Documents for the Record

Subcommittee on Health Hearing
"The Fiscal Year 2026 Department of Health and Human Services Budget"
June 24, 2025

Majority:

1. May 1, 2025, document submitted by Rep. Harshbarger

Minority:

1. June 24, 2025, collection of letters submitted by Rep. DeGette
2. April 17, 2025, document submitted by Rep. DeGette
3. May 29 and 30, 2025, collection of articles submitted by Rep. Ruiz
4. May 22, 2025, document from the Federation of American Hospitals
5. June 16, 2025, document from the Federation of American Hospitals
6. May 13, 2025, article from the Center for Economic and Policy Research titled *Alleged Kickbacks Further Expose Medicare Advantage Corruption*
7. May 29, 2025, article from AFP titled *'Make America Healthy Again' report cites nonexistent studies: authors*
8. January 16, 2025, report from United Health Group
9. June 24, 2025, statement from the American Academy of Pediatric Dentistry
10. May 27, 2025, statement from the American College of Obstetricians and Gynecologists
11. June 1, 2025, policy brief from America's Essential Hospitals titled *ADDITIONAL HOSPITAL UNCOMPENSATED CARE COSTS PROJECTED UNDER PROPOSED SENATE REVISIONS TO H.R. 1*
12. September 25, 2024, article titled *RFK Jr. plugs ag reform on Capitol Hill amid talk of role with Trump*
13. May 21, 2025, statement by the American Hospital Association
14. June 16, 2025, statement by the American Hospital Association
15. June 24, 2025, statement by the ALS Association
16. May 13, 2025, article from the American Society of Addiction Medicine titled *ASAM: Sweeping Medicaid Reforms Could Weaken America's Addiction Treatment Efforts, Pose a National Security Threat*
17. June 10, 2025, article from the Associated Press
18. June 24, 2025, document titled *The Bethesda Declaration: A Call for NIH and HHS Leadership to Deliver on Promises of Academic Freedom and Scientific Excellence*
19. May 20, 2025, document from the Bloomberg Government
20. June 1, 2025, policy brief from America's Essential Hospitals titled *ESTIMATED EFFECTS OF H.R. 1 ON HOSPITAL UNCOMPENSATED CARE COSTS*

21. May 28, 2025, article titled *CDC blindsided as RFK Jr. changes covid-19 vaccine recommendations*
22. April 21, 2025, article from U.S. News titled *CDC Cancels Measles Help for Texas Schools Amid Staff Layoffs*
23. May 27, 2025, article from NPR titled *RFK Jr. says COVID shots no longer recommended for kids, pregnant women*
24. May 22, 2025, article from the Catholic Health Association titled *CHA Opposes H.R.1, The One Big Beautiful Bill*
25. June 17, 2025, statement by the Children's Hospital Association titled *CHA Opposes New Senate Finance Reconciliation Proposal*
26. May 12, 2025, statement by the Children's Hospital Association titled *CHA Opposes Proposed Cuts to Medicaid Program*
27. April 7, 2025, press release by Centers for Medicare & Medicaid Services (CMS) titled *CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs*
28. June 24, 2025, webpage of HHS.gov COVID-19 Vaccines
29. May 29, 2025, article from JAMA Health Forum titled *Cutting the NIH—The $8 Trillion Health Care Catastrophe*
30. June 13, 2025, article titled *Cuts to HIV Vaccine Research Come Amid Challenges to Other Vaccines, Treatment*
31. May 19, 2025, article from KFF titled *Cutting HIV Prevention Funding at CDC: What Would it Mean?*
32. April 4, 2025, article titled *Deep cuts to HIV research could halt decades of progress, scientists say*
33. May 11, 2025, article from NPR titled *Dr. Casey Means, Trump's pick for Surgeon General, faces criticism across the spectrum*
34. May 15, 2025, article from the Wall Street Journal titled *UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud*
35. June 16, 2025, United States District Court for the District of Massachusetts Case Record
36. June 24, 2025, article from the New York Times titled *The Disappearing Funds for Chronic Diseases*
37. April 1, 2025, article from Stat Plus Health titled *50 canceled measles clinics, and other local impact from HHS cuts*
38. May 9, 2025, article from the Wall Street Journal titled *How RFK Jr. Is Boosting 'Food Babe' and Other MAHA Acolytes*
39. June 18, 2025, article from CAP titled *How the Big, Beautiful' Bill Would Undermine Access to Life-Saving Substance-Use Disorder Treatment*
40. April 7, 2025, article from HealthWatch titled *How Trump health agency cuts could impact Alzheimer's research and patients*
41. June 24, 2025, H.R. 1_HSA provisions
42. June 23, 2025, article from KFF titled *Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders*
43. June 23, 2025, article titled *Kim Calls Out Secretary Kennedy for Gutting Ground Zero Firefighters and 9/11Survivors'*
44. March 6, 2025, article titled *Lea County resident tests positive for measles after death*

45. June 17, 2025, press release titled *LAC Opposes Senate's Proposed Reconciliation Package, Emphasizing Harms of Medicaid and SNAP Funding Cuts*
46. June 12, 2025, letter
47. June 24, 2025, list of MAHA Commission Members
48. June 24, 2025, screenshot of Main Street Health
49. March 1, 2025, Chapter 11 of March 2025 MedPAC report
50. June 17, 2025, document titled *Measles Outbreak – June 17, 2025* from the Texas Department of State Health Services
51. April 29, 2025, article title *Medicaid Work Reporting Requirements – Even with Exemptions – Will Have Significant Consequences for People with Substance Use Disorders*
52. May 13, 2025, statement from the American Hospital Association
53. June 16, 2025, screenshot
54. May 22, 2025, statement from the National Alliance on Mental Illness titled *NAMI Statement on Devastating Medicaid, SNAP Cuts Passed by U.S. House*
55. May 20, 2025, article from Science Insider titled *NIH director faces pointed questions at first staff town hall*
56. June 10, 2025, report from the Association of American Medical Colleges titled *Impact of NIH Grant Terminations*
57. May 6, 2025, report from the Association of American Medical Colleges titled *Impact of NIH Grant Terminations*
58. June 16, 2025, article titled *'Have we no shame?' Federal judge declares hundreds of NIH grant terminations 'void and illegal.*
59. May 22, 2025, article from the New York Times titled *The Influential Adviser Helping Shape Kennedy's Policies*
60. April 4, 2025, article titled *Will Dr. Oz Push Medicare Advantage Plans Now That He's Confirmed?*
61. March 31, 2025, article from Politico titled *Mass firings hit speed bump at HHS*
62. May 12, 2025, article from Politico titled *Wellness CEO files ethics complaint against top RFK Jr. Adviser*
63. March 18, 2025, article from Reuters titled *White House names Kennedy ally Means as health adviser, source says*
64. March 2, 2025, article titled *RFK Jr. And Trump are torpedoing Alzheimer's research*
65. June 18, 2025, article titled *RFK Jr. Moves on vaccines could have broad ramifications for public health, says expert*
66. January 31, 2025, article by Bloomberg Government titled *RFK Jr. Commits to Divesting Interests in HPV Vaccine Litigation*
67. April 4, 2025, article titled *RFK Jr. says HHS will reinstate 20% of reduced workforce after DOGE errors*
68. January 23, 2025, article titled *RFK Jr.'s referral fees in litigation over Merck's Gardasil raise conflict-of-interest questions: reports*
69. January 29, 2025, article by Politico titled *Senate Finance with HHS Secretary Nominee Kennedy*
70. June 2, 2025, article titled *The shrewd startup founder who led DOGE's cost cutting at HHS*

71. May 21, 2025, statement from America's Essential Hospitals titled *Statement on House Reconciliation Bill*
72. June 16, 2025, statement from America's Essential Hospitals titled *Statement on Senate Reconciliation Bill*
73. June 10, 2025, article titled *Takeaways from AP's report on financial interests of RFK Jr. Adviser who runs wellness platform*
74. September 17, 2024, article titled *Tucker Carlson, RFK Jr, and Larry Elder React to Second Trump Shooting*
75. May 30, 2025, article from HealthWatch titled *Trump administration ending multiple HIV vaccine studies, scientists and officials say*
76. May 30, 2025, article from the New York Times titled *Trump Administration Ends Program Critical to Search for an H.I.V. Vaccine*
77. June 17, 2025, article from ProPublica titled *Federal Judge Deems Trump Administration's Termination of NIH Grants Illegal*
78. June 6, 2025, press release titled *Update on Proposed Cuts to Medicaid Funding*
79. May 30, 2025, article from Vanity Fair titled *The Dizzying Rise of MAHA Warrior Calley Means, RFK Jr.'s Right-Hand Man*
80. June 16, 2025, collection of letters submitted by Rep. Auchincloss
81. April 23, 2025, letter

Alliance for Pharmacy Compounding

Compounding the Joy of Living®

Pharmacy Compounding:

A Blueprint for Eliminating Redundant, Unauthorized, or Ineffective Regulation that Impedes Patient Access to Compounded Drugs

May 2025

Overview

Pharmacy compounding plays a vital and time-honored role in American healthcare, offering customized medication solutions when FDA-approved drugs are in shortage or a prescriber judges a custom formulation is needed for an individual patient's needs. Compounded medications are prepared in licensed pharmacies by trained professionals under rigorous oversight from state pharmacy boards and in general accordance with compounding standards established by the U.S. Pharmacopeia.

Under President Trump's 10:1 Executive Order requiring the elimination of unnecessary federal rules, we believe pharmacy compounding presents a clear opportunity for reform. This document highlights key federal policies or proposals that are redundant, unauthorized by statute, or unproven in their benefit to public health. It offers constructive recommendations to support smarter, more effective regulatory approaches—ones that preserve safety without undermining access or innovation.

A strong regulatory framework for pharmacy compounding is essential. But unnecessary regulation—especially when it fails to deliver a measurable safety benefit—is more than a nuisance; it's a threat to patient access and a burden on the small businesses that serve those patients.

1. Unauthorized or redundant regulation

Obsolete: A 1997 MOU between FDA and States

In 1997, Congress amended the Food, Drug, and Cosmetic Act to require FDA to develop a Memorandum of Understanding with state boards of pharmacy. The MOU was intended to help FDA monitor traditional compounding pharmacies that distributed a substantial portion of their compounded drugs across state lines — specifically those distributed without patient-specific prescriptions for in-clinic or in-hospital use. In pharmacy law, this kind of "distribution" is distinct from "dispensing." Dispensing is what traditional pharmacies do: They provide commercially available or compounded drugs to individual patients based on a prescription from a licensed provider.

This distinction became even more important after Congress passed the Drug Quality and Security Act in 2013. The DQSA created a new category of compounding facility — the 503B outsourcing facility — which is allowed to distribute compounded medications in bulk without a prescription under strict regulatory oversight and compliance with Current Good Manufacturing Practices. With passage of DQSA, FDA has interpreted the prescription requirement in Section 503A to mean that 503A pharmacies are limited to **dispensing** medications pursuant to patient-specific prescriptions and are not permitted to engage in non-patient-specific **distribution** at all.

This shift in regulatory framework rendered the original 1997 MOU requirement effectively obsolete. The 1997 MOU was designed to provide oversight of an activity – distribution – that 503A pharmacies are no longer authorized to perform.

Nevertheless, because the 1997 statutory requirement for an MOU was never formally repealed, FDA finalized one in 2020 — more than two decades after it was first directed to do so. That MOU was quickly challenged in federal court *(Wellness Pharmacy, Inc. et al. v. Xavier Becerra)*, and FDA ultimately acknowledged that it had not followed proper notice-and-comment rulemaking protocols or conducted the required economic impact analysis.

FDA agreed to go back to the drawing board and reinitiate the MOU process. But this raises a fundamental question: **Why should the agency continue pursuing an MOU that, with passage of DQSA, was made obsolete under current law?**

The implications are not theoretical. Multiple states have said they either cannot sign the MOU (due to conflicts with state privacy laws) or will not sign it (due to the administrative and financial burden). For those that do sign, the MOU imposes unfunded mandates, requiring new systems for inspection, reporting, and enforcement. For states that don't sign, the consequences are more severe: Under that 1997 law, pharmacies in those states will be limited to shipping no more than 5% of their compounded preparations across state lines — a restriction that could jeopardize patient access to needed therapies, especially in rural and underserved areas.

The persistence of this outdated MOU requirement creates uncertainty, imposes unjustified burdens, and fails to reflect the modern regulatory framework Congress put in place through the DQSA. We urge the Administration to support the repeal by Congress of the 1997 MOU directive from the FD&C Act, thereby aligning federal law with the current realities of compounding oversight.

Overreach on "Demonstrably Difficult to Compound" Lists

Based on its interpretation of the 2013 Drug Quality and Security Act, FDA has chosen to regulate compounding through two distinct pathways:

- **Section 503A** allows state-licensed pharmacies to compound medications and dispense them to individual patients based on a practitioner's prescription.
- **Section 503B** creates a new category of outsourcing facilities that may compound in bulk and distribute without patient-specific prescriptions — provided they follow CGMP. (503Bs may also dispense patient-specific prescriptions if they choose to do so; however, most do not.)

Both sections 503A and 503B give FDA authority to prohibit compounding of certain medications deemed "demonstrably difficult to compound in a manner that reasonably demonstrates an adverse effect on the safety or effectiveness" of the drug. But Congress drew a sharp distinction in the language it used for each:

- In **503A**, FDA may bar specific *drug products* from compounding — a narrow authority focused on individual formulations.
- In **503B**, FDA is authorized to restrict both *drug products* and *categories of drugs* — a broader power that reflects the scale and manufacturing practices of outsourcing facilities.

There is a big difference between a drug product and a category of drugs. For example, a drug product is a finished drug formulation with a defined strength, dosage form and route of administration, like tacrolimus 0.3% ophthalmic drops. A category of drug products (ophthalmic drug products) would include an entire class of medications intended for use in the eye, regardless of active ingredient or concentration.

Despite this distinction, FDA has proposed regulations that would apply the broader category-based prohibition to 503A pharmacies — an approach not supported by the statute. In its March 2024 proposed rule [Docket No. FDA-2023-N-0061], the agency outlined six vague criteria for evaluating whether a drug is "demonstrably difficult to compound" and may choose to use them to justify banning entire drug classes from 503A compounding.

This is not a permissible interpretation of the statute. Section 503A refers only to "drug products" — not categories — and makes no provision for banning entire classes of medications. By attempting to impose the 503B framework into 503A, FDA is acting beyond its authority.

We urge the Administration to:

- Prevent FDA from finalizing any rule that exceeds its statutory authority under Section 503A; and
- Ensure that only individual drug products — not entire categories — may be added to the 503A DDC list, consistent with congressional intent.

Arbitrary Restriction of Dietary Supplement Monographs

Section 503A of the FD&C Act also permits compounding with active ingredients that comply with applicable monographs in the USP or National Formulary. However, FDA has taken the position — unsupported by statute — that only monographs in the drug section of the USP are "applicable," ignoring those in the dietary supplement section.

This interpretation does not reflect the plain language of the law. It also creates an illogical double standard: Patients can purchase dietary supplements at a supermarket, but their licensed pharmacist cannot compound a precise, prescriber-directed formulation for therapeutic use.

Dietary supplement monographs are developed using the same rigorous scientific standards as drug monographs and define key quality attributes such as identity, strength, purity, and performance — making them equally valid for ensuring safety and consistency in compounding. We ask the Administration to direct FDA to recognize all USP monographs — including dietary supplement monographs — as "applicable" under Section 503A, as the law requires.

2. Proposed restrictions or processes rooted in bias, misinformation, or insufficient evidence

FDA Communications on Compounding Need Evidence and Balance — Not Alarmism

We are increasingly concerned that FDA's public communications about compounded medications too often veer into alarmism — relying on unverified data, disproportionate scrutiny, and selective messaging that can mislead the public, the media, and policymakers.

A recent example underscores the problem. In March 2025, FDA issued a "safety communication" about compounded GLP-1 medications, citing adverse event reports. But as APC outlined in a formal protest letter, the agency provided no specifics, no verification of source data, and no evidence of a causal link between any adverse events and compounded products — much less products prepared by legitimate 503A or 503B facilities. Despite this lack of substantiation, the warning was picked up by major media outlets and widely reported as an official finding of harm.

This is not an isolated case. A permanent page on FDA's website titled "FDA's Concerns with Unapproved GLP-1 Drugs Used for Weight Loss" conflates counterfeit substances with drugs compounded by licensed pharmacies, as if they represent equal risk. They do not. Another example: FDA's publication, "Drug Safety Priorities Fiscal Year 2024," pages 27-28, makes the same conflation; the headline for that section is "Continuing Oversight and Outreach of Compounded Drugs and Fraudulent Products." By lumping them together, the agency misleads the public and discredits lawful, state-regulated therapies that patients rely on.

The language used in these communications is also problematic. FDA has stated that compounded drugs "can be risky for patients" — an imprecise, stigmatizing claim. Yes, compounded medications may carry different risk profiles than FDA-approved drugs, and it is appropriate for the agency to say so. But to broadly label them "risky" — when they are explicitly authorized under the Food, Drug & Cosmetic Act — is misleading and unhelpful.

This imbalance in communication does not reflect the letter or spirit of the FD&C Act, which authorizes the regulation of compounding, not its disparagement. **With recent leadership changes at FDA, we see an opportunity for the agency to take a fresh, more patient-centered approach to how it communicates about compounded therapies — one rooted in evidence, transparency, and public trust.**

We urge the Administration to direct FDA to adopt a more balanced and scientifically grounded tone in its public communications. Alerts and safety messages should be specific, proportionate, and clearly distinguish between legitimate compounded medications and counterfeit or unsafe products. Alarmist messaging without proper context undermines both patient care and FDA's own credibility.

A Case in Point: Compounded Ketamine and FDA's Mixed Messages

Ketamine therapy has emerged as a potentially transformative treatment for patients suffering from PTSD and treatment-resistant depression — conditions that afflict millions of Americans and are often unresponsive to conventional therapies. As clinical interest grows, compounded ketamine has become an essential part of patient care, particularly when customized dosages or alternative delivery forms are required. In these cases, licensed compounding pharmacists, working in concert with prescribers, are helping to bridge critical gaps in access and treatment.

Yet **FDA's messaging around compounded ketamine has been, at best, misleading**. In the past 30 months, the agency has issued two separate warnings about compounded ketamine (February 2022 and October 2023), neither of which was grounded in clinical evidence from human trials. Instead, both relied on animal data and included vague references to adverse event reports, without establishing causality or context. These were not formal guidances or rulemakings — yet they carried the weight of official pronouncements and, as with compounded GLP-1s, were quickly amplified by the media, often with little nuance or balance.

This pattern reflects a broader problem in FDA's communications around compounding: the tendency to issue unverified or premature alerts that disproportionately target compounded medications, even when the evidence is inconclusive. The agency must ensure its public statements support informed perspective — not fear or confusion.

Keep Demonstrably Difficult to Compound Lists Science-Based, Not Profit-Driven

Congress directed FDA to identify drug formulations that are demonstrably difficult to compound — meaning they pose a genuine challenge to compound safely and effectively, based on sound scientific evidence. The goal was clear: protect patients by limiting compounding of formulations where the risks clearly outweigh the benefits.

Unfortunately, some drug manufacturers are now attempting to hijack the process. In its recent proposed rule [Federal Register, March 20, 2024 – Docket No. FDA-2023-N-0061], FDA outlined six criteria it will use to determine whether a drug or category of drugs should be added to the DDC list under Sections 503A or 503B of the FDCA. **But rather than let science lead, companies like Eli Lilly and Novo Nordisk have lobbied aggressively to have GLP-1 active pharmaceutical ingredients added to the DDC lists — not because compounding with the APIs is genuinely difficult, but because drugmakers want to shut down legitimate compounding that they see as a threat to market share.**

APC's formal comments to FDA detail how these GLP-1 APIs fail to meet FDA's own difficulty criteria. These formulations are routinely and safely compounded by both 503A pharmacies and 503B outsourcing facilities. The drugmakers' arguments, by contrast, are often speculative, unsupported by data, and plainly aimed at eliminating lawful competition, not protecting patients.

We recognize the role of innovation and profit in driving pharmaceutical development — but public health decisions must not be swayed by corporate pressure. If FDA allows companies to use the DDC list as a tool for market protectionism, it risks setting a dangerous precedent: one in which science takes a backseat to shareholder value, and patients lose access to therapies their doctors deem necessary.

