redacted]
AAP: Devin Mazziotti | [redacted]
ACOG: Kate Connors | [redacted]
ACP: Jacquelyn Blaser [redacted]
APA: Erin Connors | [redacted]

The statement below is issued by the American Academy of Family Physicians, the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians and American Psychiatric Association:

"For decades, the Medicaid program has provided health care coverage for millions of people, including children and parents, low-income adults, older adults, pregnant patients, individuals with mental health and substance use disorders and individuals with disabilities, in communities large and small, urban and rural.

Our organizations, representing more than 400,000 physicians who serve millions of patients, are alarmed by proposals to implement cuts or other structural changes to Medicaid during the budget reconciliation process. Cuts to Medicaid will have grave consequences for patients, communities and the entire health care system. With reduced federal funding, it will be harder for patients to access care, states will be forced to drop enrollees from coverage, and it will limit the health care services patients can access and cut payment rates. Slashing already-low Medicaid payment rates will make it

even harder for physicians to provide care to people covered under Medicaid and will ultimately increase health care costs as patients are forced to forgo vital preventive care.

Our members are not alone in support of Medicaid and concern for potentially reduced funding. Americans widely support Medicaid, with two-thirds of adults in the U.S. saying they have had some connection to the Medicaid program, through their own coverage or coverage of a loved one. Imposing arbitrary restrictions and limitations on Medicaid enrollment runs counter to the mission of the program, which is to provide people with the health care coverage--and peace of mind--that they need.

The impact of cuts to Medicaid funding is significant and wide-reaching, and it must be reconsidered. Medicaid is a lifeline for our nation's most vulnerable — from visits with a primary care physician, to maternal health care and pediatrics, to labor and delivery services, to behavioral health and to preventive care that saves lives. To that end, it is of the utmost importance that Congress protect this vital program."

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About American Academy of Family Physicians

Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits — that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary, nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care;

maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities. acog.org

About the American College of Physicians

The American College of Physicians is the largest medical specialty organization in the United States with members in more than 172 countries worldwide. ACP membership includes 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Follow ACP on X, Facebook, Instagram, Threads and LinkedIn.

About the American Psychiatric Association

The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with nearly 39,000 physician members specializing in the diagnosis, treatment, prevention, and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment. For more information, please visit www.psychiatry.org.

LEUKEMIA & LYMPHOMA SOCIETY®

February 24, 2025

The Honorable Mike Johnson
Speaker of the House
US House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
US House of Representatives
Washington, DC 20515

Dear Speaker Johnson & Minority Leader Jeffries,

At LLS, our mission is to cure blood cancer and improve the quality of life of all patients and their families. In light of that mission, LLS urges Members of the House to vote NO on the Concurrent Resolution on the Budget for Fiscal Year 2025 as passed by the House Budget Committee, to prevent Congress from making cuts to Medicaid that are ill-conceived, unpopular, and deeply harmful to patients with cancer.

As passed by the Budget Committee, the FY25 Budget Resolution would create not just the opportunity but the obligation for the House Committee on Energy & Commerce to make dangerous cuts to the Medicaid program in the budget reconciliation process expected in the coming weeks. **The hundreds of billions in cuts demanded by the budget resolution can not be achieved without slashing benefits for enrollees or altogether taking away Medicaid coverage from millions of Americans.**

To be clear, LLS and the patients we represent are clamoring for Congress to lower health care costs. But the framework before the House today would pave the way for policies that do just the opposite—putting affordable access to health care out of reach for millions of Americans.

LLS firmly believes that all patients and consumers should have access to high-quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. The drastic cuts being considered to reach the savings target outlined in the budget resolution before the Committee clearly threaten access to necessary care for the tens of millions of working families, children, seniors, and people with disabilities who rely on Medicaid.

We urge Members to vote NO on the FY25 budget resolution and instead bring forward a framework that does not demand harmful cuts to Medicaid.

Sincerely,

Brian Connell
Vice President, Federal Affairs
The Leukemia & Lymphoma Society

Mental Health Association in Michigan

February 24, 2025

Michigan Members of the United States Congress VIA EMAIL
Washington, DC

Rep. Jack Bergman
Rep. John Moolenaar
Rep. Hillary Scholten
Rep. Bill Huizenga
Rep. Tim Walberg
Rep. Debbie Dingell
Rep. Kristen McDonald Rivet
Rep. Lisa McClain
Rep. John James
Rep. Haley Stevens
Rep. Rashida Tlaib
Rep. Tom Barrett
Rep. Shri Thanedar
Sen. Elissa Slotkin
Sen. Gary Peters

RE: Concerns regarding the proposed cuts to Medicaid for FY'25/'26

Dear Honorable Members of the Michigan Congressional Delegation:

The Mental Health Association in Michigan (MHAM) is the state of Michigan's oldest, non-governmental organization dedicated to ensuring that all individuals with mental health conditions and substance use disorders have access to quality mental health services and supports. MHAM is a 501© (3) non-profit located in Lansing, Michigan and we were founded in 1936. Our sole mission has been and continues to be to act as the advocate for adults and children with behavioral health-related conditions.
We write today to express our concern about the Medicaid reductions that are being proposed by Congress. In Michigan, 2,540,906 individuals receive assistance through the Medicaid program. According to the Kaiser Family Foundation (August,2024), 1 in 5 individuals between the ages of 19 and 64 received Medicaid benefits. 2 in 5 children in Michigan receive Medicaid benefits.

Access to behavioral health services is critically important when we are in the depths of a mental health crisis and opioid epidemic. Across the United States, Medicaid is the largest payer of behavioral health services, spending $52 billion per year on mental health and substance use disorder services. Nearly four in ten Medicaid enrollees have a mental health condition or substance use disorder. This is a significantly higher rate than found among those with private insurance (39% to 31%).

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www.mha-mi.com

A reduction in Medicaid funding means reducing our commitment to fighting overdoses and suicides. People with mental health conditions and substance use disorders on Medicaid are the most vulnerable in our community. They are most likely to suffer if Medicaid funding is cut for the next fiscal year.

On February 13, 2025, President Donald Trump created the Make America Healthy Again Commission and acknowledged that, "An estimated one in five United States adults lives with a mental illness." MHAM appreciates the recognition that many American citizens struggle with the burden of a behavioral health condition. For many of those citizens, Medicaid ensures that they have access to critical mental health services and supports. If Medicaid funding is reduced, the risk of harm to these individuals increases significantly.

MHAM is asking that the Michigan Congressional delegation speak up on behalf of those in our state on Medicaid who experience mental health conditions and substance use disorders during the budget resolution discussion. Our experience at MHAM is that those who have the most serious mental illnesses often have no voice in mental health public policy. These individuals require protection and many in Congress may be unaware of the vital role Medicaid plays in behavioral health treatment. We urge you to let leadership know that cuts to Medicaid are going to damage our community and put lives at risk.

Thank you for your help and advocacy on behalf of Michigan's children, adolescents and adults who rely upon the Medicaid program. If you have any questions, please contact me at 313-641-1109 or via email at mhuffmham@gmail.com.

Sincerely,

Marianne Huff, LMSW
President and CEO

Mental Health Association in Michigan

The Honorable Lindsey Graham
U.S. Senate
211 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Jeff Merkley
U.S. Senate
531 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Jodey Arrington
U.S. House of Representatives
204 Cannon House Office Building
Washington, D.C. 20515

The Honorable Brendan Boyle
U.S. House of Representatives
507 Cannon House Office Building
Washington, D.C. 20515

January 29, 2025

Re: Protect Medicaid for People with Mental Health Conditions and Substance Use Disorders

Dear Chairman Graham, Chairman Arrington, Ranking Member Merkley, and Ranking Member Boyle:

The Mental Health Liaison Group (MHLG), a coalition of national organizations representing people with mental health conditions and substance use disorders, family members, mental health and addiction providers, advocates and other stakeholders, is committed to strengthening Americans' access to mental health and substance use disorder care. We are writing to urge Congress to protect Medicaid, including in any reconciliation efforts. Cutting Medicaid funding or benefits, as well as imposing burdensome work requirements, would disproportionately harm people with mental health (MH) conditions and substance use disorders (SUD), who make up approximately 40% of nonelderly adults on Medicaid. In the midst of our nation's ongoing mental health crisis, including its devastating impact on youth, and our ongoing overdose epidemic, we cannot reduce access to community- and school-based life-saving services.

Our organizations are deeply concerned by policy proposals under consideration that would change Medicaid's financing structure, shift costs to the states, reduce eligibility or benefits, or impose additional barriers to coverage and enrollment. Any of these policy changes or cuts would take away quality, affordable MH/SUD care from approximately 80 million Americans who rely on Medicaid, including low-income children, pregnant women, people with disabilities, and seniors. However, the need for MH/SUD services would not go away. Many people would be forced to forgo community-based and routine MH/SUD care, such as medications for opioid use disorder (MOUD), therapy, and prescription MH medications. This would lead to people's conditions worsening until they require more costly and more intensive treatment at a point of crisis. Moreover, limiting access to Medicaid threatens to undermine gains in reducing overdose mortality rates, and could lead to increasing rates of incarceration and hospitalization.

Medicaid is the single largest payer of MH and SUD services, and we fear the devastating consequences to our nation if the federal Medicaid program were to be weakened. All people, regardless of their economic circumstances, deserve access to evidence-based MH and SUD care, and we all pay a high cost when that care is unattainable. We strongly urge you to reject any cuts to the Medicaid program. If you have any questions or would like to discuss this issue, please do not hesitate to contact Hannah Wesolowski, Chief Advocacy Officer at the National Alliance on Mental Illness [redacted], or Deborah Steinberg, Senior Health Policy Attorney at the Legal Action Center [redacted].

Sincerely,

National Alliance on Mental Illness (NAMI)
Legal Action Center
American Academy of Nursing
American Association for Marriage and Family Therapy
American Association for Psychoanalysis in Clinical Social Work
American Association of Child and Adolescent Psychiatry
American Association of Psychiatric Pharmacists
American Association on Health and Disability
American Foundation for Suicide Prevention
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association Services
American Society of Addiction Medicine
Anxiety and Depression Association of America
Association for Behavioral Health and Wellness
Bazelon Center for Mental Health Law
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
Crisis Text Line
Depression and Bipolar Support Alliance
Epilepsy Foundation of America
Global Alliance for Behavioral Health and Social Justice
Huntington's Disease Society of America
Inseparable
International OCD Foundation
International Society of Psychiatric-Mental Health Nurses
Maternal Mental Health Leadership Alliance
Mental Health America
NAADAC, the Association for Addiction Professionals
National Association for Rural Mental Health (NARMH)
National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
National Association of Pediatric Nurse Practitioners
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Mental Wellbeing
National Federation of Families
National Health Law Program
National League for Nursing
National Register of Health Service Psychologists
National Women's Shelter Network, Inc.
Network of Jewish Human Service Agencies
Postpartum Support International
Psychotherapy Action Network
School Social Work Association of America
SMART Recovery
The Kennedy Forum

The National Alliance to Advance Adolescent Health/Got Transition
UnidosUS
Vibrant Emotional Health
Western Youth Services
Youth Villages

Cc: House and Senate Leadership; Chairs and Ranking Members of E&C and Finance

February 14, 2025

House Budget Resolution Would Put Access to Mental Health and Substance Use Disorder Services at Risk for Millions of Americans

Statement of the Mental Health Liaison Group (MHLG), on the House Budget Committee budget resolution, as approved on February 13, 2025:

The House budget resolution will have a devastating impact on the American health care system and the millions of Americans with mental health (MH) conditions and substance use disorders (SUD) who rely on Medicaid, as a lifeline, to access needed health care services. The House budget resolution calls for the Energy and Commerce Committee to find $880 billion in savings, a target that we fear will be attained with significant coverage losses or benefits reductions within Medicaid.

Changing Medicaid's financing structure, reducing eligibility or benefits, or imposing additional barriers to coverage and enrollment would take away quality, affordable MH/SUD care from approximately 72 million Americans who rely on Medicaid, including children, pregnant women, people with disabilities, seniors, and veterans. In the midst of our nation's ongoing mental health crisis, including its devastating impact on youth, and our ongoing overdose epidemic, it is paramount that access to life-saving MH/SUD services is not reduced, and the integrity of the Medicaid program to serve as a vital, federal and state partnered safety-net is preserved.

Limiting access to Medicaid threatens to undermine gains in reducing overdose mortality rates and could lead to increasing rates of incarceration and hospitalization. Medicaid is the single largest payer of MH and SUD services, and cuts of this magnitude will undeniably have devastating consequences for our citizens, states and health care providers. We urge Congress not to pursue harmful cuts to Medicaid. All people, regardless of their economic circumstances, deserve access to evidence-based MH and SUD care, and we all pay a high cost when that care is unattainable.

The Mental Health Liaison Group (MHLG) is a coalition of over 100 national organizations representing people with mental health conditions and substance use disorders, family members, mental health and addiction providers, advocates and other stakeholders, and is committed to strengthening Americans' access to mental health and substance use disorder care.

February 24, 2025

State of Michigan Department of Health and Human Services (MDHHS) Behavioral Health Advisory Council (BHAC)
Lansing Michigan.

Michigan Members of the United States Congress
Washington, DC

RE: Concerns regarding the proposed cuts to Medicaid for FY'25/'26

Dear Honorable Members of the Michigan Congressional Delegation:

The State of Michigan Department of Health and Human Services (MDHHS) Behavioral Health Advisory Council (BHAC) advises the Michigan Department of Community Health (MDCH) concerning proposed and adopted plans affecting both mental health and substance use disorder services provided or coordinated by the State of Michigan and the implementation thereof. BHAC's responsibilities as defined in the applicable federal law include but are not limited to: Advocating for improved services to persons with behavioral health problems, and monitoring and evaluating the implementation of the application of the applicable federal law.

We write today to express our concern about the Medicaid reductions that are being proposed by Congress. Medicaid is the largest payer in Michigan of behavior health services for those with mental health and substance use disorders. A reduction in Medicaid funding would mean our most vulnerable citizens would be denied access to critically important behavioral health services and supports and substance use disorder services and supports.