We urge the Administration to hold the agency to its own standards. FDA should reject any attempt to add substances to the DDC list without clear, evidence-based justification. Under President Trump's Executive Order, FDA is empowered to deprioritize enforcement of regulations not grounded in the best reading of the statute — and the agency should do just that when confronted with rules shaped more by lobbying than by science. In doing so, FDA would reaffirm its role as a guardian of patient access and public health — not a gatekeeper for corporate interests.



Preserve Patient Access to Compounded Hormone Therapy

Millions of Americans — particularly women — depend on compounded hormone therapy (cBHT) to manage the effects of age-related hormonal changes. These are not fringe treatments; they are life-enhancing therapies that physicians prescribe when commercially available options fall short or don't exist — due to limited FDA-approved dosages and delivery methods, patient allergies, or individual patient response.

Yet **FDA may be poised to restrict access to cBHT, not because of legitimate, documented safety concerns or scientific discovery, but based on a flawed and discredited 2020 report** it commissioned from the National Academies of Sciences, Engineering, and Medicine. The agency has stated in public forums and correspondence with Congress that it intends to use the NASEM report to guide future policies on compounded hormones. This is cause for serious concern.

The NASEM report reviewed only four hormones, yet recommended sweeping restrictions on all compounded hormones. No one on the NASEM panel had direct experience prescribing or compounding these therapies. Even more troubling, an independent analysis by Dr. Alyson Wooten of the nonpartisan Berkeley Research Group — "The Panel Put Policy-Making Before Patient Need" — found evidence that FDA improperly influenced the report's direction, resulting in biased and scientifically unsound conclusions. (That report is available at a4pc.org/Berkeley.)

Despite this, FDA has already submitted to the Office of Management and Budget a proposed rule that, based on its summary, may seek to add categories of compounded therapies to the DDC list — a move that could include compounded hormones. If that happens, it would make it unlawful for pharmacies to compound with those ingredients, cutting off access to essential medications for millions of patients.

Under President Trump's Executive Order, agencies like FDA are directed to deprioritize regulations not clearly grounded in statute or sound science. **We ask the Administration to take a clear stand and prohibit FDA from using the flawed NASEM report as the basis for any rulemaking or enforcement related to compounded hormone therapy.**

This is not just regulation rooted in bias — it's a direct threat to patient care. FDA-approved hormone drugs do not meet the needs of all patients. That's why prescribers turn to compounding: to tailor medications to the individual. If FDA is allowed to restrict that clinical freedom based on biased policymaking, patients will pay the price.

Identifying Drug Shortages — FDA Should Rely on Broad Data Sources, Not Just Manufacturer Claims

Drug shortages in the U.S. remain at record highs — and too often, it's compounding pharmacies and facilities that serve as the final safety net, stepping in to prepare medications when manufacturers can't deliver. But current federal law hampers their ability to do so, not because of safety concerns, but because of flawed processes for identifying drug shortages in the first place.

Under current law, FDA can only authorize compounding copies of a drug in shortage if it appears on the agency's official shortage list. But here's the catch: to make that determination, FDA is only required to consider data provided by drug manufacturers — the very companies that often have a financial interest in not acknowledging a shortage.

That means if a drug is technically "available" in a company's inventory system — even if it's functionally inaccessible to hospitals, pharmacies, or patients in quantities or

routes of administration necessary to meet demand — FDA is not required to consider data submitted from prescribers, health systems, and pharmacies. To its credit, the agency has created a webpage where information on drug shortages may be submitted by anyone. Unfortunately, as a means of data collection, such a page is relatively random. Moreover, the agency doesn't specify how it uses and weighs such submissions in its shortage decisions – an important distinction since it is not legally required to consider those submissions.

One fix: Support the reintroduction of Senator Tom Cotton's 2024 End Drug Shortages Act (and the companion proposal by Rep. Adrian Smith in the House). When introduced, the bill would require FDA to consider broader input — from pharmacists, physicians, hospitals, and patients — when assessing whether a drug is in fact in shortage. It brings common sense to the process, ensuring that decisions reflect patient accessibility, not just manufacturer accounting.

The bill also strengthens the system on the front end by requiring drugmakers to notify FDA when demand surges could lead to a shortage — giving the agency a more complete picture and time to respond before care is disrupted.

We urge the Administration to support this bipartisan proposal. In a system meant to serve patients, real-world insight must carry as much weight as manufacturer-supplied data — especially when patient access hangs in the balance.

Restore Patient-Facing Expertise and Balance to Pharmacy Compounding Advisory Committee

Federal advisory committees are meant to provide government agencies with balanced, expert input. But when it comes to FDA's Pharmacy Compounding Advisory Committee, that vision has gone badly off course.

PCAC was established to advise FDA on scientific, medical, and technical issues related to drug compounding under Sections 503A and 503B of the FD&C Act. In practice, however, PCAC functions less as an advisory body and more as a formality — a committee structured to affirm, not challenge, the FDA's internal recommendations. The result is a process that lacks transparency, diversity of viewpoints, and real-world grounding.

The process is broken. Under current procedures, FDA staff receive nearly unlimited time to present their perspective to the committee — often guiding the discussion with prepared questions and backgrounders — *while outside voices, including expert stakeholders, are collectively limited to just 10 minutes of public comment. This lopsided approach silences divergent views and undermines the committee's ability to engage in meaningful deliberation.*

The composition is skewed. By statute, PCAC members are to be drawn from diverse fields, including pharmacy, pharmaceutical compounding, medicine, public health, and patient advocacy. Yet of the six pharmacists currently serving, only two are not FDA employees, academics, or professional advocates — and neither of those two appears to have current patient-facing compounding experience. Incredibly, the FDA has treated actual compounding pharmacists as having a conflict of interest merely because they practice in the field.

That logic is self-defeating. You wouldn't convene a panel on aviation safety and exclude pilots. The same principle should apply here.

We urge the Administration to demand a full review of PCAC's appointment criteria and processes and operating procedures to ensure it meets the standards set forth by law — standards that require balance, transparency, and genuine expert engagement. A properly constituted and functioning PCAC would serve as a vital source of informed, nuanced input — not just for FDA, but for the millions of patients who rely on compounded medications.

Further detail on our concern is available at a4pc.org/PCACreform.



3. Unauthorized, misguided, or misinterpreted regulation

Restore Access and Clinical Flexibility in the Evaluation of Compounded Substances

Under current FDA policy, a substance may not be compounded unless the agency evaluates its suitability for use in compounding and determines that it meets established criteria.

However, **this framework is poorly suited to the context of personalized medicine. In compounding, where pharmacists are prohibited from making clinical claims about a medication's intended use, applying rigid approval standards ignores the unique nature of individualized therapies — and undermines the principle that prescribers and patients should be free to choose the treatment pathway that works best for them.**

The result? Substances with no identified significant safety concerns and potential clinical utility are excluded from the 503A bulks list and from compounding, simply because no drug company has invested the time and resources required to demonstrate effectiveness through traditional pharmaceutical models. That barrier to access is especially troubling given that compounders are legally prohibited from making any claims about effectiveness at all.

In truth, if a substance has an acceptable risk profile, and if pharmacists make no clinical claims about its use, there is no legitimate basis for the government to prohibit its inclusion in compounded therapies. Doing so interferes with the ability of licensed healthcare professionals to deliver patient-specific care — and with patients' ability to access it.

We urge the Administration to direct the FDA to revise its policy so that the assessment of safety risks — not rigid definitions of 'effectiveness' — becomes the appropriate gating standard for compounded substances. A regulatory framework that respects clinical judgment and patient choice is both reasonable and overdue.

FDA's Veterinary Compounding Guidance Lacks Statutory Foundation and Undermines Animal Care

When Congress passed the Animal Medicinal Drug Use Clarification Act (AMDUCA) in 1996, it gave veterinarians the authority to prescribe approved animal and human drugs for "extra-label" use — that is, in ways not specified in approved labeling. Nowhere in the statute did Congress mention compounding or the use of bulk drug substances. **Yet FDA has inserted itself into veterinary compounding through regulation and guidance, despite having no clear congressional mandate to do so.**

FDA's 2023 Guidance for Industry #256 is the latest and most problematic example. While technically nonbinding, GFI 256 imposes broad restrictions on the use of bulk drug substances in veterinary compounding — limitations that second-guess the clinical judgment of veterinarians and create unnecessary barriers to care for animal patients.

Under GFI 256, veterinarians and compounding pharmacies must justify the need for compounded medications and may only use bulk drug substances from an FDA-approved list for compounding office stock medications. Submitting a substance for consideration requires a lengthy, opaque nomination process, and FDA has rejected nearly 93 percent of the roughly 300 substances proposed to date by veterinarians, pharmacists and others — often without clear rationale.

The result is a system that risks failing animal patients. For many species and conditions, FDA-approved products are not available in appropriate strengths, delivery forms, or combinations. Finished drugs may also contain excipients that are harmful to certain animals or lead to poor compliance. Animal drug products do not disclose their excipients in the package insert like human drug products, making it impossible to assess whether an animal drug product can be used in species other than those it was approved for. In these cases, compounding from bulk ingredients is the only viable path to treatment — and one that veterinarians have safely relied on for decades.

FDA's current approach, however, assumes a gatekeeping role Congress never authorized. By constraining the ability of veterinarians and compounding pharmacists to tailor medications to animal patients, the agency is not just overstepping — it is interfering with clinical care.

The guidance should be rescinded in full — and any future effort to regulate veterinary compounding should begin not with a rigid list, but with collaboration among FDA, veterinarians, pharmacists, and other stakeholders. That's the only way to protect both the intent of AMDUCA and the health of millions of animal patients nationwide.

If FDA insists on maintaining GFI 256, it must substantially revise the guidance and align its inspectors' understanding of it to respect the realities of veterinary practice and the essential role of compounded medications in animal health. At minimum, the agency must streamline the bulk substance nomination process, increase transparency in its evaluations, and defer to the expertise of prescribing veterinarians.

FDA's Insanitary Conditions Guidance: Needed, But Not Yet Useful

Compounding pharmacists recognize the importance of FDA's "Guidance for Industry: Insanitary Conditions at Compounding Facilities." Clear expectations around cleanliness and sterility are critical to patient safety—and pharmacists want to meet them. But while the guidance offers useful examples, it stops short of providing the kind of bright-line standards necessary for consistent, reliable compliance.

As it stands, the guidance leaves too much room for interpretation. Without objective criteria, pharmacists are left uncertain about where the lines are drawn—and inspectors are left to make subjective determinations – determinations that routinely differ from inspector to inspector. A facility can adhere fully to USP standards and still be found in violation, simply because an inspector sees something differently.



Clarifying Constructive Transfer: Empowering Patients, Not Undermining Prescribers

In certain circumstances, a compounding pharmacist prepares a controlled substance for a specific patient, and that medication—by medical necessity—must be administered by the prescriber in a clinical setting. From the FDA's perspective, Section 503A of the FD&C Act allows the pharmacy to deliver the medication either directly to the patient or to the prescriber for in-office administration.

Unfortunately, the DEA takes a conflicting view. Under its interpretation of the Controlled Substances Act, such a "constructive transfer" of a controlled substance is prohibited—even with explicit patient authorization. The DEA insists that the medication must be handed only to the patient or their agent, even in cases involving medications like intrathecals, where unsupervised administration can pose serious risks.

This interpretation seems to be based on a startling and illogical assumption: that a member of the patient's household is somehow less likely to misuse or divert a controlled substance than a licensed physician or veterinarian is.

Anticipatory Compounding Is Legal and Necessary—But DEA Thinks Otherwise

Some DEA offices have taken the position that the Controlled Substances Act requires a pharmacy to receive a patient-specific prescription before compounding a controlled medication. However, FDA—under Section 503A of the FD&C Act—explicitly permits anticipatory compounding based on historical prescription trends. The DEA, for its part, allows anticipatory compounding of controlled substances—but only if the pharmacy holds a manufacturer's permit, which isn't feasible (and shouldn't be necessary) for smaller, state-licensed pharmacies.

This narrow interpretation ignores clinical and operational realities. **For sterile injectable controlled substances, anticipatory compounding is essential. It allows pharmacists to complete required sterility, potency, and stability testing before the medication is dispensed—ensuring both safety and timely access to care.**

Despite this, during inspections some DEA field inspectors have warned or disciplined pharmacies for engaging in lawful, FDA- and DEA-recognized anticipatory compounding. Others have not. This patchwork enforcement of unclear rules imposes costly burdens on compliant pharmacies, delays patient treatment, and wastes agency resources.





4. A directive FDA has (mostly) ignored

Where's the 503B Bulks List?

Nearly a decade after Congress created the 503B Outsourcing Facility pathway, the FDA has yet to complete one of its core responsibilities: finalizing the 503B bulks list, the list of substances FDA allows 503Bs to compound. The agency's review of nominated substances has been unreasonably slow and overly restrictive—so much so that the Outsourcing Facilities Association has taken the unprecedented step of suing the FDA to spur action.

This delay is not just bureaucratic—it has real-world consequences. **Hundreds of APIs remain stuck in regulatory limbo, preventing 503B facilities from producing much-needed compounded medications for hospitals, clinics, and patients nationwide.** In this case, it's the absence of action—not overreach—that is limiting patient access and creating uncertainty for outsourcing facilities. It has now been a dozen years, and FDA still has not done what Congress authorized.

We urge the Administration to direct FDA to accelerate and complete its review of the nominated substances and establish a comprehensive, science-based 503B bulks list. Outsourcing facilities need clarity to serve patients—and patients need timely access to the medications these facilities are equipped to provide.

A Smarter Path Forward

Compounding pharmacists are asking for clarity, consistency, and a regulatory framework grounded in science and statute. Unfortunately, current federal policies often miss that mark, imposing unnecessary burdens, restricting access to care, and stretching the bounds of regulatory authority.

Key Priorities for Removal or Reform:

- **Eliminate** the 1997 MOU requirement in Section 503A of the FD&CA.
- **Correct** overt overreach in FDA's draft DDC rules for 503A pharmacies.
- **Mandate** that both drug and dietary supplement USP monographs are considered "applicable" in law and regulation.
- **Demand** balance and evidence in FDA communication about compounded therapies.
- **Reject** drugmaker petitions to add GLP-1 APIs to the DDC list and ensure that decisions about items added to the DDC list are rooted in science and facts.
- **Reject** any effort to restrict patient access to compounded hormone therapy and disqualify using the 2020 NASEM report in future policy making.
- **Support** legislation to require FDA to rely on a broader range of data in determining drug shortages.
- **Overhaul** the FDA PCAC to include pharmacists with current patient-facing experience and allow for those other than the FDA to have an equal amount of time to present to the PCAC.
- **Repair or rescind** FDA's GFI 256 regarding animal drug compounding.
- **Instruct** DEA to clarify "constructive transfer" policies to allow for the delivery of controlled substance prescriptions to provider offices for administration.
- **Amend** FDA's "Insanitary Conditions" Guidance to include bright-line standards for compliance.
- **Instruct** FDA to finalize a robust 503B bulks list with all deliberate speed.

We urge the Administration to prioritize these reforms. With the right policy leadership, we can protect the integrity of compounding, reduce regulatory confusion, and ensure that patients—human and animal alike—continue to receive personalized treatments their provider says they need.

Alliance for Pharmacy Compounding

Compounding the Joy of Living®

About APC:

The Alliance for Pharmacy Compounding is the industry trade association and the voice for pharmacy compounding, representing more than 600 compounding small businesses — including compounding pharmacists and technicians in both 503A and 503B settings — as well as prescribers, educators, researchers, and suppliers.

In traditional compounding, pharmacists create a customized medication, most often from pure ingredients, for an individual patient pursuant to a prescription. Pharmacists' ability to compound medications is authorized in federal law and for good reason: Manufactured drugs don't come in strengths and dosage forms that are right for everyone, and prescribers need to be able to prescribe customized medications when, in their judgment, a manufactured drug is not the best course of therapy for a human or animal patient or the appropriate FDA-approved drug is not commercially available.

Every day, APC members play a critical role in patients' lives, preparing essential, custom medications for a range of health conditions, including autism, oncology, dermatology, ophthalmology, pediatrics, women's health, animal health, and others.

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Congress of the United States

Washington, DC 20515

February 13, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Kennedy:

Congratulations on your confirmation as Secretary of the Department of Health and Human Services (HHS). We are the Democrats on the Committee on Energy & Commerce's Subcommittee on Health, which has jurisdiction over the majority of your activities. You now bear responsibility for executing laws Congress passes to promote the health and wellbeing of over 330 million Americans. This includes stewardship of our public health infrastructure, oversight of health insurance including the Medicare and Medicaid programs, ensuring the safety and effectiveness of drugs and medical devices, and responsibility for the world's greatest biomedical research enterprise.

Because of Medicaid expansion, the American Rescue Plan Act, and the Inflation Reduction Act, the United States has a historically low uninsured rate – 9.5 percent in 2023, down from a recent high of 10.9 percent in 2019 – and more Americans than ever have access to quality, affordable care. Under your leadership, it is imperative no action is taken that would compromise these advances, and instead you must work to make health care ever more accessible. Currently, Republicans in Congress are plotting cuts to Medicaid, which covers nearly 80 million Americans. Such cuts would be devastating to countless families across the country. Your Department must do its part to promote enrollment in health insurance and access to care nationwide.

President Donald Trump's first weeks in office have been characterized by disorder, confusion, and fear on the part of providers, patients, researchers, and others. Following a funding freeze, a communications freeze, and ill-conceived executive actions that threaten access to health care, chaos has reigned for federally funded health care providers, the research community, and the public health world. We started hearing from our states that they could not access federal Medicaid dollars or already-approved grant dollars to support community health centers following the announcement of a funding freeze. After an outcry from states and a court order, as well as a January 28, 2025 letter from the undersigned, those funds are flowing again. Still, human services organizations, health care providers, and others are concerned the funds they rely on to help individuals in their communities may never arrive.

Many of us signed a February 5, 2025 letter calling for a resumption of National Institutes of Health (NIH) grantmaking, and we reiterate politics must not get in the way of the nation's biomedical research enterprise. HHS' ongoing restrictions on communications hinder NIH's ability to do its job, which in turn prevents America's researchers from doing theirs. HHS must provide predictability and clear guidance to its grantees and health care providers, and the agency must follow through on its promises in line with laws Congress has passed.

The component agencies of HHS are the most respected of their kind in the world. They include NIH, a powerhouse of biomedical research; the Food and Drug Administration, whose stamp of approval for medical products is the gold standard worldwide; and the Centers for Medicare and Medicaid Services, which hundreds of millions of Americans rely on to oversee affordable, quality care. We are concerned indiscriminate attempts

to remove dedicated employees from federal service, without regard to their scientific expertise or job performance will cripple key functions of HHS agencies. You must take action to recruit and retain a workforce sufficient to carry out the laws Congress has passed and continue the world-leading work your agency has historically conducted.

Biological threats do not care about politics or ideology. Every day, pathogens mutate and evolve, and there are currently multiple concerning disease outbreaks in the U.S. right now, including tuberculosis in Kansas, measles in Texas, and avian flu nationwide. The wrong mutation or inopportune circumstances can lead to a global pandemic as we all experienced beginning in 2020. It is of paramount importance the United States has a strong capacity to detect and respond to biological threats, whether intentional, accidental, or natural, worldwide. An energetic CDC, guided by science and insulated from political interference, is crucial to monitor the worldwide threat landscape and respond to pathogens that threaten Americans' health. Furthermore, vaccines are an important part of the public health toolkit for responding to infectious disease and are some of the most world's most rigorously studied products. In rare instances in which an individual is injured by a vaccine, the National Vaccine Injury Compensation Program (VICP) provides compensation to such individuals. We wish to underscore that the National Childhood Vaccine Injury Act of 1986 requires giving notice, providing an opportunity for public hearing, and granting at least 180 days for public comment before making any changes to VICP.

In the years since the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health*, many urgent, high-stakes reproductive health care decisions have come before HHS. During your confirmation process, you expressed you did not know whether you planned to enforce federal law protecting access to emergency abortion care. It is critical you act knowing the lives and health of emergency care patients across the country are at stake and enforce the full scope of the Emergency Medical Treatment and Labor Act (EMTALA), including its protections for life- and health-saving abortion care.

The Trump Administration's executive order on gender-affirming care is already resulting in children not receiving the necessary care they need. Many hospitals are stopping gender-affirming care services under threat they'll lose federal funding, leading to uncertainty and chaos for parents and children who rely on those services. This leads to mental anguish for individuals whose care is being interrupted and their families. This executive order ignores scientific and medical expertise and puts politics in charge of dictating care instead of centering decision-making by patients, families, and medical providers.