BHAC is asking that the Michigan Congressional delegation speak up on behalf of those in our state on Medicaid who experience mental health and substance use disorders during the budget resolution discussion. The voices of our most vulnerable citizens must be heard. We urge you to let leadership know that cuts to Medicaid are going to put our vulnerable citizens's lives at risk.

Thank you for your help and advocacy on behalf of those who rely on Medicaid programs's supports and services for survival. If you have any questions please contact me at [redacted] or via email at [redacted]

Sincerely,

Mark Maggio
Chair
State of Michigan Department of Health and Human Services Behavioral Heath Advisory Council

Modern Medicaid ALLIANCE

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General

Modern Medicaid Alliance Statement on Budget Reconciliation Process

Press Release

Published: February 24 • 2025

February 24 • 2025

Washington, D.C. – The Modern Medicaid Alliance issued the following statement:

"A strong, healthy American economy depends on strong, healthy American families. With over 70 million children, seniors and hardworking families relying on Medicaid for their health and well-being, it is critical Congress listens to **state and local government officials**, **faith leaders**, **health care providers and hardworking Americans** and blocks proposed cuts to the program. As organizations representing and caring for the millions of Americans who receive coverage and benefits through Medicaid, we know firsthand how the current level of cuts being considered by Congress would impact their care – they will cause Americans to lose coverage, reduce health access and increase costs. We oppose any cuts or harmful policy changes to Americans' Medicaid benefits as part of the budget reconciliation process, and call on Congressional leaders to reverse course and protect the program moving forward."

Protecting Medicaid Is A Priority

- **President Trump (Jan. 31)**: "We'll love and cherish Social Security, Medicare, and Medicaid. We're not going to do anything with that…The people won't be affected."
- **Rep. Rob Bresnahan Jr (R-PA) (Feb. 14)**: "I ran for Congress under a promise of always doing what is best for the people of Northeastern Pennsylvania. If a bill is put in front of me that guts the benefits my neighbors rely on, I will not vote for it."
- **President Trump (Feb. 18)**: "Medicare, Medicaid – none of that stuff is going to be touched."
- **Reps. Tony Gonzales (Texas), Monica De La Cruz (Texas), David Valadao (Calif.), Juan Ciscomani (Ariz.) Rob Bresnahan (Pa.), Nicole Malliotakis (N.Y.), along with Dels. James Moylan of Guam and Kimberlyn King-Hinds of Northern Mariana Islands (Feb. 19)**: "The House Budget Resolution proposed $800 billion

in cuts to programs under the House Committee on Energy and Commerce, with Medicaid expected to bear the brunt of these reductions. Nearly 30% of Medicaid enrollees are Hispanic Americans, and for many families across the country, Medicaid is their only access to healthcare. Slashing Medicaid would have serious consequences, particularly in rural and predominantly Hispanic communities where hospitals and nursing homes are already struggling to keep their doors open. Moreover, the possibility of cutting Medicaid Disproportionate Share Hospital (DSH) funding threatens hospitals that serve low-income and uninsured patients."

- **Rep. Nicole Malliotakis (N.Y.) (Feb. 19)**: "I appreciate the president's comments on Hannity last night reaffirming his commitment to not cut Social Security, Medicare and Medicaid, but I still need some clarity from my colleagues in the House on how we're gonna get to the numbers mandated in the resolution without cutting Medicaid in a way that it impacts beneficiaries or my hospitals."
- **U.S. Conference of Mayors, National Conference of State Legislatures, etc. (Feb. 19)**: "Medicaid accounts for over half of all federal funds to states and is the largest source of federal funding for state budgets, making it essential to states' ability to design and administer healthcare programs that meet the unique needs of their populations. Preserving state flexibility and preventing significant funding cuts are both critical to ensuring Medicaid can be tailored to local priorities, as such cuts would severely limit this ability, forcing states to reduce services, restrict eligibility, or shift costs to local governments. These reductions would jeopardize access to affordable healthcare and long-term services and place an unsustainable financial burden on states and counties, which often serve as payers of last resort."

About the Modern Medicaid Alliance: *The Modern Medicaid Alliance is a partnership between Americans who value Medicaid and leading advocacy organizations. Our mission is to educate policymakers and the public about the benefits of Medicaid to the American people in terms of cost savings, health outcomes and social impact, and to highlight how Medicaid is innovating in the delivery of care — especially for America's most vulnerable citizens — and accountability of the program.*

For Modern Medicaid Alliance news and updates, visit ModernMedicaid.org and Data.ModernMedicaid.org, and follow us on Twitter @modernmedicaid or facebook.com/ModernMedicaid.

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General

Health Care Leaders Urge Congress to Uphold President Trump's Promise to Protect Medicaid Beneficiaries

Press Release

Published: February 6 • 2025

February 6 • 2025

Washington, D.C. – Following President Trump's statement this weekend that his administration is **committed to protecting the Medicaid program and not undermining the millions of Americans who rely on it**, the Modern Medicaid Alliance — which represents organizations caring for, representing, and serving Medicaid beneficiaries across the country — urged Congressional leaders to follow the President's lead by opposing cuts to the Medicaid program.

President Trump's position underscores the critical need to maintain funding for the Medicaid program, particularly as proposed cuts threaten to destabilize state budgets, weaken local economies and undermine essential health services for beneficiaries.

Recent analysis on Congressional proposals to cut Medicaid funding show that these policies would decimate Medicaid as well as the critical support services the program provides to working families and at-risk patients. The cumulative impact would be wide-ranging across states, leading to job losses, hospital closures and direct beneficiary harm, including for those living in rural communities, pregnant women, new moms, children, low-wage workers in jobs that do not provide health benefits, those in need of mental health and substance abuse support and seniors and people with disabilities who rely on Medicaid for long-term care assistance.

Public opinion is **strongly opposed** to cutting Medicaid, with recent polling showing that **a majority of Republican voters** view the program favorably.

As policymakers look to reduce health care spending, members of the Modern Medicaid Alliance are committed to engaging state and federal leaders about the critical role of the Medicaid program in reducing the burden of uncompensated care on the broader health system and for millions of beneficiaries.

For more information about the Modern Medicaid Alliance and its initiatives, visit **modernmedicaid.org**.

About the Modern Medicaid Alliance: The Modern Medicaid Alliance is a partnership between Americans who value Medicaid and leading advocacy organizations representing patients, health care workers, children, older adults, people with disabilities, pregnant and postpartum women and health insurance providers. Our mission is to educate policymakers and the public about the benefits of Medicaid to the American people in terms of cost savings, health outcomes and social impact and to highlight how Medicaid is innovating in the delivery of care — especially for America's most vulnerable citizens — and accountability of the program.

For Modern Medicaid Alliance news and updates, visit **ModernMedicaid.org** and follow us on X/Twitter **@modernmedicaid** or **facebook.com/ModernMedicaid**.

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Modern Medicaid ALLIANCE

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National Patient Organizations United in Opposition to House Budget Resolution that Threatens Medicaid Coverage for Millions

WASHINGTON, D.C. (February 24, 2025) – This week, the House of Representatives is expected to consider a budget resolution instructing the House Energy and Commerce Committee to cut spending by $880 billion, with most of these cuts expected to come from the Medicaid program. Given the devastating impact these cuts would have on the almost 80 million people with Medicaid and CHIP coverage nationwide, 38 national patient advocacy organizations released the following statement, urging lawmakers to vote no on the budget resolution:

"Our organizations strongly oppose the House budget resolution, which requires massive cuts that can only be achieved by decimating the Medicaid program. There is no way to make cuts of this magnitude without taking healthcare away from seniors, children, and people with disabilities and chronic health conditions. We and the patients we represent have repeatedly voiced our opposition about the devastating, real world consequences of Medicaid cuts and urge lawmakers to oppose the budget resolution.

“Cuts of this magnitude would require enormous changes – such as instituting per capita caps, reducing the federal match rate for Medicaid expansion, adding barriers to coverage including work reporting requirements, and repealing rules that strengthen enrollment processes and access to care in Medicaid – that would severely harm many individuals fighting serious and chronic health conditions. Our organizations oppose any cuts to either traditional or Medicaid expansion that take away coverage, jeopardize access to services and providers, shift costs to states, and reduce patients’ access to care.

“Simply put, it is impossible to achieve the $880 billion savings target for the Energy and Commerce Committee without making deep cuts to the Medicaid program. And it is impossible to structure these cuts in a way that protects seniors, children, and people with disabilities and chronic health conditions.

We urge members to vote no on this and all other legislation that threatens access to Medicaid coverage.”

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AiArthritis
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American Heart Association
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American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autoimmune Association
Cancer Support Community
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Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Sickle Cell Disease Association of America, Inc.
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart: The National Coalition for Women with Heart Disease

National
Multiple Sclerosis
Society

February 20, 2025

Dear Members of the United States House of Representatives:

We are writing on behalf of people affected by multiple sclerosis (MS) to urge you to protect Medicaid from proposed cuts. We are extremely concerned about the budget resolution that will soon be considered by the U.S. House of Representatives instructing the House Energy and Commerce Committee to cut spending by $880 billion, with most of these cuts expected to come from the Medicaid program. Medicaid is a vital program that provides health coverage and long-term services and supports for 80 million low-income individuals, people living with disabilities, and families across the United States—including those affected by MS. As you consider legislative proposals that will impact the future of Medicaid, we ask that you recognize the program's life-saving role in ensuring access to comprehensive, affordable healthcare. We urge you to vote NO on this budget resolution.

MS is an unpredictable disease of the central nervous system. Currently, there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimize disability. Significant progress is being made to achieve a world free of MS.

The National Multiple Sclerosis Society (Society), founded in 1946, is the global leader of a growing movement dedicated to creating a world free of MS. The Society provides global leadership, funds research for a cure, drives change through advocacy, and provides programs and services to help people affected by MS live their best lives. Additionally, the Society sees itself as a partner to the government in many critical areas. While we advocate for the government's involvement in accelerating the discovery, development, and delivery of new treatments, we do so as an organization whose research investment exceeds $1.2 billion.

The Critical Role of Medicaid for Individuals Living with Multiple Sclerosis

For individuals living with MS and their carepartners, Medicaid is more than just a safety net—it is a critical lifeline. We estimate that Medicaid covers 15% of people living with MS; however, that number does not capture the percentage that receives long-term services and support through Medicaid.[1] Analysis of Komodo's Healthcare Map, which is derived primarily from medical claims data, indicated that within a nationally

[1] Komodo Health. Demographics of the U.S. Multiple Sclerosis Population [Internet]. Komodo Insights; 2025 Feb 19. Available from: https://www.komodohealth.com/insights/ms-demographics-2015-2023

represented cohort between 2015-2023, 108,659 (12%) of individuals living with MS utilized Medicaid Managed Care as their payer, while 22,667 (3%) used Medicaid services.[2]

Managing MS requires continuous care, including prescription medications known as disease-modifying therapies (DMTs). To prevent further disease progression, it is essential that individuals begin an FDA-approved DMT as soon as possible following diagnosis, and continued adherence to medication is essential for treatment effectiveness. Delays or gaps in necessary diagnostic tests or treatments can worsen the prognosis for an individual living with MS and may lead to serious, long-term, and irreversible consequences and disease progression. However, without adequate medical and prescription drug coverage, managing this disease becomes financially impossible for many individuals.

- The average annual cost of living with MS is $88,487 per year.[3]
- The median annual cost of brand DMTs was over $107,000 as of July 2024.

For individuals and families already struggling financially, these costs are insurmountable without access to Medicaid. Ensuring continuous and adequate coverage reduces the risk of disease progression, prevents costly hospitalizations, and enables people with MS to remain engaged in their communities and the workforce.

Medicaid provides access to more than just medications. Bladder dysfunction occurs in at least 80% of people living with MS. Medicaid provides coverage for incontinence supplies, which are expensive to pay for out-of-pocket. Medicaid also covers wound care supplies that can be critical in preventing serious health conditions. This is essential for people living with MS, who are more at risk for pressure sores due to factors like decreased sensation in the skin, mobility challenges which can lead to increased sitting or lying down, and cognitive confusion.

Medicaid helps people living with MS access a range of healthcare providers. Since the symptoms of MS vary from person to person, some individuals require access to a neurologist and a primary care provider—while others need access to a more comprehensive care team. For example, people living with MS may seek treatment from a urologist, a mental health professional, a physical therapist, an occupational therapist, and other providers. For many people living with MS, losing access to their Medicaid providers could be catastrophic and would lead to significantly worse health outcomes.

Finally, Medicaid plays a crucial role for individuals living with MS who are in the two-year waiting period for Medicare. When someone qualifies for Social Security Disability Insurance due to MS, they typically must wait two years before accessing Medicare. During this time, Medicaid can provide healthcare coverage to fill the gap so they can manage their MS, if they meet income and asset requirements.

[2] Komodo Health. Demographics of the U.S. Multiple Sclerosis Population [Internet]. Komodo Insights; 2025 Feb 19. Available from: https://www.komodohealth.com/insights/ms-demographics-2015-2023
[3] The Economic Burden of Multiple Sclerosis in the United States

Medicaid Is a Lifeline for People with Disabilities Who Need Access to Long-Term Services and Supports

Medicaid serves as a cornerstone of support for over 10 million children and adults living with disabilities in the United States, comprising about 15% of all Medicaid beneficiaries.[4] This program is pivotal in providing health coverage and long-term services and support (LTSS), including home and community-based services (HCBS). HCBS enables individuals living with disabilities to lead more independent lives within their communities. HCBS not only aligns with the preference of many individuals to receive care in their own homes and communities, but it is offered at a lower cost than care in a skilled nursing facility (SNF) and allows states to comply with the *Olmstead* decision. HCBS enable people living with disabilities to remain at home and connected to their communities.