Additionally, you must guarantee HHS will always be a resource patients and providers alike can turn to for reliable, accurate, and science-based guidance on reproductive health care options as well as health care considerations relevant to diverse communities. To that end, it is critical all webpages and HHS resources be immediately restored and preserved and future HHS actions, including medication approval and dispensing protocols, reflect the independent, evidence-based standard expected of the agency. You must act to preserve the dignity, autonomy, and freedom of every person and patient in America and ensure they can make the personal medical decisions that are best for their case, family, and future.

We are disturbed by reports of individuals associated with the Department of Government Efficiency accessing critical information technology systems within HHS, and we are concerned access to HHS systems by individuals unconnected with the administration of health care presents an unacceptable security risk. It also raises concerns politically motivated actors could access sensitive health information and compromise the privacy of Americans. Sensitive information must be restricted to individuals who can demonstrate worthiness of the public trust and used only to carry out HHS's mission. It is entirely appropriate the administration would

analyze existing processes to identify inefficiencies and to submit recommendations to Congress for its consideration. It is not appropriate for the administration to take unilateral action to gut federal agencies authorized by Congress.

You must take action to preserve and promote the missions of the agencies you oversee, and you must lead with science and integrity to be an HHS Secretary for all of the American people. We ask that you meet with us no later than March 7, 2025 to discuss these and additional concerns with you, as well as hear your plan to administer HHS. Thank you for your attention to these matters.

Sincerely,

Diana DeGette
Member of Congress
Ranking Member, Energy and Commerce Subcommittee on Health

Raul Ruiz, M.D.
Member of Congress

Debbie Dingell
Member of Congress

Robin L. Kelly
Member of Congress

Nanette Diaz Barragán
Member of Congress

Kim Schrier, M.D.
Member of Congress

Lori Trahan
Member of Congress

Marc A. Veasey
Member of Congress

Lizzie Fletcher
Member of Congress

Alexandria Ocasio-Cortez
Member of Congress

Jake Auchincloss
Member of Congress

Troy A. Carter, Sr.
Member of Congress

Greg Landsman
Member of Congress

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-3641
Minority (202) 225-2927

February 28, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy:

We are writing to express our opposition to your reckless and illegal termination of an estimated 1,300 probationary employees at the Centers for Disease Control and Prevention (CDC) thus far.[1] This mass termination of a reported 1,300 employees represents nearly 10 percent of CDC's workforce.[2] We are deeply concerned these widespread terminations took place without any review of these employees' work history or without any analysis of the impacts these job losses would have on the Department's ability to protect the health and well-being of the American people. Future extreme, arbitrary, and unlawful layoffs will further endanger the agency's mission to protect public health.[3]

These terminations create a threat to the foundation of our country's public health systems and will leave us less safe and less secure at a time when we are facing significant public health threats. Currently, our nation is facing the worst measles outbreak in Texas in 30 years, and concerning cases of avian influenza A (H5NI), and a highly contagious strain of

[1] National Public Radio, *Staff at CDC and NIH are reeling as Trump administration cuts workforce* (Feb. 14, 2025). (https://www npr.org/sections/shots-health-news/2025/02/14/nx-s1-5297913/cdc-layoffs-hhs-trump-doge).

[2] NBC Washington, *CDC to lose one-tenth of workforce under Trump admin probationary job cuts* (Feb. 14, 2025) (https://www.nbcwashington.com/news/politics/cdc-trump-admin-probationary-job-cuts/3845489/).

[3] Associated Press, *The Trump administration sets the stage for large-scale federal worker layoffs in a new memo* (Feb. 26, 2025).

monkeypox.[4,5,6] We request immediate answers to understand the nature and scope of these terminations, your authority to undertake these terminations, and whether you have conducted any analysis of the impact these terminations will have on the readiness of the CDC workforce to counter current and future public health threats.

CDC's workers are vital in promoting and protecting our health, preventing disease domestically and abroad, as well as providing a state-level and community-level response to public health emergencies. Over the past few weeks alone, the Administration's failure to contain and disseminate timely information about the ongoing bird flu outbreak is having ripple effects for American families, with escalating H5N1 creating a soaring spike in the price of household goods like eggs.[7,8] CDC workers' ability to monitor and address these threats for the benefit of American families will surely be impacted by your recent arbitrary and seemingly indiscriminate staff purges.

CDC personnel work to prevent infectious disease outbreaks, promote healthy behaviors, and intervene in chronic disease management. Ninety percent of the nation's $4.5 trillion in annual health care expenditures are for people with chronic health conditions.[9] The CDC is at the forefront of funding prevention screenings for chronic conditions and provides workforce training to local health departments on screening and prevention.[10] We are seeking information from the Administration on whether you have done any analyses to inform your termination decisions. We also want to know if the Administration has devised plans on how you plan to continue to deliver services at the state and local level for key public health programs. For example, programs like the World Trade Center Health Program (serving 130,000 people in all 50 states), the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (in all 50 states), the National and State Tobacco Control Program (the only nationwide initiative for comprehensive tobacco prevention and control efforts that supports all 50 states), and the Colorectal Cancer screening program (operating in 20 states).[11]

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[4] Centers for Disease Control, *Mpox in the United States and Around the World: Current Situation* (https://www.cdc.gov/mpox/situation-summary/index html) (accessed Feb. 21, 2025).

[5] Centers for Disease Control, *H5 Bird Flu: Current Situation* (https://www.cdc.gov/bird-flu/situation-summary/index.html) (accessed Feb. 21, 2025).

[6] Associated Press, *Texas measles outbreak rises to 48 cases. It's the state's worst in nearly 30 years* (Feb. 14, 2025) (https://apnews.com/article/measles-texas-mmr-vaccine-homeschooling-b29d08d53cf26704968e8c00dfa712ba).

[7] *Trump Administration Temporarily Mutes Federal Health Officials,* The New York Times (Jan. 22, 2025).

[8] CBS News, *What to know about bird flu in 2025, from how it's spread to symptoms and egg impacts* (Feb. 13, 2025) (https://www.cbsnews.com/news/bird-flu-2025-symptoms-eggs-humans/).

[9] Centers for Medicare & Medicaid Services, *National Health Expenditure Data: Historical* (https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical) (accessed Feb. 6, 2025).

[10] de Beaumont Foundation and Public Health National Center for Innovations, *Staffing Up: Investing in Public Health Workforce* (Oct. 2021).

[11] Center for Disease Control, *Health and Economic Benefits of Chronic Disease Interventions* (May 15, 2024).

In addition to these and many other evidence-based interventions to prevent and manage chronic diseases, CDC operates programs to directly support and provide technical assistance to state and local health departments on the prevention and containment of infectious diseases and food-borne illnesses, such as current Listeria, Salmonella, and E. Coli cases the United States. Direct staffing programs such as the CDC's Preparedness Field Assignees program, the Epidemiological Intelligence Services, the Public Health Associate Program, and the Laboratory Leadership Service, strengthen critical capabilities in local health departments and public health laboratories. It appears they are slated for elimination, although it is unclear from conflicting agency pronouncements, tweets from Elon Musk, and news reports.[12,13,14] We are seeking information from your agency on whether you intend to eliminate these programs, and if so, what analyses you have performed on the capacity of CDC and state and local health departments to address current public health threats. We also want to know how you plan to ensure continued capacity to detect outbreaks of these foodborne and other infectious diseases while indiscriminately cutting essential staff.

Given the enormous consequences that sweeping layoffs at CDC will have on our nation's public health infrastructure, we request detailed responses and all Department of Health and Human Services (HHS)-wide memorandums, no later than March 10, 2025, on:

1. The total number of probationary and non-probationary employees terminated from CDC since Thursday, February 13, 2025. Specify the number of employees in both classifications terminated from each CDC center, department, and program, and indicate the percentage of the workforce assigned to each center, department, and program represented by the workers who have now been terminated.

2. Are there additional layoffs planned for CDC employees at this time, including those directed by the Office of Management and Budget and the Office of Personnel Management in the February 26, 2025, memorandum?[15] If further resignation or termination requests are ordered, how many additional layoffs are expected? Specify the total number of layoffs by center, department, and program at CDC.

3. How many of the positions that are now vacant will be permanently eliminated and how many positions will be filled by new personnel? Specify each total by center, department, and program at CDC.

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[12] U.S. News, *Layoffs Hit Lab Program at CDC That Was Started to Prevent Previous Failures* (Feb. 18, 2025) (https://www.usnews.com/news/health-news/articles/2025-02-18/layoffs-hit-many-at-cdc-lab-program-that-was-started-to-address-previous-failures).

[13] The Seattle Times, *Trump cuts target next generation of scientists and public health leaders* (Feb. 18, 2025) (https://www.seattletimes.com/nation-world/trump-cuts-target-next-generation-of-scientists-and-public-health-leaders/).

[14] The New York Times, *Trump Cuts Target Next Generation of Scientists and Public Health Leaders* (Feb. 18, 2025) (https://www.nytimes.com/2025/02/18/us/politics/fda-cdc-health-department-trump.html).

[15] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative* (Feb. 26, 2025).

4. What role did the Department of Government Efficiency (DOGE) have in identifying or prioritizing employees for termination? What metrics did they use?

5. How many employees were terminated who are responsible for responding either domestically or globally to the first clade 1b monkeypox outbreak?
    a. Did the agency conduct any analysis of the current and future staffing needs to address the threat of monkeypox prior to the terminations? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Please provide a detailed plan on how CDC intends to effectively prevent further spread of monkeypox despite the layoffs.

6. How many employees were terminated who are responsible for responding to the measles outbreak in Texas?
    a. Did the agency conduct any analysis of the current and future staffing needs to address the threat of measles outbreaks prior to the terminations? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Please provide a detailed plan on how CDC intends to address current and future measles outbreaks domestically despite the layoffs.

7. How many employees were terminated who are responsible for foodborne illness surveillance, data collection and response?
    a. Did the agency conduct any analysis of the current and future staffing needs to address the threat of foodborne illness in the United States? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Please provide a detailed plan on how CDC intends to effectively prevent current and future outbreaks of foodborne illness despite the layoffs.

8. Recent reports note that between terminations and buyouts, there is a 20 percent reduction in staff for the World Trade Health Center Program (WTHCP), run by the National Institutes of Occupation Safety and Health (NIOSH) at the CDC. How many WTHCP positions were terminated since February 13, 2025, and how many positions are now vacant due to early retirement buyout decisions accepted by February 6, 2025?
    a. Did the agency conduct any analysis of the current and future staffing needs to of the 9/11 health program prior to conducting the terminations? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Please include a detailed plan on how CDC plans to ensure that there will not be any limits or delays in the program's support of 9/11 first responders or survivors despite the staff layoffs.

9. CDC, in collaboration with federal, state, and local partners, has been actively engaged in a coordinated response to outbreaks of avian influenzaH5N1 in the United States. How many positions with specific H5N1 surveillance, testing, or technical support responsibilities were terminated since February 13, 2025, and how many positions are now vacant due to early retirement buyout decisions accepted by February 6, 2025?

    a. Did the agency conduct any analysis of the current and future staffing needs to address the threat of H5N1 in the United States? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Please include a detailed plan on how CDC intends to effectively address the threat of H5N1 despite the layoffs.

10. List any research, data collection, public campaigns or surveillance programs that have been paused or suspended or had their mission altered at CDC because of the recent layoffs, beginning February 13, 2025.

11. Under 5 C.F.R. 315.803(a), prohibitionary employees can be terminated "if the employee fails to demonstrate fully his or her qualifications for continued employment." Please document the steps that the Department has taken to align recent terminations with these requirements under law.

12. Under 5 CFR 315.803(b), prohibitionary employees who are terminated must be notified in writing as to the "inadequacies of [their] performance of conduct." Please provide copies of each letter documenting the inadequacies in each terminated employee's performance since the beginning of the prohibitionary period. If multiple employees were identified as having the same performance inadequacy, please provide the template letter the Department sent and how many staff received the same letter.

13. Federal law prohibits the partisan dismissal of prohibitionary employees, and the Federal circuit has identified a right to appeal termination decisions when the action was a result of partisan politics.[16,17] President Trump has called his efforts to purge

[16] 5 CFR 315.806(b). *See* Stokes v. Aff, 761 F.2d 682 (probationary staff can appeal decisions when the action was a result of partisan politics).

[17] Letter from Mike Zamore, National Directory of Policy and Government Affairs; Kia Hamadancy, Senior Policy Counsel; Monica Hopkins, Executive Director of the ACLU of the District of Columbia, American Civil Liberties Union, to Sen. Rand Paul, Chair, Senate Homeland Security and Governmental Affairs Committee; Sen. Gary C. Peters, Ranking Member, Senate Homeland Security and Governmental Affairs Committee; Rep. James Comer, Chair, House Committee on Oversight and Accountability; Rep. Gerald E. Connolly, Ranking Member, House Committee on Oversight and Accountability (Feb. 7, 2025).

career workers in the government "retribution" and disparaged them for undermining his power.[18,19] Given this,

a. What process has HHS put in place to process appeals?
b. How many appeals have been filed since the terminations began?
c. How many terminations have been reversed and how many have been sustained?

As the Secretary of HHS, we ask you to reconsider these ill-advised terminations, and to consider and take seriously the momentous responsibility you have for protecting public health. The impending impact of these terminations, including exposing Americans to greater death and illness due to outbreaks of foodborne illness and infectious disease, will fall on your shoulders.

Sincerely,

Rep. Frank Pallone, Jr
Ranking Member
Committee on Energy and Commerce

Diana DeGette
Ranking Member
Subcommittee on Health

[18] C-Span, *Clip: Former Pres. Trump: "I Am Your Justice…I Am Your Retribution"* (Mar. 4, 2023) (https://www.c-span.org/clip/campaign-2024/former-pres-trump-i-am-your-justicei-am-your-retribution/5060238).

[19] Citizens for Responsibility and Ethics in Washington, *Trump has said he wants to destroy the "deep state" 56 times on Truth Social* (Aug. 1, 2024) (https://www.citizensforethics.org/reports-investigations/crew-investigations/trump-has-said-he-wants-to-destroy-the-deep-state-56-times-on-truth-social/).

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FRANK PALLONE, JR., NEW JERSEY
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ONE HUNDRED NINETEENTH CONGRESS

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House of Representatives

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Minority (202) 225-2927

February 28, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy:

We are writing to express my strong opposition to the recent indiscriminate and unauthorized termination of workers at the Food and Drug Administration (FDA) that began on Thursday, February 13, 2025. We are deeply concerned these widespread terminations took place without any review of these employees' work history or without any analysis of the impacts these job losses would have on the Department's ability to protect the health and well-being of the American people.[1] Therefore, we are requesting additional information regarding these terminations and their impact on the agency and its mission to ensure the safety of medical products Americans use and prevent harm from public health threats. The activities undertaken to accomplish this mission are congressionally mandated and are effectuated by the agency's workforce. We are concerned that your recent termination of FDA employees with no regard for their performance, their functions, or ensuring the continuity of the agency's congressionally mandated functions demonstrates a gross lack of understanding and disregard for the complex work that the agency undertakes to protect the American public. Future extreme, arbitrary, and unlawful layoffs will further endanger the agency's mission to protect public health.[2]

We have continuously heard that the agency faces difficulty recruiting and retaining staff with specific clinical expertise due to the complex and highly technical work.[3] These recent actions further undercut the FDA's ability to keep pace with hiring the skilled workers it needs to ensure that food Americans eat and medical products they use are safe.

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[1] CBS News, *Thousands of probationary federal health agency workers fired by letter this weekend. Here's what it said.* (Feb. 15, 2025) (https://www.cbsnews.com/news/thousands-of-probationary-federal-health-agency-workers-fired-by-letter-this-weekend/).

[2] Associated Press, *The Trump administration sets the stage for large-scale federal worker layoffs in a new memo* (Feb. 26, 2025).

[3] Regulatory Focus, *Firing of FDA probationary staff creates widespread uncertainty* (Feb. 17, 2025) (https://www.raps.org/news-and-articles/news-articles/2025/2/firing-of-fda-probationary-staff-creates-widesprea).

These terminations have real world implications. This action included indiscriminate firing of experts in nutrition, infant formula, and food safety, such as those that review food ingredients to ensure they are not harmful to Americans.[4] At a time when FDA is investigating the current H5N1 outbreak and ensuring the continued safety of our milk, dairy products, and animal feed supply, these workers are vital to protecting the public from a potentially even larger outbreak.[5] Moreover, reports show that there were layoffs in the FDA office that conducts inspections and criminal investigations, which leaves Americans vulnerable to unsafe products entering our supply chain and allows bad actors to more easily get away with infiltrating our stores with dangerous products.[6] Cuts to both of these workforces are especially concerning in light of the infant formula crisis that so recently devastated our nation's families and contaminated eyedrops that led to blindness. With fewer workers to conduct inspections, Americans will be left vulnerable to such events happening more readily.

Additional FDA layoffs included scientists and engineers working on artificial intelligence and technology.[7] These layoffs will undoubtably impact the timing of product reviews by the agency, delaying access to products for Americans that could otherwise improve their health. This allows other countries such as China to outpace us in innovation, treatments, and cures.

The firings also raise concerns about the political influence on product review and how your Department will approach settled science, promote snake oil therapies, or influence review of therapies from those who show their support for the Trump Administration. Notably, among the FDA staff that were fired are 20 employees in FDA's Office of Neurological and Physical Medicine Devices, which is responsible for reviewing clinical trial applications of the brain implant technology from billionaire Elon Musk's Neuralink, who is leading up the Administration's so-called Department of Government Efficiency (DOGE).[8] These employee terminations came as FDA officials were raising concern over the safety of trials for Neuralink.[9]

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[4] Bloomberg, *Food Head at FDA Resigns, Citing Numerous Job Cuts* (Feb. 18, 2025) (https://www.bloomberg.com/news/articles/2025-02-18/food-head-at-fda-resigns-citing-numerous-job-cuts-in-division?srnd=homepage-americas&sref=fqqmZ8gi).

[5] U.S. Food and Drug Administration, Investigation of Avian Influenza A (H5N1) Virus in Dairy Cattle (Jan. 17, 2025).

[6] Politico, *Mass firings continue across nation's health agencies* (Feb. 16, 2025) (https://www.politico.com/news/2025/02/16/mass-firings-health-agencies-00204570).

[7] *Id.*

[8] Fortune, *DOGE reportedly fired the FDA employees who were reviewing clinical trials for Elon Musk's Neuralink* (Feb. 18, 2025) (https://fortune.com/2025/02/18/doge-fired-fda-employees-overseeing-elon-musk-neuralink/).

[9] Reuters, *Exclusive: FDA staff reviewing Musk's Neuralink were included in DOGE employee firings, sources say* (Feb. 18, 2025) (https://www.reuters.com/world/us/fda-staff-reviewing-musks-neuralink-were-included-doge-employee-firings-sources-2025-02-17/).

Further, the secretive nature of these terminations raises significant concerns about this Administration's lack of accountability to the American people.[10, 11] Given the consequences these layoffs at FDA will have on our nation's access to safe and effective medical products and public health safety, we request detailed responses to the following questions no later than March 10, 2025. Where relevant, your response should include any and all memoranda, directives or orders meant to effectuate these recent terminations.

1. What is the total number of probationary and non-probationary employees terminated from FDA since Thursday, February 13, 2025? Specify the number of terminated workers, in both classifications, from each office, center, and division, at FDA in raw numbers, and as a percentage of each office's, center's, and division's total workforce.

2. Are there additional layoffs planned for FDA employees at this time, including those directed by the Office of Management and Budget and the Office of Personnel Management in the February 26, 2025 memorandum?[12] If further resignation or termination requests are ordered, how many additional layoffs are expected? Specify the total number of layoffs by office, center, and division at FDA.

3. What role did DOGE have in identifying or prioritizing employees for termination? What metrics did they use?

4. How many of the positions that are now vacant will be permanently eliminated and how many positions will be filled by new personnel? Specify each total by office, center, and division at FDA.

5. How many personnel that were fired were in positions funded, in whole or in part, by user fees? Specify each total by office, center, and division at FDA.

6. How many of these terminated employees were in positions intended to fulfill full-time equivalent (FTE) requirements agreed to by FDA and industry?

7. What is the length of delay for review times of regulated products created by these terminations? Specify the delay by office, center, and division at FDA.

8. How many user fee performance goals, as agreed to by FDA and industry and ratified by Congress, will be missed due to these terminations?

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[10] *See note 5.*

[11] *See note 1.*

[12] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative* (Feb. 26, 2025).