Many people living with MS do not need the level of care provided by an SNF but cannot remain living independently at home without access to in-home care. This includes people in their 30s and 40s living with progressive MS, who are much better served by living at home versus in a nursing home setting. HCBS can include access to skilled nursing care and therapies at home, and personal care (e.g., dressing, bathing, toileting, eating, transferring to or from a bed or chair, etc.). Medicaid also provides critical coverage for durable medical equipment (DME), including items such as canes, walkers, and commodes. Medicaid covers equipment that helps prevent falls, injuries, and hospitalization. Total Medicaid spending attributable to non-fatal older adult falls is approximately $3.5 billion annually.[5] In addition, Medicaid covers items such as hospital beds, specialized mattresses to prevent wounds, and Hoyer lifts to help with transferring—all of which help people remain safely in their homes, and cost significantly less than a stay in a hospital or a skilled nursing facility.

Travel-related barriers to care can be significant for the person living with MS and potentially a carepartner, including the actual time to and from a physician visit, the cost of gasoline, and time off work (either paid or unpaid). Without transportation, getting to their doctors and treatments can be unaffordable or even impossible. Many people living with MS, including those in rural areas, are reliant on non-emergency medical transportation (NEMT) provided via Medicaid HCBS for assistance getting to and from medical appointments. Additionally, lack of access to neurologic care disproportionately affects people living in rural areas, with only 13% of rural areas having full access, as measured by neurologist density and travel distance.[6] In most rural communities, the closest neurologist is over 60 minutes away. In summary, access to HCBS improves health outcomes for people living with MS and reduces Medicaid expenditures by preventing serious and life-threatening problems.

The Importance of Medicaid Access for Carepartners

MS profoundly affects not only those diagnosed but also their families and carepartners. The unpredictable nature of MS, characterized by symptoms like fatigue, mobility challenges, and cognitive impairments, necessitates varying levels of support. This often places significant emotional, physical, and financial burdens

[4] Medicaid Provides Health Coverage for People with Disabilities
[5] Healthcare spending for non-fatal falls among older adults, USA
[6] Desert Mapping to Promote Health Equity in Multiple Sclerosis Care: Julie Fiol, MSCN; Andreina Barnola, MD, MPH

on carepartners. Due to their responsibilities, carepartners frequently face employment disruptions. Studies indicate that 40% of MS carepartners reported missing work in the past year, with 24% reducing their hours or leaving their jobs to provide care.[7] These employment challenges can lead to a loss of employer-sponsored health insurance, leaving carepartners vulnerable to health-related financial strains. Medicaid supports the ability of carepartners providing intensive support for their loved ones to receive some reimbursement for the provision of care, secure respite and take care of their own healthcare needs.

Medicaid Funding Cuts Would Destabilize Hospitals and Health Systems—and Jeopardize Access to Care

Medicaid is essential for individuals' health and reduces costs across the healthcare system. When individuals do not have access to adequate coverage, they are less likely to seek early treatment and adhere to medications and more likely to utilize costly emergency room visits or hospitalizations. Without Medicaid reimbursement, hospitals and healthcare providers would bear the financial burden of uncompensated care. The size and scale of the potential cuts to Medicaid would have enormous ramifications—especially in rural and underserved communities. Safety-net hospitals serve a higher proportion of Medicaid patients. This dynamic makes hospitals in rural and underserved areas particularly vulnerable to financial instability due to the proposed cuts. Such reductions may lead to decreased access to care for Medicaid beneficiaries and could force hospitals to limit services or close entirely.

The National Multiple Sclerosis Society Urges Congress to Protect Medicaid

The Society strongly opposes reductions to Medicaid, including cuts to the Federal Medical Assistance Percentage (FMAP) for the expansion population, the implementation of per capita caps, and work reporting requirements. These measures would fundamentally alter Medicaid's financing structure, shift significant costs to states, and jeopardize healthcare access for millions of Americans, particularly low-income individuals, people living with disabilities, and children. Instead, we encourage you to support policies that strengthen and expand Medicaid to ensure that all individuals—particularly those living with chronic conditions and disabilities—can receive the healthcare they need to live their best lives.

If you have any questions please contact Okey Enyia, Associate Vice President of Federal Government Relations, at [redacted]

Sincerely,

Bari Talente

Bari Talente, Esq.
Executive Vice President, Advocacy and Healthcare Access
National Multiple Sclerosis Society

[7] Caregiver Burden in Multiple Sclerosis: Recent Trends and Future Directions

THE PARTNERSHIP FOR MEDICAID

For Immediate Release

February 24, 2025

Partnership for Medicaid Urges a No Vote on House Budget Resolution

WASHINGTON, D.C. — The Partnership for Medicaid — a nonpartisan, nationwide coalition of organizations representing clinicians, health care providers, safety net health plans, and counties — calls on Congress to vote "no" on the budget resolution which includes $880 billion in cuts for the Energy and Commerce Committee, which would likely significantly impact Medicaid. The Partnership for Medicaid stands ready to work with policymakers to identify more sustainable strategies to strengthen Medicaid and improve on its promise of providing high quality coverage and access to care for populations in need.

Medicaid currently provides health coverage to nearly 80 million people, including half of all of America's children, including children with complex medical conditions, pregnant women, adults, seniors, and individuals with disabilities. In communities across the country, including those in rural and underserved areas, Medicaid plays an important role in providing access to maternity care, labor and delivery services, pediatric services, behavioral health services, primary and dental care, long-term services and supports, and other necessary services for patients who cannot afford other options for care.

State Medicaid programs are already stretched thin financially. We are concerned that the scope of policies needed to meet the budget resolution's instruction to drastically cut hundreds of billions of dollars from federal Medicaid spending would shift more of the program's costs onto state and local governments, providers, plans, patients, and local taxpayers that would not be able to absorb them. We also are concerned about efforts to limit each state's ability to expand coverage and ensure adequate payment for covered services.

These efforts to cut spending in Medicaid will have long-term consequences. For example, reductions in coverage will result in increased costs of uncompensated care, and the added financial strain on significant Medicaid providers could result in closures of essential services. In addition, these significant reductions in federal funding for Medicaid could lead to the loss of thousands of jobs, especially in rural areas where citizens are more likely to rely on Medicaid for their health coverage and health care providers serve as a major source of employment

Learn more about the Partnership for Medicaid at www.partnershipformedicaid.org.

THE PARTNERSHIP FOR MEDICAID

For Immediate Release

February 6, 2025

Statement from the Partnership for Medicaid on Proposals to Cut Medicaid

WASHINGTON — The Partnership for Medicaid — a nonpartisan, nationwide coalition of organizations representing clinicians, health care providers, safety net health plans, and counties — calls on Congress to reject cuts to Medicaid during the budget reconciliation process. The Partnership for Medicaid stands ready to work with policymakers to identify more sustainable strategies to strengthen Medicaid and improve on its promise of providing high-quality coverage and access to care for populations in need.

Medicaid currently provides health coverage to more than 80 million low-income people, including millions of children, including children with complex medical conditions, pregnant women, adults, seniors, and individuals with disabilities. In communities across the country, Medicaid plays an important role in providing access to maternity care, labor and delivery services, pediatric services, behavioral health services, primary and dental care, long-term services and supports, and other necessary services for patients who cannot afford other options for care.

State Medicaid programs are already stretched thin financially. We are concerned that the proposals being discussed would shift more of the program's costs onto state and local governments, providers, plans, patients, and local taxpayers that would not be able to absorb them. We also are concerned about efforts to limit each state's ability to expand coverage and ensure adequate payment for covered services.