9. What meetings, including, but not limited to, Advisory Committees, International Council for Harmonisation updates, International Standards Organization meetings, webinars, and panels, have been paused, suspended, or altered at FDA because of the recent HHS workforce reductions, beginning February 13, 2025?

10. How many product reviews have been paused, suspended, or altered at FDA because of the recent HHS workforce reductions, beginning February 13, 2025? Specify each total by office, center, and division at FDA.

11. Did the office assigned with reviewing clinical trial applications for Neuralink receive any instructions specific to this product's review, such as guidance to issue favorable determinations to advance the application?

12. How many inspections have been paused, suspended, or altered at FDA because of the recent HHS workforce reductions, beginning February 13, 2025? Specify each total by office, center, and division at FDA.

13. Under 5 C.F.R. 315.803(a), probationary employees can be terminated "if the employee fails to demonstrate fully his or her qualifications for continued employment." Please document the criteria that the Department reviewed to assess employee qualifications in accordance with this provision.

14. Under 5 CFR 315.803(b), probationary employees who are terminated must notify in writing as to the "inadequacies of [their] performance of conduct." Please provide copies of each letter documenting the inadequacies in each terminated employee's performance since the beginning of the probationary period. If multiple employees were identified as having the same performance inadequacy, a template letter will suffice so long as the Department identifies how many staff received the same letter.

15. Federal law prohibits the partisan dismissal of probationary employees, and the Federal circuit has identified a right to appeal termination decisions when the action was a result of partisan politics.[13,14] President Trump has called his efforts to purge

[13] 5 CFR 315.806(b). *See* Stokes v. Aff, 761 F.2d 682 (probationary staff can appeal decisions when the action was a result of partisan politics).

[14] Letter from Mike Zamore, National Directory of Policy and Government Affairs; Kia Hamadancy, Senior Policy Counsel; Monica Hopkins, Executive Director of the ACLU of the District of Columbia, American Civil Liberties Union, to Sen. Rand Paul, Chair, Senate Homeland Security and Governmental Affairs Committee; Sen. Gary C. Peters, Ranking Member, Senate Homeland Security and Governmental Affairs Committee; Rep. James Comer, Chair, House Committee on Oversight and Accountability; Rep. Gerald E. Connolly, Ranking Member, House Committee on Oversight and Accountability (Feb. 7, 2025).

career workers in the government "retribution" and disparaged them for undermining his power.[15,16] Given this:

a. What process has HHS put in place to process appeals?
b. How many appeals have been filed since the terminations began?
c. How many terminations have been reversed and how many have been sustained?

16. Provide a full accounting of all FDA Reports to Congress due in 2025 and FDA's plans for ensuring that these congressionally mandated reports are completed and submitted on time.

We urge you to reverse these mass firings and to prioritize the stability and integrity of our nation's gold standard for medical product review, innovation, and public health safety. You have a duty to the American public to ensure that our public health agencies deliver them innovative medical products and protect them from harm. We expect to see immediate steps to restoring the workforce that delivers on FDA's mission to accomplish this for Americans.

As the Secretary of Health and Human Services, responsibility for these anti-public health actions and their impending impacts, including exposing Americans to unsafe products, will fall on your shoulders.

Sincerely,

Rep. Frank Pallone, Jr
Ranking Member
Committee on Energy and Commerce

Diana DeGette
Ranking Member
Subcommittee on Health

[15] C-Span, *Clip: Former Pres. Trump: "I Am Your Justice…I Am Your Retribution"* (Mar. 4, 2023) (https://www.c-span.org/clip/campaign-2024/former-pres-trump-i-am-your-justicei-am-your-retribution/5060238).

[16] Citizens for Responsibility and Ethics in Washington, *Trump has said he wants to destroy the "deep state" 56 times on Truth Social* (Aug. 1, 2024) (https://www.citizensforethics.org/reports-investigations/crew-investigations/trump-has-said-he-wants-to-destroy-the-deep-state-56-times-on-truth-social/).

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-3641
Minority (202) 225-2927

February 28, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy:

We are writing to express my strong opposition to the recent firings of more than 1,100 probationary workers at the National Institutes of Health (NIH), publicly announced on February 14, 2025. This initial round of terminations accounts for about six percent of the 20,000 people employed by the NIH, an agency overseeing 27 institutes and centers.[1] We are deeply concerned these widespread terminations took place without any review of these employees' work history or without any analysis of the impacts these job losses would have on the Department's ability to protect the health and well-being of the American people. Future extreme, arbitrary, and unlawful layoffs will further endanger the agency's mission to promote lifesaving biomedical research.[2]

NIH is the world's largest funder of biomedical research and the driving force behind decades of live-saving scientific advances. For example, NIH's scientists and hundreds of supporting staff enabled the development of Naloxone spray, [3] a key tool in opioid use disorder deaths, and the identification of the BRCA gene mutations[4] for breast, ovarian, prostate, and pancreatic cancers.

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[1] The Economic Times, *Trump administration's NIH layoffs total 1,165 people, internal email shows* (Feb. 16, 2025) (https://economictimes.indiatimes.com/news/international/world-news/trump-administrations-nih-layoffs-total-1165-people-internal-email-shows/articleshow/118308003.cms?from=mdr).

[2] Associated Press, *The Trump administration sets the stage for large-scale federal worker layoffs in a new memo* (Feb. 26, 2025).

[3] National Institutes of Health, *Impact of NIH Research: Improving Health, Substance Abuse* (https://www.nih.gov/about-nih/what-we-do/impact-nih-research/improving-health/substance-use) (accessed Feb. 21, 2025).

[4] National Institutes of Health, *Impact of NIH Research: Improving Health, Cancer* (https://www.nih.gov/about-nih/what-we-do/impact-nih-research/improving-health/cancer) (accessed Feb. 21, 2025).

We are concerned that your indiscriminate termination of workers at NIH as well as your recent decision to drastically cut funding for biomedical research, will have long-lasting consequences undermining biomedical innovation and the search for new treatments and cures.[5] These actions also threaten our nation's global leadership in biomedical innovation and could cede our standing to adversaries, like China. Moreover, these firings raise concerns about political influence on scientific research and the potential chilling effects of how your Department will approach settled science. We request answers to understand the nature and scope of these terminations, your purported authority to undertake these terminations, and whether you have undertaken any actual analysis of the impact they would have on the lifesaving research and treatment that is being funded through the NIH research portfolio.

In fiscal year 2022, NIH funding generated an estimated $96.8 billion in economic activity and supported over seven million jobs including significant support for small businesses.[6,7] The recent decisions to target NIH through illegal freezing of federal grant funding, sharp reductions in support to our nation's research universities through the unlawful decision to cut federal funding for researchers' "indirect costs," and the loss or removal of key NIH leadership staff will irreversibly impact the promise of future life-saving treatments, including potentially in the area of cancer, infectious diseases, blood disorders, heart disease, lung disease, and drug abuse.[8,9,10]

Furthermore, your actions will have ripple effects for sick Americans currently receiving care through NIH initiatives. In total, about half a million patients from all 50 states, and many countries around the world, have participated in clinical research at NIH, and many continue to get care and treatment through agency programs today. There are currently about 1,600 clinical research studies underway at the NIH Clinical Center—a leader in the bench-to-bedside model of medicine.[11] For instance, the Children's Inn, a non-profit lifeline for children and their families at the NIH, has treated more than 14,500 children, teens, and young adults with cancer and other serious health issues since 1990.[12] These patients have already been adversely affected by the

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[5] Michigan Medicine, *America Sits on Top in Science — but China Is Rising Fast* (June 15, 2017) (https://www.michiganmedicine.org/health-lab/america-sits-top-science-china-rising-fast).

[6] National Institutes of Health, *Impact of NIH Research: Serving Society, Direct Economic Contributions* (https://www.nih.gov/about-nih/what-we-do/impact-nih-research/serving-society/direct-economic-contributions) (accessed Feb. 21, 2025).

[7] National Institutes of Health, *Impact of NIH Research: Serving Society, Spurring Economic Growth* (https://www.nih.gov/about-nih/what-we-do/impact-nih-research/serving-society/spurring-economic-growth) (accessed Feb. 21, 2025).

[8] *White House Failed to Comply With Court Order, Judge Rules,* The New York Times (Feb. 10, 2025).

[9] National Public Radio, *What National Institutes of Health funding cuts could mean for U.S. universities* (Feb. 12. 2025) (https://www.npr.org/2025/02/12/nx-s1-5292359/what-cuts-to-nih-funding-could-mean-for-american-universities).

[10] *Top N.I.H. Official Abruptly Resigns as Trump Orders Deep Cuts*, The New York Times (Feb. 12, 2025).

[11] National Institutes for Health, NIH Clinical Center Data Report 2024 (Nov. 13, 2024).

[12] The Children's Inn at NIH, A Place Like Home (https://childrensinn.org/) (accessed Feb. 21, 2025).

Trump Administration's illegal funding freeze,[13] and will be further impacted by your staffing decisions. These initiatives hinge on dedicated, competent workers, and we have yet to see evidence that your termination decisions considered the impact of staff reductions on these important programs.

Given the consequences that these sweeping layoffs at NIH will have on our nation's biomedical and public health research, we request detailed responses to the following questions no later than March 10, 2025. Where relevant, your response should include any and all memoranda, directives or orders meant to effectuate these recent terminations.

1. What is the total number of probationary and non-probationary employees terminated from NIH since Thursday, February 13, 2025? Specify the number of terminated workers, in both classifications, from each institute, center, department, and program at NIH in raw numbers, and as a percentage of each institute's, center's, department's, and program's total workforce.

2. Are there additional layoffs planned for NIH employees at this time, including those directed by the Office of Management and Budget and the Office of Personnel Management in the February 26, 2025, memorandum?[14] If further resignation or termination requests are ordered, how many additional layoffs are expected? Specify the total number of layoffs by institute, center, department, and program at NIH.

3. How many of the positions that are now vacant will be permanently eliminated and how many positions will be filled by new personnel? Specify each total by institute, center, department, and program at NIH.

4. NIH is the federal leader in supporting extramural research through grants to extramural partners. How many positions with grant review and administration duties were terminated since February 13, 2025, and how many positions are now vacant due to early retirement buyout decisions accepted by February 6, 2025?

5. How many patients enrolled in clinical trials have been affected by the communication pause initiated by the Trump Administration's Department of Health and Human Services (HHS) Memo Dated January 21, 2025, or President Trump's Executive Order 13985? [15] Does the agency have any idea?

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[13] Reuters, *Trump loses bid to pause judge's order barring funding freezes* (Feb. 11, 2025) (https://www.reuters.com/world/us/trump-asks-us-court-end-judicial-overreach-allow-funding-freezes-2025-02-11/).

[14] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative* (Feb. 26, 2025).

[15] Science Adviser, *Trump hits NIH with 'devastating' freezes on meetings, travel, communications, and hiring* (Jan. 22, 2025) (https://www.science.org/content/article/trump-hits-nih-devastating-freezes-meetings-travel-communications-and-hiring).

a. Did the agency conduct any analysis of the impact on patients currently enrolled in clinical trials prior to the funding freeze? If so, please provide such analyses; if not, please state that no such analyses were conducted.
b. Has the agency conducted any analysis of the potential impact on patients currently enrolled in clinical trials prior to the staffing terminations? If so, please provide such analyses; if not, please state that no such analyses were conducted.

6. The Federal Register halted the publication of meeting schedules for research grant reviews with the consequence that study sections and advisory councils at agencies, such as NIH, are unable to convene to make funding decisions on research proposals. When was the halt on Federal Register meeting notifications issued and how long will this halt last?
    a. On what authority is the Administration halting the Federal Register publication of meeting schedules?
    b. Please provide a detailed list of all HHS study sections and advisory committee meetings that have not met since January 20, 2025.

7. What is the rationale behind the proposed cut to indirect costs, and how was the new rate determined?
    a. Has the agency undertaken any analyses of how the reduction in indirect cost order would impact the recruitment and retention of qualified researchers, particularly in competitive fields? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    b. Has the agency undertaken any analyses of the impact of the reduction in indirect costs on the current pipeline for innovative treatments and therapies? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    c. Has the agency undertaken any analyses of the impact of the reduction in indirect costs on patients currently enrolled in studies funded through NIH grant dollars? If so, please provide such analyses; if not, please state that no such analyses were conducted.
    d. Please provide the Committee with all HHS or NIH memos detailing decision making and outlining economic, workforce, and research effects as a result of the flat rate.

8. What research, data collection, public campaigns or surveillance programs have been paused, suspended, or mission-altered at NIH because of the recent workforce reductions, beginning February 13, 2025?

9. Under 5 C.F.R. 315.803(a), prohibitionary employees can be terminated "if the employee fails to demonstrate fully his or her qualifications for continued employment." Please document the criteria that the Department reviewed to assess employee qualifications in accordance with this provision.

10. Under 5 CFR 315.803(b), prohibitionary employees who are terminated must notify in writing as to the "inadequacies of [their] performance of conduct." Please provide anonymized copies of each letter documenting the inadequacies in each terminated employee's performance since the beginning of the prohibitionary period. If multiple employees were identified as having the same performance inadequacy, a template letter will suffice so long as the Department identifies how many staff received the same letter.

11. Federal law prohibits the partisan dismissal of prohibitionary employees, and the Federal circuit has identified a right to appeal termination decisions when the action was a result of partisan politics.[16,17] President Trump has called his efforts to purge career workers in the government "retribution" and disparaged them for undermining his power.[18,19] Given this,
    a. What process has HHS put in place to process appeals?
    b. How many appeals have been filed since the terminations began?
    c. How many terminations have been reversed and how many have been sustained?

[16] 5 CFR 315.806(b). *See* Stokes v. Aff, 761 F.2d 682 (probationary staff can appeal decisions when the action was a result of partisan politics).

[17] Letter from Mike Zamore, National Directory of Policy and Government Affairs; Kia Hamadancy, Senior Policy Counsel; Monica Hopkins, Executive Director of the ACLU of the District of Columbia, American Civil Liberties Union, to Sen. Rand Paul, Chair, Senate Homeland Security and Governmental Affairs Committee; Sen. Gary C. Peters, Ranking Member, Senate Homeland Security and Governmental Affairs Committee; Rep. James Comer, Chair, House Committee on Oversight and Accountability; Rep. Gerald E. Connolly, Ranking Member, House Committee on Oversight and Accountability (Feb. 7, 2025).

[18] C-Span, *Clip: Former Pres. Trump: "I Am Your Justice…I Am Your Retribution"* (Mar. 4, 2023) (https://www.c-span.org/clip/campaign-2024/former-pres-trump-i-am-your-justicei-am-your-retribution/5060238).

[19] Citizens for Responsibility and Ethics in Washington, *Trump has said he wants to destroy the "deep state" 56 times on Truth Social* (Aug. 1, 2024) (https://www.citizensforethics.org/reports-investigations/crew-investigations/trump-has-said-he-wants-to-destroy-the-deep-state-56-times-on-truth-social/).

We urge you to reverse these mass firings and to prioritize the stability and integrity of our gold star national research institution. As the Secretary of HHS, it is your duty to our nation to generate—not knee-cap—innovative solutions, treatments and cures. We hope to see immediate steps to restore confidence in the NIH, its mission to improve patients' lives, and spur advancements in the scientific research only possible in the U.S.

Sincerely,

Rep. Frank Pallone, Jr
Ranking Member
Committee on Energy and Commerce

Diana DeGette
Ranking Member
Subcommittee on Health

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

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Minority (202) 225-2927

March 13, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy:

We are writing to express our strong opposition to the recent indiscriminate and unauthorized termination of workers at the Substance Abuse and Mental Health Services Administration (SAMHSA) and to request additional information regarding these terminations and their impact on the agency. Millions of Americans receive mental health and substance use services through programs administered by SAMHSA, and adequate staffing is paramount to being able to continue to deliver care to vulnerable communities across the nation. We request answers to our questions to understand the nature and scope of these terminations, which have been conducted without any public disclosure, your authority to undertake these terminations, and whether you have undertaken any analysis of the impact of these terminations on the programs that SAMHSA administers.

SAMHSA's staff support and manage programs that prevent substance use and overdose, enhance access to suicide prevention and mental health services, promote resilience and emotional health for children, youth, and families, integrate behavioral and physical health care, and strengthen the behavioral health workforce. Through these programs, SAMHSA helps to ensure people affected by mental health and substance use conditions receive care in order to live healthy and productive lives.

Two of SAMHSA's largest programs are the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG). Since 1992, the MHBG has distributed funds to 59 states and territories that can be used for a variety of behavioral health services, including outpatient treatment for patients with serious mental illnesses, rehabilitation services, crisis stabilization and case management, jail diversion programs, and wraparound services for children and families, among others. The MHBG is a significant safety net source of funding for mental health services for some of the most at-risk populations across the country. The SUPTRS BG funds states and

territories efforts to plan, implement, and evaluate substance use disorder prevention, treatment, harm reduction, and recovery support services. This program aims to ensure that individuals and communities have access to a range of substance use-related prevention, treatment, and recovery support services necessary to improve health and reduce the impact of substance use on communities across the country. SAMHSA staff play a pivotal role in administering these programs, and state programs will be negatively impacted if there are not adequate staff for the program.

SAMHSA also funds the 988 Suicide & Crisis Lifeline. In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. This program operates over 200 local crisis centers that offer 24/7, free, confidential access to trained crisis counselors who can help people experiencing mental health-related distress.[1] This service is vitally important, as suicide was the second-leading cause of death for people aged 10-14 and 25-34 years old and 1.6 million American adults attempted suicide in 2022.[2] Again, SAMHSA staff are critically important for the continuation of lifesaving programs such as the 988 Lifeline. Mass layoffs endanger not only the program but the many Americans who rely on access to lifesaving care.

These programs make up a fraction of the universe of programs and services that SAMHSA supports. All of SAMHSA's programs exist in the context of a rising mental health and substance use crisis in the United States. An estimated 48.5 million Americans battled a substance used disorder in the past year,[3] and 57.8 million Americans experienced mental illness.[4] Many of these Americans struggle to access appropriate care. Now more than ever, SAMHSA programs are integral to the health and well-being of the American population.

Given the enormous consequences that sweeping layoffs at SAMHSA will have on our nation's access to behavioral health services, we request detailed responses to the following questions no later than March 27, 2025. Where relevant, your response should include any and all memoranda, directives, or orders meant to effectuate these recent terminations.

1. What is the total number of probationary and non-probationary employees terminated from SAMHSA since Thursday, February 13, 2025? Specify the number of terminated workers, in both classifications, from each office and center.

2. Are there additional layoffs planned for SAMHSA employees at this time, including those directed by the Office of Management and Budget and the Office of

[1] Substance Abuse and Mental Health Services Administration, *988 Key Messages* (Oct. 2023) (https://www.samhsa.gov/mental-health/988/key-messages).

[2] Centers for Disease Control and Prevention, *Suicide Data and Statistics* (https://www.cdc.gov/suicide/facts/data.html) (accessed Mar. 13, 2025).

[3] American Addiction Centers, Alcohol and Drug Abuse Statistics (Facts About Addiction) (Dec. 31, 2024) (https://americanaddictioncenters.org/rehab-guide/addiction-statistics-demographics).

[4] *Ibid.*

Personnel Management in the February 26, 2025, memorandum?[5]

a. Please provide copies of any memoranda or documents detailing any proposed Reductions in Force at the Department of Health and Human Services (HHS) or any of its operating divisions, including SAMHSA. Please provide a response in writing on how these plans were drafted, as well as the names of individuals involved in drafting these plans, both within the agency or outside of it.

b. If further resignation or termination requests are ordered, how many additional layoffs are expected? Specify the total number of layoffs by office and center.

3. What role did DOGE have in identifying or prioritizing employees for termination? What metrics did they use?

4. How many of the positions that are now vacant will be permanently eliminated, and how many positions will be filled by new personnel? Specify each total by office and center.

5. What meetings have been paused, suspended, or altered at SAMHSA because of the recent terminations, beginning February 13, 2025?

6. What will the impact of the mass layoffs be on the MHBG and SUPTRS BG programs and their ability to continue supporting behavioral health services across the country?

7. What will the impact of the mass layoffs be on the 988 Suicide & Crisis Lifeline?

8. Under 5 C.F.R. 315.803(a), prohibitionary employees can be terminated "if the employee fails to demonstrate fully his or her qualifications for continued employment." Please document the criteria that the Department reviewed to assess employee qualifications in accordance with this provision.

9. Under 5 CFR 315.803(b), prohibitionary employees who are terminated must notify in writing as to the "inadequacies of [their] performance of conduct." Please provide copies of each letter documenting the inadequacies in each terminated employee's performance since the beginning of the prohibitionary period. If multiple employees were identified as having the same performance inadequacy, a template letter will suffice so long as the Department identifies how many staff received the same letter.

[5] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative* (Feb. 26, 2025).

10. Federal law prohibits the partisan dismissal of prohibitionary employees, and the federal circuit has identified a right to appeal termination decisions when the action was a result of partisan politics.[6,7] President Trump has called his efforts to purge career workers in the government "retribution" and disparaged them for undermining his power.[8,9] Given this:
    a. What process has HHS put in place to process appeals?
    b. How many appeals have been filed since the terminations began?
    c. How many terminations have been reversed and how many have been sustained?

    Provide a full accounting of all SAMHSA Reports to Congress due in 2025 and SAMHSA's plans for ensuring that these congressionally mandated reports are completed and submitted on time.

[6] 5 CFR 315.806(b). *See* Stokes v. Aff, 761 F.2d 682 (prohibitionary staff can appeal decisions when the action was a result of partisan politics.) See generally https://thehill.com/wp-content/uploads/sites/2/2025/02/ACLU-AaCLU-DC-Potential-Mass-Layoffs-of-Government-Employees.pdf.

[7] Letter from Mike Zamore, National Director of Policy and Government Affairs; Kia Hamadanchy, Senior Policy Counsel; Monica Hopkins, Executive Director of the ACLU of the District of Columbia, American Civil Liberties Union, to Senator Rand Paul, Chairman, Senate Homeland Security and Governmental Affairs Committee; Senator Gary Peters, Ranking Member, Senate Homeland Security and Governmental Affairs Committee; Rep. James Comer, Chairman, House Committee on Oversight and Accountability; Rep. Gerald E. Connolly, Ranking Member, House Committee on Oversight and Accountability (Feb. 7, 2025).

[8] C-SPAN, *Former Pres. Trump: "I Am Your Justice...I Am Your Retribution"* (Mar. 4, 2023) (https://www.c-span.org/clip/campaign-2024/former-pres-trump-i-am-your-justicei-am-your-retribution/5060238).

[9] Citizens for Responsibility and Ethics in Washington, *Trump has said he wants to destroy the "deep state" 56 times on Truth Social* (Aug. 1, 2024) (https://www.citizensforethics.org/reports-investigations/crew-investigations/trump-has-said-he-wants-to-destroy-the-deep-state-56-times-on-truth-social/)

We urge you to reverse these mass firings and protect the vital work that SAMHSA is doing to respond to the substance use and mental health crises. As the Secretary of HHS, these actions and their impending impacts are your responsibility, and you have a duty to the American people to ensure that our health agencies are serving their purpose. We expect to see immediate steps to restore the workforce that delivers on SAMHSA's mission.

Sincerely,

Rep. Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce

Rep. Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce

BRETT GUTHRIE, KENTUCKY
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COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-3641
Minority (202) 225-2927

March 13, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Thomas Engels
Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Secretary Kennedy and Administrator Engels:

We are writing to express our strong opposition to the recent indiscriminate and unauthorized termination of workers at the Health Resources and Services Administration (HRSA) and to request additional information regarding these terminations and their impact on the agency. Tens of millions of Americans receive quality, affordable health care and other services through the programs HRSA administers, and adequate staffing is paramount to being able to continue to deliver care to vulnerable communities across the nation. We request answers to our questions to understand the nature and scope of these terminations, which have been conducted without any public disclosure, your authority to undertake these terminations, and whether you have undertaken any analysis of the impact of these terminations on the programs that HRSA administers.

HRSA's staff support and manage its 90-plus programs and more than 3,000 grantees. These programs deliver health services to people who are geographically isolated, economically or medically vulnerable, people with HIV, pregnant women, mothers and their families, those with low incomes, residents of rural areas, American Indians and Alaska Natives, and many others. HRSA programs support health infrastructure, including the training of health professionals in areas where they are needed most and the advancement of telehealth. HRSA also oversees programs that provide discounts on prescription drugs to safety net providers, facilitate organ, bone marrow, and cord blood transplantation, and compensate individuals

injured by vaccination.

HRSA's Health Center Program provides access to affordable, comprehensive, and high-quality primary health care services to patients, regardless of their ability to pay. In 2023, health centers served 32.5 million patients, and nearly 1,500 grantees and look-alikes provided care at 16,000 sites across the country.[1] In the past month, the Trump Administration's funding freezes have jeopardized health centers' ability to keep their doors open. In Virginia, over half of the health centers were cut off from federal grant money, forcing some to limit services and others to close.[2] Others reported trouble accessing needed funds, even after a federal judge ordered funding to resume. The stability of health centers is already fragile, with almost half of the health centers in the country having negative financial margins in 2023,[3] and terminating staff at the agency responsible for dispensing federal dollars to health centers will only make it more difficult for them to keep their doors open.

Over the past two years, HRSA has taken historic steps as part of its Organ Procurement and Transplantation Network (OPTN) Modernization Initiative and its implementation of the Securing the U.S. OPTN Act signed into law by President Biden. This includes creating an independent OPTN Board of Directors, transitioning from a single vendor to multiple vendors to support OPTN operations, and issuing new contracts to support modernization, all while ensuring the continuity of OPTN operations. Given this hugely important work, we are troubled to learn that a significant number of employees at HRSA's Division of Transplantation who have been working on modernizing the organ transplant system have been terminated. Mass layoffs are in direct opposition to the goals of the OPTN Modernization Initiative, and these layoffs will have a negative impact on the more than 100,000 Americans who are waiting for lifesaving organ transplants.[4]

HRSA also administers many different workforce programs, including the National Health Service Corps, Nurse Corps, and many others, that connect skilled health care providers to communities in need. Last year, more than 22,000 health professionals in HRSA loan and scholarship programs cared for over 23 million patients, and two-thirds of HRSA training sites supported medically underserved communities.[5] These programs are particularly important as we see continuing provider shortages across the country. The National Center for Health Workforce Analysis projects nationwide health care providers shortages in 2037, including 207,980 registered nurses, 187,130 physicians, and over 400,000 behavioral health providers.

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[1] National Association of Community Health Centers, *America's Health Centers: By the Numbers* (Oct. 2024) (https://www.nachc.org/resource/americas-health-centers-by-the-numbers/).

[2] VPM, *Virginia community health centers close over federal funding access* (Feb. 2025) (https://www.vpm.org/news/2025-02-04/virginia-community-health-centers-close-federal-funding-grant-access).

[3] George Washington University Milken Institute of Public Health, *72. Community Health Centers Grew Through 2023, But Serious Hazards Are on the Horizon* (Sept. 2024) (https://geigergibson.publichealth.gwu.edu/72-community-health-centers-grew-through-2023-serious-hazards-are-horizon).

[4] Health Resources & Services Administration, *Organ Donation Statistics* (https://www.organdonor.gov/learn/organ-donation-statistics) (accessed Mar. 13, 2025).

[5] Health Resources & Services Administration, *Bureau of Health Workforce* (https://bhw hrsa.gov/) (accessed Mar. 13, 2025).

The mass termination of HRSA staff, who are crucial in supporting its many workforce programs, will jeopardize not only the health workforce but the entire American people who need care.

Given the enormous consequences that sweeping layoffs at HRSA will have on our nation's health workforce and access to care, we request detailed responses to the following questions no later than March 27, 2025. Where relevant, your response should include any and all memoranda, directives, or orders meant to effectuate these recent terminations.

1. What is the total number of probationary and non-probationary employees terminated from HRSA since Thursday, February 13, 2025? Specify the number of terminated workers, in both classifications, from each bureau, division, and office.

2. Are there additional layoffs planned for HRSA employees at this time, including those directed by the Office of Management and Budget and the Office of Personnel Management in the February 26, 2025, memorandum?[6]

    a. Please provide copies of any memoranda or documents detailing any proposed Reductions in Force at HHS or any of its operating divisions, including HRSA. Please provide a response in writing on how these plans were drafted, as well as the names of individuals involved in drafting these plans, both within the agency or outside of it.

    b. If further resignation or termination requests are ordered, how many additional layoffs are expected? Specify the total number of layoffs by bureau, division, and office.

3. What role did DOGE have in identifying or prioritizing employees for termination? What metrics did they use?

4. How many of the positions that are now vacant will be permanently eliminated, and how many positions will be filled by new personnel? Specify each total by bureau, division, and office.

5. What meetings have been paused, suspended, or altered at HRSA because of the recent terminations, beginning February 13, 2025?

6. What will the impact of the mass layoffs be on the Health Center Program and its ability to continue supporting health centers across the country?

7. Given the employees you have terminated in the Division of Transplantation, how do you plan to continue the OPTN Modernization Initiative without impacting the

[6] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative* (Feb. 26, 2025).

thousands of Americans who are waiting for a lifesaving organ transplant?

8. What will the impact of the mass layoffs be on the Bureau of Health Workforce and the many workforce programs it administers? Do you anticipate a reduction in these programs?

9. How many employees were terminated that work on the Teaching Health Center Program, including its Planning and Development program? Will there be any reduction in the number of centers and/or residents supported by the program?

10. Under 5 C.F.R. 315.803(a), prohibitionary employees can be terminated "if the employee fails to demonstrate fully his or her qualifications for continued employment." Please document the criteria that the Department reviewed to assess employee qualifications in accordance with this provision.

11. Under 5 CFR 315.803(b), prohibitionary employees who are terminated must notify in writing as to the "inadequacies of [their] performance of conduct." Please provide copies of each letter documenting the inadequacies in each terminated employee's performance since the beginning of the prohibitionary period. If multiple employees were identified as having the same performance inadequacy, a template letter will suffice so long as the Department identifies how many staff received the same letter.

12. Federal law prohibits the partisan dismissal of prohibitionary employees, and the federal circuit has identified a right to appeal termination decisions when the action was a result of partisan politics.[7,8] President Trump has called his efforts to purge career workers in the government "retribution" and disparaged them for undermining his power.[9,10] Given this:
    a. What process has HHS put in place to process appeals?
    b. How many appeals have been filed since the terminations began?
    c. How many terminations have been reversed and how many have been sustained?

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[7] 5 CFR 315.806(b). *See* Stokes v. Aff, 761 F.2d 682 (prohibitionary staff can appeal decisions when the action was a result of partisan politics.)

[8] Letter from Mike Zamore, National Director of Policy and Government Affairs; Kia Hamadanchy, Senior Policy Counsel; Monica Hopkins, Executive Director of the ACLU of the District of Columbia, American Civil Liberties Union, to Senator Rand Paul, Chairman, Senate Homeland Security and Governmental Affairs Committee; Senator Gary Peters, Ranking Member, Senate Homeland Security and Governmental Affairs Committee; Rep. James Comer, Chairman, House Committee on Oversight and Accountability; Rep. Gerald E. Connolly, Ranking Member, House Committee on Oversight and Accountability (Feb. 7, 2025).

[9] C-SPAN, *Former Pres. Trump: "I Am Your Justice...I Am Your Retribution"* (Mar. 4, 2023) (https://www.c-span.org/clip/campaign-2024/former-pres-trump-i-am-your-justicei-am-your-retribution/5060238).

[10] Citizens for Responsibility and Ethics in Washington, *Trump has said he wants to destroy the "deep state" 56 times on Truth Social* (Aug. 1, 2024) (https://www.citizensforethics.org/reports-investigations/crew-investigations/trump-has-said-he-wants-to-destroy-the-deep-state-56-times-on-truth-social/)

13. Provide a full accounting of all HRSA Reports to Congress due in 2025 and HRSA's plans for ensuring that these congressionally mandated reports are completed and submitted on time.

We urge you to reverse these mass firings and protect the vital work that HRSA is doing to provide quality, affordable health care to patients across the country. As the Secretary of HHS and Administrator of HRSA, these actions and their impending impacts are your responsibility, and you have a duty to the American people to ensure that our health agencies are serving their purpose. We expect to see immediate steps to restore the workforce that delivers on HRSA's mission.

Sincerely,

Rep. Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce

Rep. Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce

Congress of the United States
House of Representatives

March 19, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy,

We write to express our concern regarding the recent announcement that the Trump Administration is planning to shut down six regional offices in the Department of Health and Human Services' (HHS) Office of General Counsel, including the Region V office in Chicago, Illinois.[1] As Members who represent states within Region V, which serves Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin, we know the value this office provides to patients, providers, payers, and American taxpayers, so we urge you to immediately reverse this decision.

The planned shutdown of more than half of the regional offices would leave only four offices to serve a country of over 330 million people and directly undermine HHS's capacity to improve America's health and effectively safeguard taxpayer dollars.[2] In addition to being a shortsighted effort that will severely hinder HHS's ability to fulfill its mission, the planned office closures stand in direct opposition to the Trump Administration's purported focus on combatting "waste, fraud, and abuse."[3] In Fiscal Year 2023, HHS retrieved $1.8 billion from civil health care fraud settlements and judgments under the False Claims Act, in addition to other judgments secured under other federal statutes.[4] In total, HHS enforcement and compliance efforts secured the return of more than $3.4 billion to the federal government or private individuals. If the Trump Administration genuinely seeks to prevent fraud and recover funds from bad actors, it should increase–not gut–HHS's compliance and enforcement efforts and maintain offices, like the Office of General Counsel, that directly serve this goal.

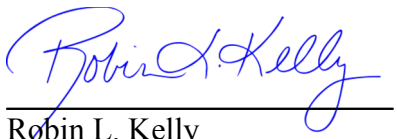
We therefore urge you to reconsider this plan to shutter vital regional offices, including the Region V office in Chicago, and instead work towards ensuring all offices remain fully operational and adequately resourced to do their jobs. The American people deserve better than this. If you are truly committed to improving the efficiency of our health care system, making America healthy, and rooting out waste, fraud, and abuse, we hope you will prioritize the

[1] Trump Administration Plans To Close HHS Legal Offices That Fight Fraud | HuffPost Latest News
[2] HHS Office of General Counsel Announces Reorganization Effort | HHS.gov
[3] Fact Sheet: President Donald J. Trump Reins in Government Waste –]
[4] https://oig hhs.gov/reports/all/2024/health-care-fraud-and-abuse-control-program-report-fiscal-year-2023/

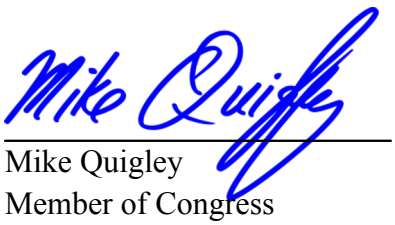
enforcement of our nation's health laws and the standards that help ensure the safety and dignity of our nation's most vulnerable.

Thank you for your attention to this critical matter. We look forward to your response and to your leadership in ensuring that HHS can continue to fulfill its important mission.

Sincerely,



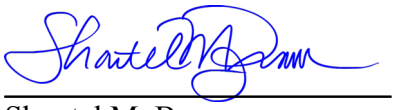
Robin L. Kelly
Member of Congress



Mike Quigley
Member of Congress



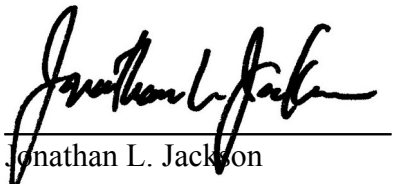
Delia C. Ramirez
Member of Congress



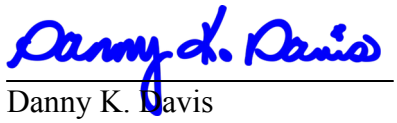
Shontel M. Brown
Member of Congress



Joyce Beatty
Member of Congress



Jonathan L. Jackson
Member of Congress



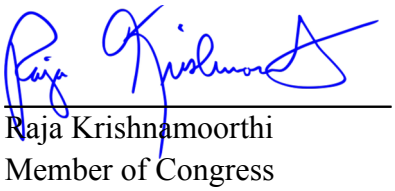
Danny K. Davis
Member of Congress



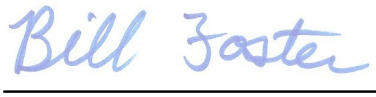
Debbie Dingell
Member of Congress



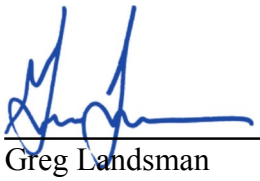
Bradley Scott Schneider
Member of Congress



Raja Krishnamoorthi
Member of Congress



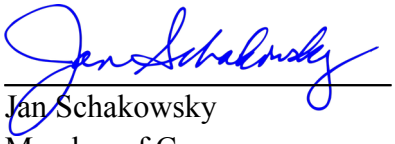
Bill Foster
Member of Congress



Greg Landsman
Member of Congress



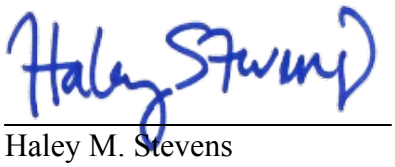
Shri Thanedar
Member of Congress



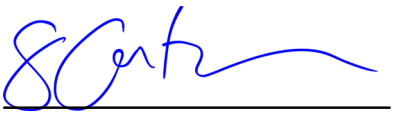
Jan Schakowsky
Member of Congress



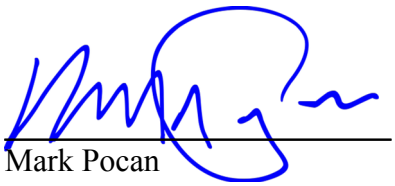
Jésús G. "Chuy" García
Member of Congress



Haley M. Stevens
Member of Congress



Sean Casten
Member of Congress



Mark Pocan
Member of Congress



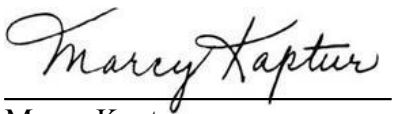
Andre Carson
Member of Congress



Emilia Strong Sykes
Member of Congress



Eric Sorensen
Member of Congress



Marcy Kaptur
Member of Congress

Kelly Morrison
Member of Congress

Lauren Underwood
Member of Congress

Congress of the United States

Washington, DC 20515

March 25, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Matthew J. Memoli, M.D.
Acting Director, National Institutes of Health
9000 Rockville Pike
Bethesda, Maryland 20892

Dear Secretary Kennedy and Acting Director Memoli:

We write to you as the co-chairs of the Congressional Diabetes Caucus. We are concerned with the March 10, 2025 termination of the National Institutes of Health's (NIH) grant support for the Diabetes Prevention Program Outcomes Study (DPPOS). DPPOS is a decades-long study into type 2 diabetes and is currently examining links between type 2 diabetes and dementia. DPPOS is currently managed by Columbia University, which is the subject of a university-wide freeze of grant funding. With more than 90% of the funds being distributed across 30 research sites nationwide, there are alternative funding management options, if necessary. As leaders of the bipartisan Congressional Diabetes Caucus, we are dedicated to the preservation of DPPOS funding and urge the continuation of this critical study advancing diabetes prevention and public health efforts.

DPPOS assesses the long-term effects of the interventions used in the Diabetes Prevention Program (DPP). The study follows the original cohort of DPP participants who took part in the DPP Lifestyle Change Program, which demonstrated people who are at high risk for type 2 diabetes can prevent or delay the disease through dietary changes and increased physical activity. 88% percent of eligible DPP participants joined the study last year. DPPOS research is conducted at 30 institutions across 21 states, and the program currently supports research on Alzheimer's disease and Alzheimer's disease-related dementias in prediabetes and type 2 diabetes. It also includes studies on the long-term effects of diabetes prevention on other health conditions including cancer, heart disease and stroke, nerve damage, kidney disease and eye disease.

We understand negotiations are ongoing regarding the restoration of funding at Columbia but remain concerned with prolonged disruptions to the program's critical research. Please respond to the following questions in detail no later than April 8, 2025:

1. While negotiations are ongoing, what is the current status of the DPPOS program? If the program remains paused for a prolonged period, how will the NIH prevent operational disruption for its research sites and participants?
2. If you deem that the DPPOS program can no longer be managed through its current university soon, will NIH consider reallocating funding management to a different institution currently within the program?
3. Finally, if the DPPOS program is terminated, how will NIH ensure the years and taxpayer dollars invested in this study do not go to waste?

Thank you for your prompt attention to this matter. We strongly urge you to take necessary action to ensure that DPPOS continues to provide insights into diabetes and related conditions for years to come and fuels improved outcomes for individuals with or at risk of type 2 diabetes.