These efforts to cut costs will have long-term consequences. For example, reductions in coverage will result in increased costs of uncompensated care, and the added financial strain on safety net providers could result in closures of essential services. In addition, reduced federal funding for Medicaid could lead to the loss of thousands of jobs, especially in rural areas where citizens are more likely to rely on Medicaid for their health coverage and health care providers serve as a major source of employment. Lastly, reducing support for the Medicaid program could result in longer term and higher health care costs when conditions are not treated early.

Learn more about the Partnership for Medicaid at www.partnershipformedicaid.org.

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Jeff Sperring, MD
Chief Executive Officer

February 23, 2025

The Honorable Kim Schrier
1110 Longworth House Office Building
Washington, D.C. 20515

Dear Congresswoman Schrier,

We are writing to strongly urge you to oppose any and all cuts to Medicaid. Medicaid is a lifeline for millions of children, ensuring access to essential health care services that help them grow, thrive, and reach their full potential. As Congress debates Fiscal Year 2026 funding, we ask you to consider the devastating impact that Medicaid cuts would have on children's health care access, particularly for those with complex medical needs.

Medicaid is the nation's largest source of children's health coverage, providing affordable care to:

- **37 million children**, including nearly **half of all children with special health care needs**
- **~3 million children in military-related families**
- **Over 40% of children in rural areas**

At Seattle Children's, Medicaid is our largest payer, accounting for over 50% of patients. Any reductions in Medicaid funding would force states to cut essential benefits, reduce already unsustainable provider payment rates, and limit access to pediatric care. Washington State, already at the lowest federal matching rate (50% FMAP), could see costs rise **by 18%**, further straining the system.

Proposals such as per-capita caps or block grants could slash Medicaid by up to **$893 billion over the next decade**, leading to: loss of coverage and increased out-of-pocket costs for families; reduced access to providers, particularly in rural areas; and deeper cuts in response to economic downturns or public health crises.

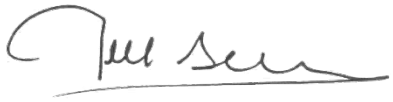
Additionally, eliminating state-directed payments and provider taxes would further destabilize hospital finances. Seattle Children's relies on **$20.4 million in supplemental payments** to help offset low Medicaid reimbursement rates.

Cuts to Medicaid wouldn't just impact Medicaid beneficiaries—reductions would limit services for **all** patients, as hospitals cannot selectively cut services based on insurance type. We cannot sustain further cuts without jeopardizing access to lifesaving pediatric care.

M/S RB.2.419 – Administration
[redacted]
TEL [redacted]
EMAIL [redacted]
www.seattlechildrens.org

We urge you to protect Medicaid from harmful funding reductions. Thank you for your time and consideration. We welcome the opportunity to discuss this further and look forward to working with you to ensure all children receive the care they need.

Sincerely,



Jeff Sperring, MD

CEO

SEIU

Contact:
SEIU National Media[redacted]

Issued February 25, 2025

SEIU's Verrett: House Republicans are ignoring their constituents with budget that guts Medicaid

WASHINGTON,DC: ***Service Employees International Union (SEIU) President April Verrett released the following statement after House Republicans moved forward with a budget resolution that proposes cuts to Medicaid and other vital services:***

"Let's be clear – Americans have flooded Congressional phone lines, rallied at town halls, and lifted their voices to make it clear that they do not support massive cuts to the healthcare and public services they depend on. Despite that, today Speaker Johnson and extremist Republicans passed a budget resolution that puts our nation on a disastrous path of ripping away healthcare for 80 million children, pregnant women, veterans, seniors and people with disabilities by gutting Medicaid. In addition, they are slashing funding for other vital services like SNAP while shifting costs to state and local governments all to pay for massive tax cuts for billionaires and corporations.

There is still time to turn back from this disastrous path and we will not let today's vote stop us from our fight to save Medicaid and the other federal services. We will hold elected officials accountable for their votes and demand that they support working peoples' priorities and the wages, healthcare, and security we all deserve."

###

Southern Poverty Law Center
400 Washington Ave
Montgomery, AL 36104
splcactionfund.org

February 25, 2025

United States House of Representatives
U.S. Capitol Building
Washington, DC 20515

RE: Vote NO on H. Con. Res. 14, The FY25 Budget Resolution

Dear Representative:

On behalf of the Southern Poverty Law Center ("SPLC"), we write to strongly urge you to **vote NO on the FY 2025 Budget Resolution (H. Con. Res. 14)**. Across the country, poor and working families are struggling to stay afloat—paying more for everything from groceries to rent to health care. Instead of easing this burden, this resolution would add to it. It would set the stage for draconian cuts to critical programs like Medicaid and the SNAP, all to fund tax breaks for billionaires and large corporations. If enacted, H. Con. Res. 14 would pave the way for a budget that raises costs for everyday Americans, pushes millions deeper into poverty, and puts the needs of billionaires above hardworking families.

Founded in the Deep South to carry forward the unfinished work of the Civil Rights Movement, the SPLC has been at the forefront of efforts to expand opportunity, eliminate poverty, and combat racial economic inequality in America. Our focus states—Alabama, Mississippi, Louisiana, Georgia, and Florida— are unfortunately home to some of the highest rates of poverty, hunger, illiteracy, and poor health outcomes in the nation.[1] Federal assistance programs don't always reach everyone in need—especially in the South—but they remain a lifeline for the millions who do benefit. They ensure families can see a doctor when sick, keep food on the table, and have a roof over their heads. These federal programs and services aren't just safety nets; they are the foundation of economic stability and mobility, essential in a region where the odds remain stacked against too many.

We are deeply concerned about the proposed cuts in this resolution, which will have immediate and devastating effects. In the South and beyond, these cuts will take food off the tables of American families, strip away their health care, and push more families deeper into poverty and housing insecurity.

Taking Food Off the Tables of American Families

The current budget resolution specifies at least $230 billion in cuts over 10 years under the jurisdiction of the Agriculture Committee. To meet that target, nearly all of these cuts will likely come from the Supplemental Nutrition Assistance Program (SNAP).[2] In fact, current proposals to meet this budget goal range from expanding harsh work requirements to reducing the already meager per-day SNAP benefit

[1] Friends Committee on National Legislation, "Top 10 Poorest States in he U.S.," September 17, 2024, https://www.fcnl.org/updates/2024-09/top-10-poorest-states-us; Institute of Education Sciences, " Comparison Charts of State and County Estimates," (accessed February 24, 2025), https://nces.ed.gov/surveys/piaac/skillsmap/src/PDF/STATE.pdf
[2] U.S. Congress, "H. Con. Res. 14 - FY 2025 Budget Resolution," 119th Congress, 2025, Congress.gov, https://www.congress.gov/bill/119th-congress/house-concurrent-resolution/14.

from $6.80 to just $4.80 for all recipients and shifting the costs to states.[3] What each of these proposals has in common is that they will take food off the tables of American families at a time when food prices have already soared.