Sincerely,

Diana DeGette
Member of Congress

Gus M. Bilirakis
Member of Congress

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-3641
Minority (202) 225-2927

April 1, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Kennedy:

We write to express our outrage at your reckless announcement terminating nearly 25 percent of the workforce at the Department of Health and Human Services (HHS) and to seek information about this decision, which you have not provided to Congress. Last week, you announced that HHS would be eliminating 10,000 jobs on top of the 10,000 public servants who have already been terminated, or who have taken the deferred resignation program. This is an alarming, irresponsible, DOGE-driven attempt to dismantle an entire department and its critical work in order to fund giant tax breaks for the wealthy. It is also a blatant effort to push out doctors and scientists whose work has been grounded in real science but that runs counter to your dangerous agenda of misinformation.

These layoffs and hastily concocted plans to restructure HHS will harm all Americans who rely on the expertise and efforts of staff across HHS for safe and effective medical products, for the delivery of essential healthcare services, and for the protection of public health and the advancement of biomedical research. To claim to want to make "America Healthy Again" and then dismiss 25percent of the people who work at HHS without regard to the impact these cuts will have on the American people is pure hypocrisy. Already, experts and organizations dedicated to public health have raised the alarm, calling the planned cuts "dangerous," "deeply misguided," and "preposterous."[1]

This announcement comes on the heels of a round of terminations of probationary employees in February that was not only illegal but also led to a substantial number of

[1] Doctors for America, *Doctors for America Condemns HHS Cuts* (March 28, 2025) (press release); Stat+, *Former HHS Secretary Donna Shalala on the Agency's 'Silly New Bureaucracy'* (Mar. 27, 2025) (https://www.statnews.com/2025/03/27/hhs-cuts-rfk-jr-kennedy-reorgnization-layoffs-donna-shalala-criticism/); *RFK Jr. Plans 10,000 Job Cuts in Major Restructuring of Health Department*, The Wall Street Journal (Mar. 27, 2025).

employees being asked to return once you and others at HHS realized they were indeed essential to HHS's mission.[2] Some HHS operating divisions are already struggling to maintain efficiency and quality after the February DOGE-led cuts. At the Food and Drug Administration (FDA), for example, scientists now have double the number of product applications to review as a result of those terminations, and the pace of review of new drug applications has slowed significantly.[3] The Department is also losing swaths of highly experienced leaders who resigned or refused to return to HHS even if their terminations were rescinded.[4] Appallingly, more experts are being forced to resign because they do not align with your misguided agenda, including your deeply misguided determination to set public health back a century by questioning the settled science regarding the safety and efficacy of vaccines.[5] We are concerned that your efforts will result in the resurgence of long eradicated diseases and the unnecessary deaths of many Americans to vaccine preventable diseases.

This is no time to carelessly eviscerate our health workforce. There is an ongoing risk of avian flu outbreaks and more cases of measles already this year than in the past five years.[6] Americans deserve the benefit of numerous treatments and cures that are being diligently researched and examined through clinical trials at NIH and elsewhere within HHS. They also deserve access to safe and effective medical products that are reviewed by FDA within the congressionally mandated timelines. Further, seniors and people with disabilities deserve the opportunity to live independently and participate in their communities—yet, you have carelessly cut the Administration for Community Living (ACL), which is the only federal agency specifically focused on this need.

Since you chose to provide only a six-minute video devoid of meaningful detail on this major announcement, Congress is left entirely without crucial information.[7] It is unacceptable that you refused to provide a briefing to the Committee or answer any questions regarding this proposed reorganization and layoffs – after all, Congress must approve many of the decisions

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[2] Fierce Healthcare, *Federal Union Draws Up Lawsuit Over Trump EO as RFK Jr. Readies 10,000 HHS Cuts* (https://www.fiercehealthcare.com/regulatory/rfk-jr-prepares-10000-job-cuts-across-hhs-new-wave-worker-reductions) (Mar. 28, 2025).

[3] Reuters, *Exclusive: FDA Staff Struggle to Meet Product Review Deadlines After DOGE Layoffs* (Mar. 27, 2025) (https://www reuters.com/business/healthcare-pharmaceuticals/fda-staff-struggle-meet-product-review-deadlines-after-doge-layoffs-2025-03-27/).

[4] CBS News, *Top FDA Food Safety Official's Resignation Letter Warns Firings Will Backfire on RFK Jr.* (Feb. 20, 2025) (https://www.cbsnews.com/news/fda-food-safety-james-jones-resigns-warning-rfk-jr/).

[5] *Top F.D.A. Vaccine Official Resigns, Citing Kennedy's 'Misinformation and Lies',* The New York Times (Mar. 28, 2025).

[6] Centers for Disease Control and Prevention, *Measles Cases and Outbreaks* (Mar. 28, 2025) (https://www.cdc.gov/measles/data-research/index html#cdc_data_surveillance_section_5-yearly-measles-cases); Centers for Disease Control and Prevention, *H5 Bird Flu: Current Situation* (Mar. 28, 2025) (https://www.cdc.gov/bird-flu/situation-summary/index.html).

[7] Secretary Kennedy (@SecKennedy), X (Mar. 27, 2025, 9:00 AM) (x.com/SecKennedy/status/1905243470366670926).

that you proposed. It is simply unclear what authority allows you to make these sweeping changes without congressional approval, and you have not provided that information.

As former Director of FDA's Center for Biologics Evaluation and Research Peter Marks wrote in his resignation letter last week, "[I]t has become clear that truth and transparency are not desired by the Secretary, but rather he wishes subservient confirmation of his misinformation and lies."[8] We demand truth and transparency, and we therefore require that you provide written answers to the following requests by April 15 and provide a briefing for Committee staff shortly thereafter.

1. Please provide a detailed list of the roles being eliminated across HHS. For each, provide:

    a. The title of the role;

    b. The operating division and office in which that role currently exists;

    c. A description of that role;

    d. How the work being performed by that role will be reassigned;

    e. Whether that role is currently occupied, and if so, whether the individual in that role will be terminated from or reassigned in HHS;

    f. What date that termination or reassignment will occur; and

    g. The statutory authority that provides the basis for these mass terminations, as well as the statutory authority that provides the basis for eliminating entire operating divisions of HHS, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health resources and Services Administration (HRSA), which have detailed and specific statutory responsibilities laid out in the Public Health Service Act.

2. Please describe in detail the process by which you determined what roles would be eliminated and produce all supporting documentation. Include in your answer:

    a. The individuals involved in deciding which roles would be eliminated, including their title and the agency for which they work;

    b. The criteria used to determine what roles could be eliminated;

[8] *Top Vaccine Official Resigns from FDA, Criticizes RFK Jr. for Promoting 'Misinformation and Lies',* Associated Press (Mar. 29, 2025).

c. The process for deciding whether the work conducted by a role would be reassigned or eliminated entirely;

d. Any risk assessments involved in determining whether a role was necessary for public health and safety and the individuals involved in conducting and reviewing those assessments;

e. What feedback, if any, was sought by leaders within operating divisions and offices as part of the process;

f. What feedback, if any, was provided by individuals outside of HHS;

g. What feedback, review, or consultation was provided by non-governmental organizations, contractors, consultants, or other non-federal entities or employees; and

h. Any impact analyses conducted by HHS of the impact these terminations will have on the ability of each operating division to meet its statutory responsibilities to the American people.

3. A fact sheet circulated by HHS states that the elimination of roles at FDA "will not affect drug, medical device, or food reviewers, nor will it impact inspectors."[9] Please specify what is meant by the elimination of 3,500 roles at FDA not "affect[ing] reviewers" or "impact[ing] reviewers."

4. The fact sheet circulated by HHS states that the reduction of 1,200 individuals at NIH will result from "centralizing procurement, human resources, and communications across its 27 institutes and centers."[10] Please confirm that this means that no other staff aside from those in purely procurement, human resources, or communications roles will be eliminated from NIH. To the extent that this is not accurate, please detail what other roles will be eliminated and why those were not described in the fact sheet.

5. The fact sheet circulated by HHS states that "programs within the Administration for Community Living (ACL) that support older adults and people of all ages with disabilities will be split across the Administration for Children and Families (ACF), Assistant Secretary for Planning and Evaluation (ASPE), and Centers for Medicare and Medicaid Services (CMS)." Please clarify specifically which programs will be transferred to which agencies and whether HHS is eliminating ACL employees, programs, and/or functions as part of this action.

[9] U.S. Department of Health and Human Services, *Fact Sheet: HHS' Transformation to Make America Healthy Again* (Mar. 27, 2025) (press release).

[10] *Id.*

6. Please specify which five regional offices will be closed and the process for determining why regional offices should be closed and which ones should be closed.

7. Please specify which operating divisions will be eliminated or consolidated. For each, please specify which new or existing operating division(s) will be responsible for carrying out the eliminated or consolidated operation division's work.

If you have any questions about this request, please contact the Committee Democratic staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Diana DeGette
Ranking Member
Subcommittee on Health

Yvette D. Clarke
Ranking Member
Subcommittee on Oversight
and Investigations

cc: The Honorable Brett Guthrie
Chairman

The Honorable Buddy Carter
Chairman
Subcommittee on Health

The Honorable Gary Palmer
Chairman
Subcommittee on Oversight and Investigations

Congress of the United States
Washington, DC 20515

April 3, 2025

The Honorable Robert F. Kennedy Jr.
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Kennedy,

We write to express our grave concern at the recent actions by the Department of Health and Human Services (HHS) to freeze tens of millions of dollars in funding for the Title X program (Title X), the nation's only federal program dedicated to family planning. Freezing these funds will unquestionably result in the loss of health care for many of the millions of people that Title X supports annually, making our country less healthy.

For almost 50 years, Title X has served as a cornerstone of safety-net care. Championed by then-Congressman George H.W. Bush and signed into law by President Nixon, Title X allows a diverse network of providers to deliver high-quality care to low-income, uninsured, or underinsured individuals confidentially. Title X health centers served 2.8 million people in FY 2023, administering high-quality family planning and sexual health care, including cancer screenings, testing and treatment for sexually transmitted infections, contraceptive services and supplies, pregnancy testing, and other essential health care services. These centers offer care to populations that often face severe structural and systemic barriers to accessing quality health care, including individuals with no or insufficient insurance and rural and underserved communities.

Freezing funds for this essential program will harm communities that otherwise may not have access to care. In 2016, 60% of the women who received birth control from a Title X health center shared that it was their only source of health care the previous year. These health centers are also an essential resource for preventative care in the communities they serve. In 2023, the program provided cervical cancer screenings for more than 430,000 people, and for every dollar spent, these preventive and family planning services save at least seven dollars in later Medicaid expenses.[1] In addition to direct clinical care, Title X also supports critical infrastructure needs for health centers, including new medical equipment and staff training that are not reimbursable under Medicaid and commercial insurance. This infrastructure is vital to ensuring safe, high-quality care at health centers which serve and provide basic health services to underserved populations.

[1] Lord-Biggers, M. & Friedrich-Karnik, A. (2025, February). Features and Benefits of the Title X Program. Guttmacher Institute

We are outraged that reports suggest that this funding is being frozen because of claims that it might support "diversity, equity, and inclusion." This is another way of saying that this program is used to help people of color access care. Nearly half of the people served each year by Title X are people of color, the vast majority are people with low-incomes and most Title X users are women.[2] A federal program's ability to provide care to people from historically marginalized and underserved communities does not make it wrong or illegal. To suggest otherwise implies that HHS would determine who is worthy of taxpayer dollars based on the color of their skin. Congress created Title X to address the needs of underserved populations across our country, regardless of background, and it has demonstrated success in doing so for 50 years.

We urge you to restore all appropriated funding for Title X providers and instead invest fully in the program which has helped people access essential health care for almost 50 years.

On behalf of our 2.8 million constituents and women across the country who depend on Title X's services, we also request a prompt reply to coordinate a meeting on this matter. We look forward to introducing you to the providers, community leaders, and patients from our districts who understand better than anyone else the importance of this program. We hope your agency will not be so reckless as to upend nearly half a century of bipartisan achievement and place Title X on the DOGE chopping block without hearing firsthand the consequences of that action.

Sincerely,

Judy Chu
Chair, Contraception, Family Planning & Education Task Force
Reproductive Freedom Caucus

Diana DeGette
Co-Chair, Reproductive Freedom Caucus

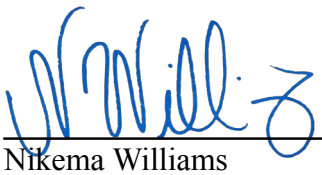
Ayanna Pressley
Co-Chair, Reproductive Freedom Caucus

Teresa Leger Fernández
Chair
Democratic Women's Caucus

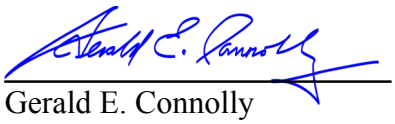
Lizzie Fletcher
Member of Congress

Sharice L. Davids
Member of Congress

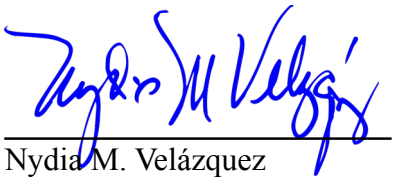
[2] Killewald, P., Leith, W., Paxton, N., Rosenthal, I., Troxel, J., Wong, M., & Zief, S. (2024, September). Family planning annual report: 2023 national summary. Office of Population Affairs, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services



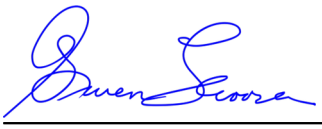
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Member of Congress



Gerald E. Connolly
Member of Congress



Nydia M. Velázquez
Member of Congress



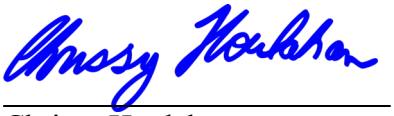
Gwen S. Moore
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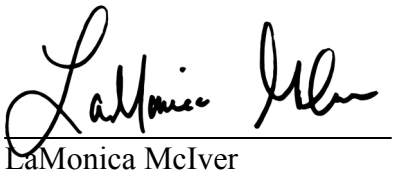
Dwight Evans
Member of Congress



Brad Sherman
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Chrissy Houlahan
Member of Congress



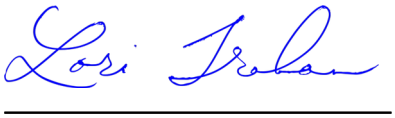
LaMonica McIver
Member of Congress



Rashida Tlaib
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Sydney Kamlager-Dove
Member of Congress



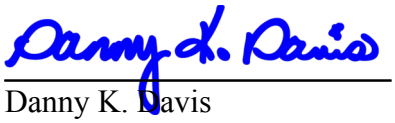
Lori Trahan
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Darren Soto
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Delia C. Ramirez
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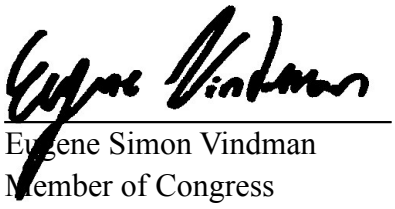
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Seth Moulton
Member of Congress



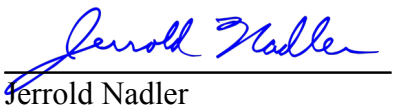
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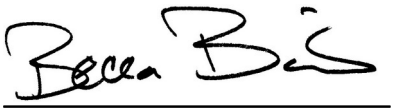
Eugene Simon Vindman
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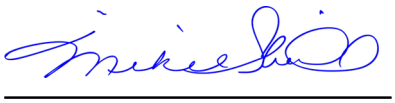
Marc A. Veasey
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Jerrold Nadler
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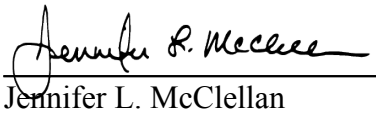
Becca Balint
Member of Congress



Mikie Sherrill
Member of Congress



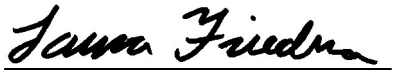
Madeleine Dean
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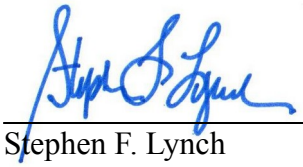
Jennifer L. McClellan
Member of Congress



Rick Larsen
Member of Congress



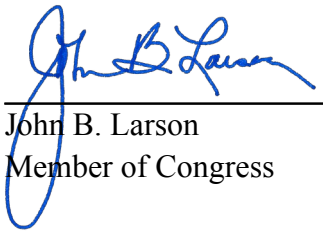
Laura Friedman
Member of Congress



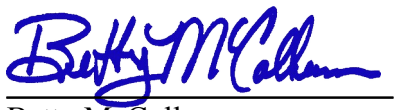
Stephen F. Lynch
Member of Congress



Joyce Beatty
National Leaders &
Advocacy Organizations
Liaison
Democratic Women's Caucus



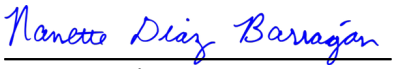
John B. Larson
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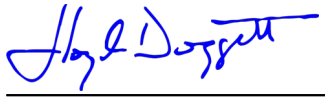
Betty McCollum
Member of Congress



Derek T. Tran
Member of Congress



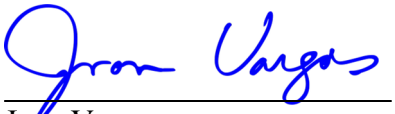
Nanette Diaz Barragán
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Lloyd Doggett
Member of Congress



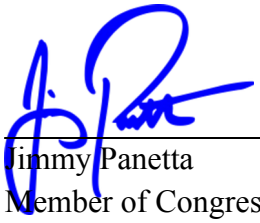
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Member of Congress



Juan Vargas
Member of Congress



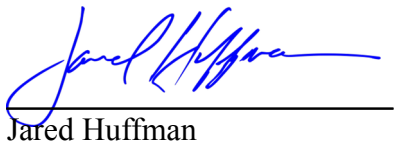
Eleanor Holmes Norton
Member of Congress



Jimmy Panetta
Member of Congress



Paul D. Tonko
Member of Congress



Jared Huffman
Member of Congress



Scott H. Peters
Member of Congress



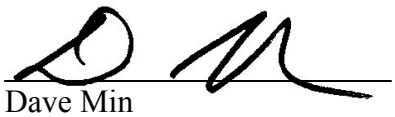
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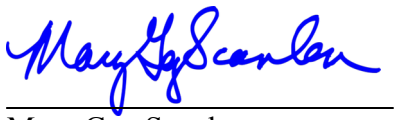
James P. McGovern
Member of Congress



Doris Matsui
Member of Congress



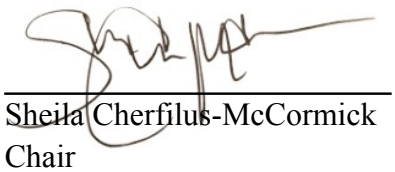
Dave Min
Member of Congress



Mary Gay Scanlon
Member of Congress



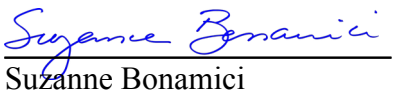
Emanuel Cleaver, II
Member of Congress



Sheila Cherfilus-McCormick
Chair
Global Women's Issues Task Force
Democratic Women's Caucus



Mark DeSaulnier
Member of Congress



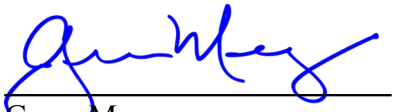
Suzanne Bonamici
Member of Congress



Terri A. Sewell
Member of Congress



Bonnie Watson Coleman
Member of Congress



Grace Meng
Member of Congress



Jake Auchincloss
Member of Congress



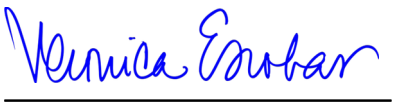
Dina Titus
Member of Congress



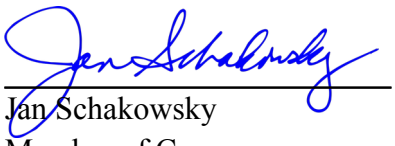
Lucy McBath
Member of Congress



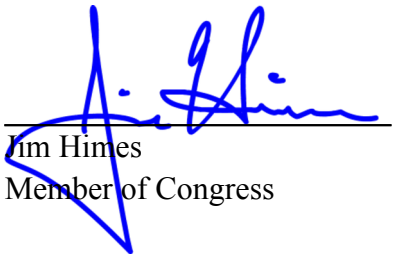
Emilia Strong Sykes
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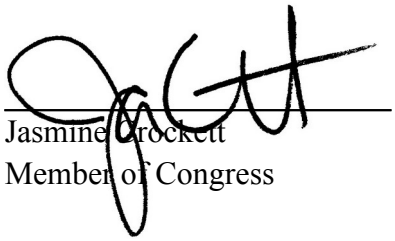
Veronica Escobar
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Jan Schakowsky
Member of Congress