SNAP is our nation's most effective tool in the fight against hunger, reaching more than 40 million children, seniors, veterans, and working parents each month[4] In our focus states, SNAP participation is higher than the national average, with Louisiana having the second-highest rate at 19.5%.[5] Alabama, Mississippi, and Louisiana are among the five states with the highest child hunger rates.[6] Families in the Deep South— including the more than 6 million in our states who rely on SNAP—would be hit hardest by these cuts. The evidence is clear: SNAP reduces poverty and improves education, health, and economic outcomes.[7] Research shows that those subject to SNAP's work reporting requirements disproportionately cause disabled adults to lose benefits.[8] In one of the wealthiest nations on Earth, children going to bed hungry is not something we should tolerate, let alone exacerbate.

Stripping Away Health care

H. Con. Res. 14 also mandates the House Energy and Commerce Committee to cut at least $880 billion over 10 years. These cuts will almost certainly target Medicaid and the Children's Health Insurance Program (CHIP), which provide lifesaving health care to nearly 80 million Americans—about 1 in 4 people—including low-income individuals, families, pregnant women, seniors, and people with disabilities.[9] Medicaid, in particular, plays an essential role in maternal health, covering 40% of all births, including 65% of births among Black women, who face disproportionately high pregnancy-related deaths.[10]

Our Deep South states have some of the worst health outcomes in the U.S.[11] They also have some of the highest rates of uninsured Americans, with Mississippi, Georgia, and Florida leading the way.[12] A large number of people, particularly people of color, in our states, can't afford health care, partly because the

[3] Center on Budget and Policy Priorities, "Republican SNAP Proposals Could Take Food Away From Millions of Low-Income Individuals and Families." Katie Bergh, Dottie Rosenbaum, and Catlin Nchako, January 13, 2025, https://www.cbpp.org/research/food-assistance/republican-snap-proposals-could-take-food-away-from-millions-of-low-income

[4] U.S. Department of Agriculture, " Supplemental Nutrition Assistance Program (SNAP) - Key Statistics and Research," January 21, 2025, https://www.ers.usda.gov/topics/food-nutrition-assistance/supplemental-nutrition-assistance-program-snap/key-statistics-and-research;

[5] Center for Budget and Policy Priorities, "Millions of Low-Income Households Would Lose Food Aid Under Proposed House Republican SNAP Cuts," February 24, 2025, https://www.cbpp.org/research/food-assistance/millions-of-low-income-households-would-lose-food-aid-under-proposed-house; Chris Gilligan, "States with the Highest Rates of SNAP Recipients," U.S. NEWS, Mar. 16, 2023, https://www.usnews.com/news/best-states/articles/food-stamp-benefits-by-state.

[6] Children Legal Defense Fund, " The State of America's Children," 2020, https://www.childrensdefense.org/wp-content/uploads/2023/08/The-State-Of-Americas-Children-2020.pdf

[7] Center for Budget and Policy Priorities, "Chart Book: SNAP Helps Struggling Families Put Food on the Table," November 7, 2019, https://www.cbpp.org/research/food-assistance/snap-helps-struggling-families-put-food-on the-table-0

[8] Chima Ndumele, et al, "Supplemental Nutrition Assistance Program Work Requirements and Safety-Net Program Participation," November 4, 2024, doi:10.1001/jamainternmed.2024.5932

[9] Center for Medicare & Medicaid Services, " October 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot," https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-2024-medicaid-chip-enrollment-trend-snapshot.pdf

[10] Vina Smith- Ramakrishnan, "Working to Expand Doula Coverage This Black Maternal Health Week," THE CENTURY FOUNDATION, Apr. 11, 2023, https://tcf.org/content/commentary/working-to-expand-doula-coverage-this black-maternal-health-week/; Latoya Hill et al.,, "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them, KAISER FAMILY FOUNDATION, Nov. 1, 2022, https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them

[11] Zoya Wazir, "The Best and Worst States for Health Care Cost, Access and Outcomes," U.S. NEWS, Aug. 4, 2022, https://www.usnews.com/news/best-states/articles/the-best-and-worst-states-for-health-care.

[12] Kaiser Family Foundation, "Key Facts about the Uninsured Population," December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

region—with the exception of Louisiana—has not expanded ACA Medicaid eligibility.[13] Moreover, Over 8 million people in our states are enrolled in Medicaid & CHIP.[14] With the proposed cuts, these individuals risk losing their health care coverage, worsening an already dire situation in our states.

A recent poll found that 37% of people nationwide, including 38% of Trump voters, said they or someone in their immediate family had benefited from Medicaid.[15] Medicaid and CHIP ensure that the most vulnerable in our communities can access health care, reflecting a fundamental value —that quality care should be available to everyone, no matter their income. Stripping federal Medicaid funding means tens of millions of people will lose Medicaid coverage. Congress must protect Medicaid funding and access to save lives.

Pushing More Families Deeper into Poverty and Housing Insecurity

If potential cuts to SNAP and Medicaid were not concerning enough, this budget resolution could also lead to devastating cuts to programs like Temporary Assistance for Needy Families (TANF) and federal housing assistance. TANF helps families who are struggling to make ends meet by providing cash and essential services for things like housing, utilities, childcare, and hygiene products like diapers. But, after years of cuts and barriers instituted by states, only 1 in 5 families living below the poverty line receive assistance from TANF.[16] Additional reductions will only make it harder for the most vulnerable families to survive. Federal rental assistance is another lifeline for 10 million people—including seniors, people with disabilities, veterans, and working families—helping them keep a roof over their heads.[17] In states like Alabama, Georgia, Mississippi, Florida, and Louisiana, more than 1.2 million people rely on this support.[18] Cutting these programs, as has been proposed in the past, would put millions at risk of losing their homes, and their futures.[19]

To be clear, the cuts outlined above are being proposed for one simple reason: to pay for $4.5 trillion in tax breaks that disproportionately benefit the wealthy. Congress can and must take a different path—one that lifts more families out of poverty and provides more Americans with the opportunity to reach their full potential. This people-first agenda should include expanding the Child Tax Credit for the 17 million children who do not receive the full credit due to low family incomes, expanding rental assistance, increasing SNAP benefits to reflect rising grocery prices, and closing the Medicaid coverage gap.[20] If

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[13] Laura Harker, "Closing the Coverage Gap a Critical Step to Advancing Health and Economic Justice," CENTER ON BUDGET AND POLICY PRIORITIES, Oct. 4, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap a-critical-step-for-advancing-health-and-economic-justice

[14] Center for Medicare & Medicaid Services, " October 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot," https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-2024-medicaid-chip-enrollment-trend-snapshot.pdf

[15] Hart Research, " Key Issues in Healthcare: Where Voters Stand," January 2025, https://www.protectourcare.org/wp-content/uploads/2025/02/POC-Hart-Poll-Press-Briefing.pdf

[16] Center for Budget Policy and Priorities, "TANF Cash Assistance Helps Families, But Program Is Not the Success Some Claim," August 2021, https://www.cbpp.org/research/income-security/tanf-cash-assistance-helps-families-but-program-is-not-the-success-some

[17] Center for Budget and Policy Priorities, "Policy Basics: Federal Rental Assistance," September 30, 2024, https://www.cbpp.org/research/housing/federal-rental-assistance

[18] Center for Budget and Policy Priorities, "Federal Rental Assistance Fact Sheets," January 23, 2025, https://www.cbpp.org/research/housing/federal-rental-assistance-fact-sheets#US

[19] U.S. House of Representatives Ways and Means Committee, Budget Payfor Menu, https://static01.nyt.com/newsgraphics/documenttools/28cb85c5ed1f6c52/44e83eb4-full.pdf.

[20] Center for Budget and Policy Priorities, Policymakers Should Expand the Child Tax Credit for the 17 Million Children Currently Left Out of the Full Credit, February 16, 2025, https://www.cbpp.org/blog/policymakers-should-expand-the-child-tax-credit-for-the-17-million-children-currently-left-out; CBPP, "Three Principles for a Rental Assistance Guarantee," October 2024, https://www.cbpp.org/research/housing/three-principles-for-a-rental-assistance-guarantee; CBPP," Closing Medicaid Coverage

Congress focused on ensuring that wealthy Americans pay their fair share, rather than providing additional tax breaks, we could fund these initiatives—and so much more.

Budgets are ultimately about choices, and with H. Con. Res. 14, the choice is crystal clear: this resolution puts billionaires and large corporations ahead of hardworking families who need our support the most. While the specifics of the program cuts will come later in the budget text, this resolution will undoubtedly lay the groundwork for imposing huge costs on your constituents, taking food from their tables, stripping away their health care, and pushing more families deeper into poverty and housing insecurity.

For the sake of your constituents and a future where this country works for everyone, we strongly urge you to vote NO on H. Con. Res. 14. For questions, please contact Theresa Lau, Eradicating Poverty Senior Federal Policy Counsel, at [redacted] or [redacted].

Sincerely

LaShawn Warren
Chief Policy Officer
SPLC Action Fund
[redacted]

Sakira Cook
Federal Policy Director
Southern Poverty Law Center
[redacted]

Gap Would Help Diverse Groups and Reduce Inequities," July 15, 2024, https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-groups-and-reduce-inequities

February 24, 2025

Dear Hill Colleague,

On behalf of UnidosUS, we urge Members to vote **NO** on H. Con. Res. 14. This resolution poses a major threat to millions of American families, workers, and children by dismantling critical support systems while diverting taxpayer dollars to fund an administration's mass deportation agenda that is both economically disastrous and a dangerous erosion of our civil liberties.

Threats to Health and Well-Being

The proposed resolution would slash at least $880 billion from programs that have long provided life-saving, affordable coverage to millions of Americans. Medicaid alone serves 80 million people—covering nearly 40 percent of all children, half of those with special health care needs, and more than 40 percent of all births. In Latino communities, Medicaid reaches 20 million individuals, protecting nearly one-third of community members, more than half of Latino children, and roughly 30 percent of Hispanic elders. Without these vital programs, higher hospitalization rates, delayed diagnoses, and increased mortality would become the norm, placing an unsustainable strain on public health and national financial security. As UnidosUS recently pointed out, **these proposed cuts would represent the largest cuts to Medicaid in U.S. history.**

Equally indispensable is the Affordable Care Act (ACA), which currently safeguards more than 24 million people—including 1.6 million children and 10 million small business employees. Eliminating enhanced premium tax credits would drive annual premiums up by about $1,200 for 20 million individuals, forcing 7 million people to drop their insurance coverage. This policy change would hit Latino communities especially hard, with projections indicating that half of the 5 million individuals buying insurance through the ACA marketplace would lose coverage.

Harm to Nutrition Security

The resolution also proposes severe cuts of $230 billion to SNAP and other nutrition security programs, which would exacerbate food insecurity for millions of low-income families. SNAP currently provides vital food assistance to 10 million Latinos, including 5 million children, yet the average benefit is just $6.20 per day. With these cuts, families that are already struggling would face an even greater risk of hunger, and the crisis of food insecurity would worsen in communities where more than one in eight Latino adults has already gone into debt to afford food.

Economic Impact of Mass Deportations

In stark contrast to protecting these critical services, the resolution allocates billions in additional funding for a policy of mass deportations that would indiscriminately target unauthorized workers. Deporting an estimated 8.1 million undocumented workers—who comprise 5 percent of the U.S. workforce—would shrink the U.S. GDP by 2.6 percent and result in economic losses of $5 trillion over a decade. This policy would also decimate the agricultural workforce by 16

percent, leading to rising food prices and further straining the budgets of American families already struggling with high grocery costs. Moreover, the projected cost of mass deportations could reach up to $967.9 billion over ten years, while simultaneously eliminating nearly $100 billion in annual tax revenue contributed by undocumented workers. History shows that measures such as the Secure Communities program, which deported 424,000 people between 2008 and 2013, did not spur job growth for U.S. citizens but instead resulted in labor shortages and increased costs for businesses.

The Administration is pushing to expand executive power in nearly every direction, affecting every aspect of American life—from unwarranted cuts to federal programs and firing federal workers, to monitoring speech online that threatens civil liberties and Constitutional freedoms. This budget resolution would take from social programs families need to fund overreach and surveillance that threatens the rights of all Americans. The $350 billion in the resolution would make taxpayers pay an astonishing $175 million for each and every mile of the southern border.

Americans want strong borders but not at the expense of trampling on our Constitution: polls show widespread public support for balanced immigration policies that secure our borders and uphold Constitutional rights. A February 2025 Ipsos poll found just 23% of poll respondents ranked immigration as a top-tier issue, while "inflation and increasing costs," is top for 47%. Voters express serious qualms about hardline measures, including use of Guantanamo and the military. The public supports effective immigration policy that focuses on real threats—targeting drug cartels and human traffickers—rather than punishing law-abiding workers and families.

Consequences for Higher Education

Furthermore, the resolution directs the House Education and Workforce Committee to cut $330 billion, putting higher education programs like Pell Grants at risk. This would force thousands of students, particularly those from low-income and Latino backgrounds, to shoulder increased debt or abandon their educational pursuits altogether. Latino students, who rely on federal financial aid due to lower median household incomes, would see their educational opportunities drastically reduced, thereby widening the existing degree attainment gap and further entrenching economic disparities.

Tax Policy that Does Not Work for Low Income Families

The 2017 Tax Cuts and Jobs Act included provisions that promised a boost to the economy, but evidence demonstrates a disproportionate impact on the wealthy while worsening the economic mobility of everyday Americans. The current resolution raises concerns about fiscal responsibility and adequately supporting working families while providing tax breaks to the wealthy and corporations.

Congress' inaction to enhance the Child Tax Credit, and its exclusion of U.S. born citizen children in mixed-status families will impact families, local economies, and the country. We urge Congress to prioritize working families and reject tax cuts that increase economic disparities.

Conclusion
H. Con. Res. 14 threatens to undermine the essential programs that protect the health, economic stability, and educational opportunities of millions of Americans. It would also allocate funds to a mass deportation policy that would significantly harm our economic prosperity and civil liberties. Attached are fact sheets detailing how the resolution would negatively affect Medicaid, the Affordable Care Act, nutrition programs, and immigrant communities—and, ultimately, our economy. If you have any questions, please feel free to reach out.

We urge Members to carefully consider these profound impacts and vote **NO** on this resolution.