Jim Himes
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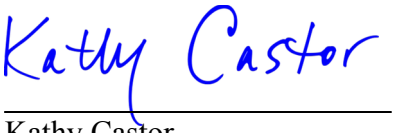
Jasmine Crockett
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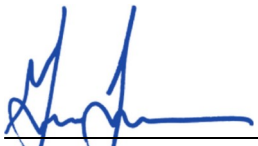
Kevin Mullin
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Joseph D. Morelle
Member of Congress



Kathy Castor
Member of Congress



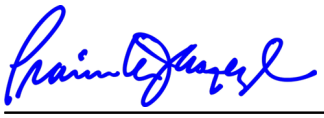
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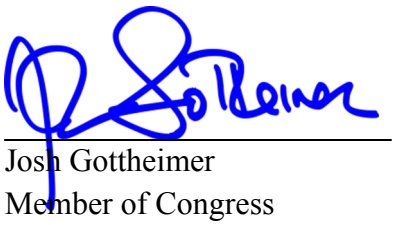
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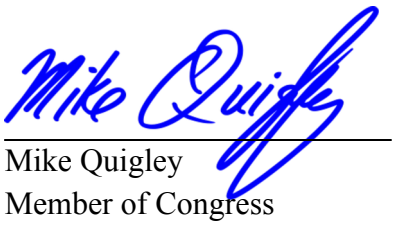
Zoe Lofgren
Member of Congress



Pramila Jayapal
Congressional Asian Pacific American Caucus Liaison
Democratic Women's Caucus



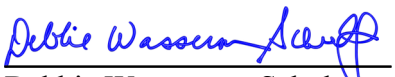
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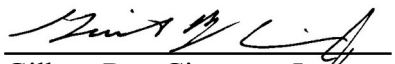
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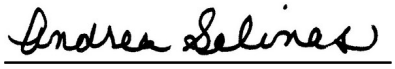
Marilyn Strickland
Member of Congress



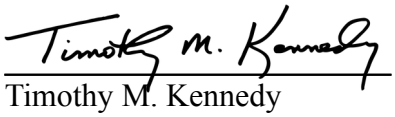
Debbie Wasserman Schultz
Member of Congress



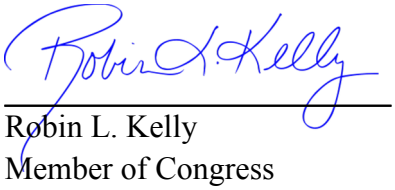
Gilbert Ray Cisneros, Jr.
Member of Congress



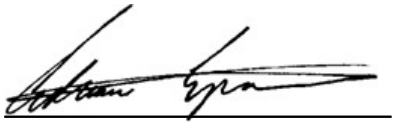
Andrea Salinas
Congressional Hispanic
Caucus Liaison
Democratic Women's Caucus



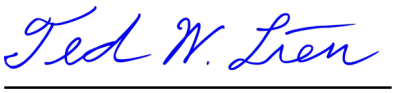
Timothy M. Kennedy
Member of Congress



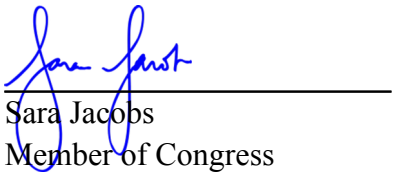
Robin L. Kelly
Member of Congress



Adriano Espaillat
Member of Congress



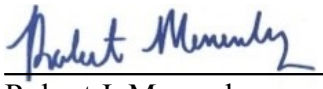
Ted W. Lieu
Member of Congress



Sara Jacobs
Member of Congress



Sarah McBride
Member of Congress



Robert J. Menendez
Member of Congress



Alexandria Ocasio-Cortez
Member of Congress



Luz M. Rivas
Member of Congress



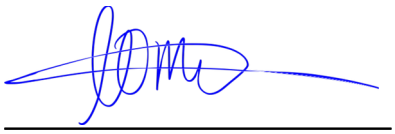
Jim Costa
Member of Congress



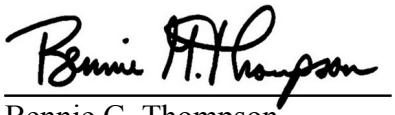
Ritchie Torres
Member of Congress



Ami Bera, M.D.
Member of Congress



Ilhan Omar
Member of Congress



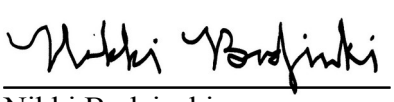
Bennie G. Thompson
Member of Congress



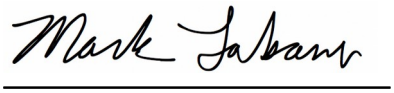
Seth Magaziner
Member of Congress



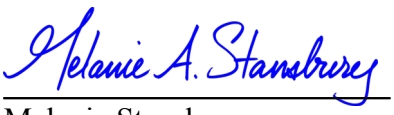
Lois Frankel
Member of Congress



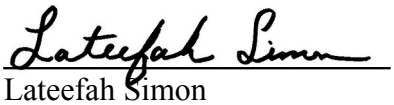
Nikki Budzinski
Member of Congress



Mark Takano
Member of Congress



Melanie Stansbury
Member of Congress



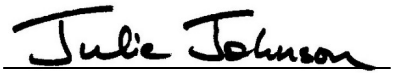
Lateefah Simon
Member of Congress



Chris Pappas
Member of Congress



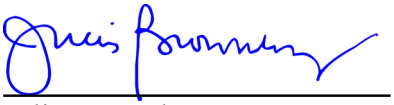
Mike Thompson
Member of Congress



Julie Johnson
Member of Congress



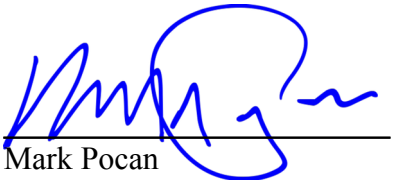
Shri Thanedar
Member of Congress



Julia Brownley
Member of Congress



Kelly Morrison
Member of Congress



Mark Pocan
Member of Congress



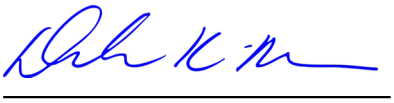
Summer L. Lee
Member of Congress



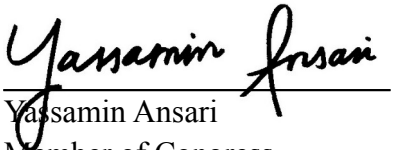
Lauren Underwood
Member of Congress



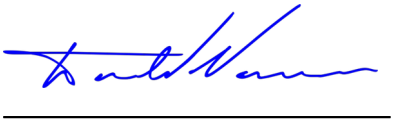
Maxine Dexter
Member of Congress



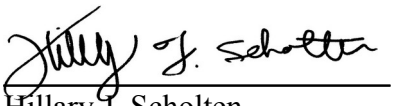
Deborah K. Ross
Member of Congress



Yassamin Ansari
Member of Congress



Donald Norcross
Member of Congress



Hillary J. Scholten
Member of Congress



Raul Ruiz, M.D.
Member of Congress



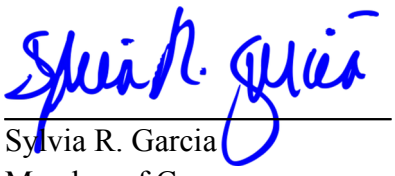
Salud Carbajal
Member of Congress



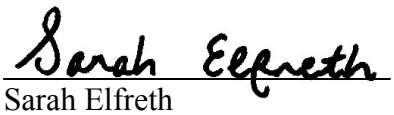
Ro Khanna
Member of Congress



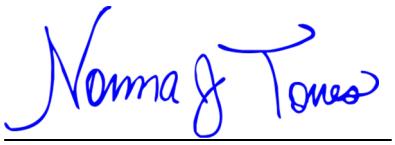
Angie Craig
Member of Congress



Sylvia R. Garcia
Member of Congress



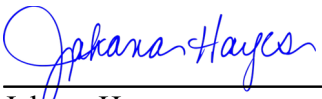
Sarah Elfreth
Member of Congress



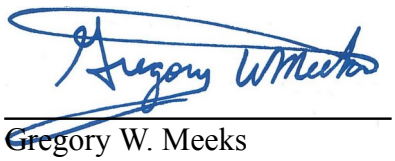
Norma J. Torres
Member of Congress



Henry C. "Hank" Johnson, Jr.
Member of Congress



Jahana Hayes
Member of Congress



Gregory W. Meeks
Member of Congress



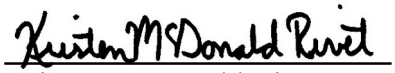
George Latimer
Member of Congress



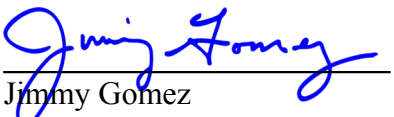
André Carson
Member of Congress



Val Hoyle
Member of Congress



Kristen McDonald Rivet
Member of Congress



Jimmy Gomez
Member of Congress



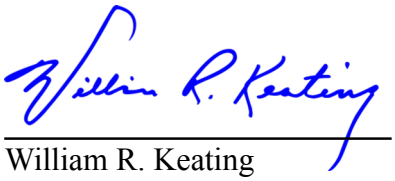
Maggie Goodlander
Member of Congress



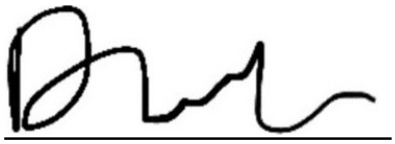
Gabe Amo
Member of Congress



Shontel M. Brown
Member of Congress



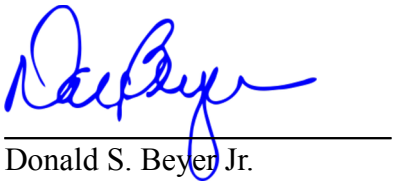
William R. Keating
Member of Congress



Dan Goldman
Member of Congress



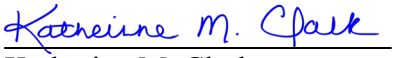
Suhas Subramanyam
Member of Congress



Donald S. Beyer Jr.
Member of Congress



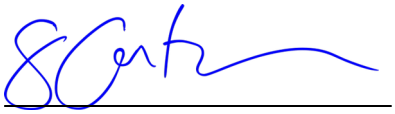
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Member of Congress



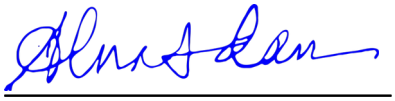
Katherine M. Clark
Member of Congress



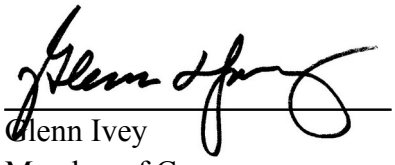
Ed Case
Member of Congress



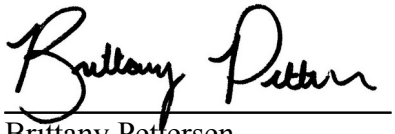
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Member of Congress



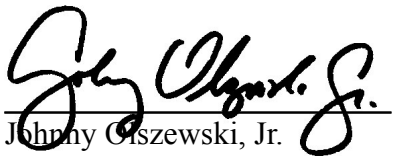
Alma S. Adams, Ph.D.
Member of Congress



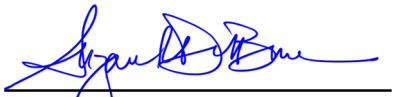
Glenn Ivey
Member of Congress



Brittany Pettersen
Member of Congress



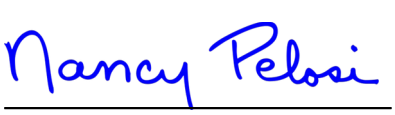
Johnny Olszewski, Jr.
Member of Congress



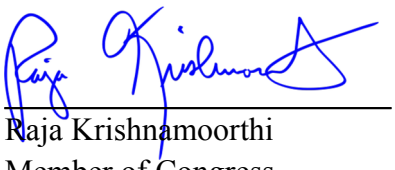
Suzan K. DelBene
Member of Congress



Debbie Dingell
Member of Congress



Nancy Pelosi
Member of Congress



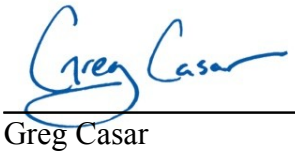
Raja Krishnamoorthi
Member of Congress



Chris Deluzio
Member of Congress



Bradley Scott Schneider
Member of Congress



Greg Casar
Member of Congress



John Garamendi
Member of Congress



Wesley Bell
Member of Congress



Maxwell Alejandro Frost
Member of Congress



Robert C. "Bobby" Scott
Member of Congress



Mike Levin
Member of Congress



Valerie P. Foushee
Member of Congress



Joe Courtney
Member of Congress



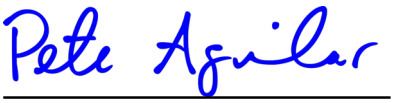
Bill Foster
Member of Congress



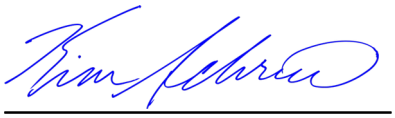
Al Green
Member of Congress



Steve Cohen
Member of Congress



Pete Aguilar
Member of Congress



Kim Schrier, M.D.
Member of Congress



Troy A. Carter, Sr.
Member of Congress

Congress of the United States

Washington, DC 20515

April 10, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Lori Chavez-DeRemer
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Dear Secretaries Kennedy and Chavez-DeRemer,

We are deeply concerned that the reckless and extreme immigration policies of the Trump Administration could cause long-term damage to our health care system, especially access to long-term services and supports for older adults and people with disabilities, which are provided by direct care workers. Immigrant workers have long been essential to this workforce, making up nearly 30 percent of all direct care workers in the U.S., and over 50 percent in some states.[1] However, under the Trump Administration, immigrants - including many who were in the country legally - have been forced out of their jobs, ripped away from their families and communities, and deported to potentially violent situations. This type of cruelty serves no one and threatens to destabilize the economy and the health care system that millions of Americans rely upon. We urge you, as Secretaries of the Department of Health and Human Services and of the Department of Labor, to protect access to long-term services and supports and the immigrants who provide this essential care every day.

For years, both parties in the House and Senate have warned of the direct care workforce shortage and its potential impacts on access to long-term care.[2] Between 2022 and 2032, there will be an estimated 8.9 million total direct care job openings,[3] making this the fastest growing occupation in the country.[4] Demand is also expected to increase by up to 41 percent between 2022 and 2037.[5] Furthermore, the number of Americans turning 65 and older this decade has outpaced the growth of working-age adults,[6] and as a result, there will be

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[1] "Growing Demand for Direct Care Workers Underscores Pressing Need to Address Job Quality Challenges," PHI, (September 2, 2024), https://www.phinational.org/growing-demand-for-direct-care-workers-underscores-pressing-need-to-address-job-quality-challenges/; "New York State's Direct Care Workforce," PHI, (January 10, 2023), https://www.phinational.org/resource/new-york-states-direct-care-workforce-2/.

[2] For example, at a House Energy & Commerce hearing on October 25, 2023, former Chair Cathy McMorris Rodgers (R-WA) delivered the following opening remarks: "Since 2020, we've lost tens of thousands of workers across both HCBS and nursing home settings, as workers left the field due to burnout or in pursuit of other career opportunities. While these stressors were present in the long-term care field prior to the pandemic, they've gotten worse, even as other parts of the health care field begin to return to pre-pandemic employment levels. The future of care for seniors and people with disabilities depends on us finding ways to support long-term care workers." See full remarks for this House Energy and Commerce Committee hearing, https://energycommerce house.gov/posts/chair-rodgers-opening-remarks-at-health-hearing-on-long-term-care-workforce. In addition, former Chair Bob Casey (D-PA) discussed this issue at a Senate Aging Committee hearing on April 16, 2024: "We wouldn't have long-term care services without the long-term care workforce. Unfortunately, the workforce that provides this critical care has long been in crisis. Between 50 to over 90 percent of long-term care settings and providers report significant staffing shortages, affecting their ability to provide services, accept new clients, or even to remain open." See full remarks, https://www.aging.senate.gov/imo/media/doc/78acd1e5-9076-9816-cdd0-f46fe9bc4454/Opening Statement_Casey 04.16.24.pdf.

[3] *Supra,* note 1; Note: This is after accounting for occupational transfers and labor force exits.

[4] *Id*.

[5] "Workforce Projections," Health Resources and Services Administration, (March 25, 2025), https://data hrsa.gov/topics/health-workforce/workforce-projections.

[6] Luke Rogers and Kristie Wilder, "Shift in Working-Age Population Relative to Older and Younger Americans," U.S. Census Bureau, (June 25, 2020), https://www.census.gov/library/stories/2020/06/working-age-population-not-keeping-pace-with-growth-in-older-americans.html.

fewer potential direct care workers available to support our aging population. Given these demographic changes, we cannot rely on the U.S.-born workforce alone to meet the nation's caregiving needs.

The consequences of workplace shortages can devastate families. For one, staffing shortages in nursing homes have been shown to be associated with increased deaths of nursing home residents.[7] Inadequate staffing is also the cause of egregious gaps in care—nursing home residents have reported being left soiled in bed for hours, being chemically and physically restrained, and suffering from painful pressure sores and falls because there is not enough staff to care for all residents.[8]

Efforts by this Administration to deport immigrants and curb immigration will aggravate the current workforce shortage and hurt the millions of Americans who need long-term services and supports. Without the vital help of immigrant direct care workers, millions across the country will receive lower quality of care or lose access to care altogether, while others may have to rely on unpaid family caregivers, who are predominantly women, for support. This would have broad economic implications. Family caregivers may be forced to leave the workforce or reduce their work hours in order to provide care,[9] jeopardizing their financial security. Family caregivers already lose an estimated $522 billion in wages each year due to caregiving, while employers lose $33 billion per year due to their employees' caregiving roles—these economic losses would no doubt increase if the direct care workforce shortage worsens.[10] Caregiving has always been a cornerstone of our economy – caregiving makes all other work possible. Counter to the Administration's plans, patients, long-term care providers, and advocates have been calling for creating a legal pathway for immigrant care workers who are already living and working in the U.S. and an *increase* in immigration to address severe workforce shortages and prepare for the expected surge in demand due to our aging population.[11]

Given the significant impact that threats of deportation and actions to reduce immigration would have on the nation's long-term care system, we ask that you provide written responses to the following questions no later than Wednesday, April 23, 2025:

1. Did the Department of Health and Human Services and the Department of Labor provide guidance to the Department of Homeland Security regarding the overall risks that deportations would pose to Americans' long-term care?
    a. If yes, please provide a copy of all guidance.
    b. If not, please explain why your agencies did not consult with the Department of Homeland Security.

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[7] Joshi S. Staffing Shortages, Staffing Hours, and Resident Deaths in US Nursing Homes During the COVID-19 Pandemic. J Am Med Dir Assoc. 2023 Aug;24(8):1114-1119. doi: 10.1016/j.jamda.2023.04.020. Epub 2023 May 8. PMID: 37253431; PMCID: PMC10165011. https://www.jamda.com/article/S1525-8610(23)00411-5/pdf.

[8] Jordan Rau, "Why Nursing Home Residents Still Suffer Despite Tough State Laws," The New York Times, (July 12, 2024), https://www.nytimes.com/2024/07/12/health/nursing-home-staffing-patients html.

[9] Elizabeth Harrington and Bill McInturff, "Working While Caring: A National Survey of Caregiver Stress in the U.S. Workforce: Key Findings," Rosalynn Carter Institute for Caregivers and Public Opinion Strategies, (September 28, 2021), https://rosalynncarter.org/wp-content/uploads/2021/09/210140-RCI-National-Surveys-Executive-Summary-Update-9.22.21.pdf.

[10] 2022 National Strategy to Support Family Caregivers, Administration for Community Living, (September 21, 2022), https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyToSupportFamilyCaregivers.pdf, at 13.

[11] Kimberly Bonvissuto, "Immigration reform imperative to addressing workforce shortages in long-term care," McKnights Senior Living, (October 30, 2024), https://www.mcknightsseniorliving.com/news/immigration-reform-imperative-to-addressing-workforce-shortages-in-aging-services/.

2. The U.S. is falling behind our international counterparts who have created immigration pathways for international care workers as a solution for their labor shortages.[12] How is the Administration working with employers and unions to create and implement similar pathways to ease the labor shortage while protecting workers?
3. How does the Administration plan to address the massive workforce shortage that will worsen if immigration is curbed and immigrant workers are deported? Are there plans to increase recruitment, training, and pay for direct care workers?
4. President Trump has authorized immigration officers to make arrests in sensitive locations, including schools, churches, and health care facilities.[13] Was the Department of Health and Human Services and the Department of Labor involved in evaluating the impact these new enforcement policies would have on the immigrants that work in health care settings and long-term care facilities, as well as the patients that they serve?
    a. Which stakeholder groups did the Department of Health and Human Services and the Department of Labor meet with to discuss the potential impacts of its new enforcement policies, including groups that represent immigrants, patients, family caregivers, older adults, people with disabilities, the health care workforce, and the health care industry?
    b. If the Department of Health and Human Services and the Department of Labor did not meet with organizations representing immigrants, patients, family caregivers, older adults, people with disabilities, the health care workforce, and the health care industry to evaluate the potential impacts of its enforcement policies, please explain why.

Sincerely,

Alexandria Ocasio-Cortez
Member of Congress

Debbie Dingell
Member of Congress

Diana DeGette
Member of Congress

Jan Schakowsky
Member of Congress

[12] Gabriele Vogt, "Japan tentatively opens its doors to international care workers," bpb, (December 14, 2023), https://www.bpb.de/themen/migration-integration/regionalprofile/english-version-country-profiles/543654/japan-tentatively-opens-its-doors-to-international-care-workers/.

[13] Ximena Bustillo and Sergio Martínez-Beltrán, "Trump administration strips schools, churches of immigration enforcement protections," (January 21, 2025), https://www.npr.org/2025/01/21/nx-s1-5269899/trump-immigration-enforcement-schools-churches. Note: On February 24, 2025, the U.S. District Court of Maryland issued an order blocking immigration enforcement operations in places of worship. See https://democracyforward.org/updates/judge-blocks-ice-enforcement-in-houses-of-worship/.

Paul D. Tonko
Member of Congress

Yvette D. Clarke
Member of Congress

Marc A. Veasey
Member of Congress

Robin L. Kelly
Member of Congress

Nanette Diaz Barragán
Member of Congress

Robert J. Menendez
Member of Congress

Grace Meng
Member of Congress

Eleanor Holmes Norton
Member of Congress

Henry C. "Hank" Johnson, Jr.
Member of Congress

Rashida Tlaib
Member of Congress

James P. McGovern
Member of Congress

Mark Pocan
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Dwight Evans
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Robert Garcia
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Yassamin Ansari
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Gerald E. Connolly
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Member of Congress

Jasmine Crockett
Member of Congress

Shri Thanedar
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Jesús G. "Chuy" García
Member of Congress

Judy Chu
Member of Congress

Dan Goldman
Member of Congress

Sylvia R. Garcia
Member of Congress

Pramila Jayapal
Member of Congress

Jerrold Nadler
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CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives

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Majority (202) 225-3641
Minority (202) 225-2927

April 10, 2025

The Honorable Robert Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20024

The Honorable Susan Monarez, Ph.D.
Acting Director
U.S. Centers for Disease Control and Prevention
400 7th Street SW
Washington, D.C. 20024

Dear Secretary Kennedy and Director Monarez:

I am writing to express my urgent concern with the Department of Health and Human Services' (HHS) reported selection of a biased and discredited individual, Mr. David Geier, to lead a large, redundant, wasteful study retreading settled science on links between vaccines and autism spectrum disorder (ASD). Mr. Geier has been a central figure in a decades-long campaign of pushing falsehoods about vaccine safety, including a retracted study on the measles, mumps and rubella vaccine (MMR).[1] Mr. Geier's documented lapses in judgment, ethics, and expertise degrades the American people's trust in reliable, science-based information to protect their public health.

[1] *See* American Academy of Pediatrics, *AAP President: Undermining Research on Vaccines, Autism 'Poses a Threat' to Children's Health* (Mar. 26, 2025) (https://publications.aap.org/aapnews/news/31704/AAP-president-Undermining-research-on-vaccines?searchresult=1?autologincheck=redirected); Autistic Self Advocacy Network, *ASAN Appalled by Hiring of Quack David Geier for HHS Study* (Mar. 26, 2025) (https://autisticadvocacy.org/2025/03/asan-appalled-by-hiring-of-quack-david-geier-for-hhs-study/); National Library of Medicine, *Lancet Retracts 12-Year Old Article Linking Autism to MMR Vaccines* (Feb. 4, 2010). Left Brain Right Brain, *Looking Back at Two Decades of Geier* (Oct. 20, 2025) (https://leftbrainrightbrain.co.uk/2013/10/20/looking-back-at-two-decades-of-geier/?fbclid=IwY2xjawJQ5ulleHRuA2FlbQIxMAABHcLk0UqrSGzyIsYfItMJD38ZOtPWb0Ed0ztstw9kVCSGTUVdfSFlbPVIuQ_aem_4pp7lKU9wDM9u9nuipGIeg).

Mr. Geier's selection is particularly shocking considering his troubling history of misrepresenting his medical credentials—or, more pointedly, lack thereof. In 2012, Mr. Geier was found liable by the Maryland State Board of Physicians for practicing medicine at his father's clinic without a license, a claim that was later affirmed by the Circuit Court for Montgomery County and upheld by the Maryland Court of Special Appeals.[2] In 2008, Mr. Geier—who is not a doctor—impermissibly diagnosed a 13-year-old child with insomnia, metabolic disorders, and a non-specified, pervasive, developmental delay—diagnoses that the Board of Physicians characterized as "medically unintelligible."[3] The Board also found that Mr. Geier falsified his father's signature on a set of laboratory orders, misrepresented his credentials on his curriculum vitae, and minimized his role at his father's medical clinic before the Board.[4] Mr. Geier was further charged with acting as an unlicensed physician in the assessments of an eight-year-old and two nine-year-old patients.[5] All the while, he touted Lupron injections—a drug that, at multiple, high doses is used to chemically castrate sex offenders—as a "miracle drug" for autism, even as experts in childhood endocrinology caution its implications on hormonal development.[6] This Administration's decision to task Mr. Geier with a study on childhood vaccinations is shocking and dangerous in light of his repeated, impermissible misrepresentations in his interactions with children and families.

Mr. Geier is patently unqualified to conduct research on vaccines. He did not go to medical school and has no other medical training.[7] Courts have called his claims about vaccines and autism "worthless" and have dismissed him as "not qualified to serve as a consultant" on medical issues pertaining to routine vaccine injury claims.[8] His previous papers linking hepatitis B vaccines to atypical autism and obesity have been described as lacking the most basic methodological rigor; they have been dismissed as rife with "spurious association[s]" rendering them "completely invalid" and "fatally flawed."[9] One of Mr. Geier's studies, initially published in *Science and Engineering Ethics*, was later retracted due to "mistakes of various types that raise concerns about the validity of the conclusion" and the authors' failure to meaningfully disclose conflicts of interest related to their roles in vaccine-related litigation.[10] Meanwhile, the Autistic Self Advocacy Network, a coalition of advocates run by and for autistic people, shared

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[2] *Geier vs. Maryland Board of Physicians*, 225 Md. 114 (2014).

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Autism Regimen Stirs Controversy,* The Los Angeles Times (May 24, 2009).

[7] Hooker v. HHS, No. 02-472V, Slip Op., 1-37 (Office of Special Master Apr. 11, 2017).

[8] *Id.;* Riggins v. HHS, No. 99–382V, 2009 WL 3319818, at *6–7 (Fed. Cl. Spec. Mstr. June 15, 2009); King v. HHS, 2010 WL 5470787, at *20.

[9] Prof Jeffrey S Morris (@jsm2334), X (Mar. 26, 2025, 10:07 AM) (https://x.com/jsm2334/status/1904898109412454650).

[10] National Library of Medicine, *Systematic Assessment of Research on Autism Spectrum Disorder and Mercury Reveals Conflicts of Interest and the Need for Transparency in Autism Research* (Oct. 27, 2015).

that Mr. Geier's appointment represents a "move towards conspiracy theories and junk science [that] puts all our lives at risk."[11] In light of this, HHS's reported decision to appoint Mr. Geier to lead a national study on vaccination—amidst a developing measles outbreak fueled by unvaccinated individuals, no less—defies reason.

Your decision to direct agency resources to conduct this study—considering long-established scientific consensus affirming no link between vaccines and ASD—is particularly appalling amidst your abrupt termination of significant federal resources to state public health agencies. [12] Meanwhile, HHS is recklessly eliminating some of the most credentialed and experienced medical experts in the country.[13] Amidst a measles outbreak in at least 21 states and the District of Columbia, affecting over 600 adults and children, and resulting in the death of two children—a six year old and an eight year old—and, likely, an unvaccinated adult, the gap between your priorities and the health of the American people is stark.[14]

In order to understand what, if any, justification you have for conducting this study and retaining Mr. Geier to conduct or otherwise be involved with this study, please provide written responses to the below questions by April 24.

1. What is the scope and methodology of the proposed study?

2. Which HHS leaders, operating divisions, and contracting entities are involved in carrying out this study?

3. How, if at all, did HHS consider Mr. Geier's liability under Maryland's unlicensed medical practice laws in selecting him to lead this study?

4. How, if at all, did HHS consider the courts' repeated findings that Mr. Geier's research is unfounded in selecting him to lead this study?

5. How, if at all, did HHS consider Mr. Geier's unfounded promotion of Lupron—a hormone suppressant—as an autism cure in selecting him to lead this study?

6. Will Mr. Geier's study be subject to peer review? If so, who will be conducting the review?

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[11] *See* note 1.

[12] *Trump Administration Says It Will Pull Back Billions in COVID Funding from Local Health Departments,* Associated Press (Mar. 26, 2025).

[13] U.S. Department of Health and Human Service, *Fact Sheet: HHS' Transformation to Make America Healthy Again* (Mar. 27, 2025).

[14] Centers for Disease Control and Prevention, *Measles Cases and Outbreaks* (Apr. 4, 2025) (https://www.cdc.gov/measles/data-research/index html); *A Second Texas Child has Died from Measles; RFK Jr. Visits*, The Texas Tribune (Apr. 6, 2025); *Measles Case Confirmed in DC with Exposures on Amtrak, in Health Clinic*, NBC4 Washington (Mar. 25, 2025).

7. What is Mr. Geier's budget to carry out this study? Where are these dollars being allocated from?

If you have any questions about this request, please contact the Committee Democratic staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Diana DeGette
Ranking Member
Subcommittee on Health

Yvette D. Clarke
Ranking Member
Subcommittee on Oversight
and Investigations

cc: The Honorable Brett Guthrie
Chairman

The Honorable Earl "Buddy" Carter
Chairman
Subcommittee on Health

The Honorable Gary Palmer
Chairman
Subcommittee on Oversight and Investigations

Congress of the United States
Washington, DC 20515

April 11, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: CMS Marketplace Integrity and Affordability Proposed Rule, CMS-9884-P

Dear Secretary Kennedy and Administrator Oz:

We write to express our alarm regarding the detrimental impact the harmful policies included in the 2025 Marketplace Integrity and Affordability Proposed Rule (the Proposed Rule), released on March 10, 2025, will have on millions of hard-working Americans.[1] The Trump Administration is proposing policies that, by its own estimates, will raise premiums by almost $3 billion over the next four years and result in two million Americans losing coverage through the Marketplaces in 2026; even that may be an underestimate, given the $364 million in administrative burden consumers will face.[2] As these policies threaten access to health care services for millions of Americans, we call on you to withdraw the Proposed Rule immediately and cease all other efforts to sabotage the *Affordable Care Act* (ACA). This Proposed Rule is detrimental to all Americans who purchase health coverage on their own by 1) threatening access to coverage, 2) making it harder for people to enroll, and 3) increasing consumer costs.

The Proposed Rule takes away insurance from working Americans

Policies in the Proposed Rule will result in two million Americans who purchase insurance on their own losing coverage through the Marketplaces in 2026—on top of the nearly four million Americans who will lose coverage if Republicans in Congress fail to extend the

[1] Department of Health and Human Services, Center for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,* 90 Fed. Reg. 12942 (Mar. 19, 2025) (proposed rule).

[2] *Id.* at 13018; *Id.* at 13002; *Id.* at 13003; *Id.* at 12945.

enhanced tax credits available until the end of this year under the Inflation Reduction Act.[3] In fact, as noted in the Proposed Rule, "this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule."[4] Such coverage losses are expected to particularly hit nine states—Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah—resulting from:

1. New restrictions on the lowest income individuals purchasing coverage on their own (largely in states that did not expand Medicaid);

2. New bureaucratic red tape; and

3. Increased out-of-pocket costs resulting from policies that reduce financial help, raise premiums, and harm the risk pool.

These changes are self-imposed policy choices the Administration is making in the name of "fraud" and are both wrong and harmful to millions of people.

The Proposed Rule makes it harder for individuals and families purchasing coverage on their own to access coverage

The Proposed Rule adds red tape to enrolling in coverage—more than *six million* hours of paperwork.[5] New income verification rules and restrictions on enrollment mean that lower income individuals will no longer be able to access coverage in states that did not expand Medicaid. Specifically, we oppose the following policies.

Shortening the open enrollment period

The proposal to shorten the annual open enrollment period by one month will undermine enrollment and destabilize the individual market that millions of Americans rely on. Longer open enrollment periods increase access to quality health coverage by ensuring individuals have the opportunity to assess their needs and enroll in the right plan.[6] The proposal to shorten the open-enrollment period fits within a pattern of Administration efforts to depress enrollment and

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[3] Letter from Phillip L. Swagel, Director, Congressional Budget Office, to Sen. Ron Wyden, Chairman, Senate Committee on Finance; Rep. Richard Neal, Ranking Member, House Committee on Ways and Means; Sen. Jeanne Shaheen; Rep. Lauren Underwood (Dec. 5, 2024).

[4] Department of Health and Human Services, Center for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,* 90 Fed. Reg. 12942 at 13025 (Mar. 19, 2025) (proposed rule).

[5] *Id.* at 13003.

[6] Center on Budget and Policy Priorities, *Broadening Marketplace Enrollment Periods Would Boost Access to Health Coverage* (Apr. 19, 2021) (https://www.cbpp.org/research/health/broadening-marketplace-enrollment-periods-would-boost-access-to-health-coverage).

sabotage the ACA. Just two months ago, the Administration announced its decision to cut funding for the ACA Navigator program by approximately 90 percent.[7] The ACA's Navigator program provides funding to nonprofits and health care organizations to promote awareness and provide in-person assistance to consumers with Marketplace enrollment. Shortening the open enrollment period coupled with drastic reduction in Navigator funding will depress Marketplace enrollment and raise premiums for millions of consumers.[8]

Eliminating special enrollment periods that help low-income families

The proposal to eliminate the Biden Administration policy establishing a monthly special enrollment period (SEP) for individuals at or below 150 percent of the federal poverty level (FPL) will harm people who experience job changes or income fluctuations. This policy expanded enrollment and reduced the potential for adverse selection, increasing access to coverage for low-income individuals, particularly consumers transitioning from Medicaid or the Children's Health Insurance Program (CHIP) into Marketplace coverage.[9] Eliminating the monthly SEP will make it harder for the lowest income families to enroll in coverage.

Creating unnecessary enrollment verification requirements

The Proposed Rule also includes several policies related to enrollment verification, which the rule admits will establish enrollment barriers and deter Marketplace enrollment. The proposal to require pre-enrollment verification of eligibility for SEPs across all Marketplaces, and the proposal to require that Marketplaces, including state Marketplaces, verify eligibility for at least 75 percent of new enrollments through SEPs, would create barriers to coverage and increase consumer burden. Pre-enrollment SEP verification contributes to a higher uninsured rate and disproportionately has a negative impact on Black American consumers who submit verification documentations at much lower rates than White consumers.[10]

Eliminating DACA eligibility

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[7] Centers for Medicare & Medicaid Services, *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025) (https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding).

[8] *Id.:* in February 2025, CMS announced an approximately 90 percent reduction in funding for the ACA Navigator program, which provides funding to nonprofits and health care organizations to promote awareness and provide in-person assistance to consumers with Marketplace enrollment. Navigators serve a crucial role in reducing the uninsured rate because their efforts target individuals who may need extra assistance with the enrollment process.

[9] Centers for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program* (CMS-9895-F).

[10] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023*, 87 Fed. Reg. 584 (Jan. 5, 2022) (proposed rule).

We strongly oppose the Administration's decision to eliminate Marketplace eligibility for 11,000 Deferred Action for Childhood Arrivals (DACA) recipients. Under the ACA, individuals qualify for Marketplace coverage if they are a "citizen or national of the United States or . . . lawfully present in the United States."[11] As the Department of Health and Human Services (HHS) previously outlined, including DACA recipients in the definition of "lawfully present" supports the goal of the ACA by making health insurance available to more people and aligns with the longstanding definition that the Department of Homeland Security (DHS) has used for purposes of applying for Social Security benefits.[12] The cruel decision to eliminate coverage for these individuals will raise premiums across the board—DACA recipients tend to be younger and healthier—and particularly harm states with the greatest number of DACA recipients enrolled: California (28 percent), Texas (17 percent), Illinois (5 percent), and Florida and New York (4 percent each).[13]

The Proposed Rule needlessly increases health care costs for individuals and saddles states with administrative costs

Multiple policies in the Proposed Rule will raise costs for consumers, including increasing premiums and cost-sharing, reducing the tax credit that helps make coverage affordable, and increasing the amount of time it takes people to get enrolled in coverage.

Imposing nuisance fees and higher deductibles for automatically re-enrolled individuals

The Proposed Rule includes a policy that would require millions of people who are automatically reenrolled in zero-dollar premium plans to pay a nuisance fee—a $5 monthly premium—until they confirm or update information. Both auto-enrollment and zero-premium plans are meant to support lower income workers and their families. Even a nominal fee applied to this population could be enough to make it impossible to continue to afford health coverage. Based on the Administration's own estimates, this policy would have affected nearly 2.7 million enrollees if it was in effect in 2025.[14]

The Proposed Rule would also end a policy that lowers out-of-pocket costs and improves coverage for automatically re-enrolled individuals. Right now, an individual who would automatically be re-enrolled in a bronze plan can be moved to a higher quality silver plan if the premium is the same or lower, while retaining their insurer and network. Eliminating this policy

[11] 42 U.S.C. § 18081(a)(1).

[12] Centers for Medicare & Medicaid Services, *Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program*, 89 Fed. Reg. 39392 (May 8, 2024) (final rule).

[13] Kaiser Family Foundation, *Key Facts on Deferred Action for Childhood Arrivals (DACA)* (Feb. 11, 2025) (https://www kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/).

[14] *See* note 1.

under the guise of "consumer choice" would only harm consumers by preventing them from accessing better coverage at a lower cost.

Creating unnecessary income verification requirements

The Proposed Rule includes multiple policies related to income verification that will increase consumer burden and kick people off coverage for which they are eligible. One policy would halt enrollment when Internal Revenue Service (IRS) tax data shows recent income below 100 percent FPL, while a second policy would halt enrollment when no IRS data are available. These changes would mostly harm individuals with variable or unpredictable incomes—such as lower income individuals, small business owners, and self-employed individuals—by making enrollment less efficient and increasing paperwork burden. Consumers will spend an estimated 15 million hours at a cost of $364 million responding to income verification requests and eligibility determinations, according to the Proposed Rule.[15] As a result of the substantial increase in burden, fewer healthy people would enroll, worsening the risk pool, and raising premiums for everyone.

Reducing the quality of health coverage insurance companies must provide

The Proposed Rule includes a policy that changes the methodology for determining the premium adjustment percentage (PAPI), which is used annually to update the limit on maximum out-of-pocket costs and determine tax credit amounts and payments by employers. The new methodology would increase the PAPI for 2026 by 4.5 percent, resulting in higher out-of-pocket costs for commercially insured Americans—including those with employer-sponsored insurance—and lower tax credits for individuals purchasing coverage on their own. The Centers for Medicare & Medicaid Services (CMS) estimates this change will increase consumer out-of-pocket costs and premiums by 4.5 percent.[16]

The Proposed Rule also includes changes to the allowable variation in actuarial value (AV) that would allow insurance companies to cover fewer health services by allowing for more variation from AV standards for each metal tier of coverage on the Marketplace. These changes will allow insurers to offer weaker coverage that reduces affordability and raises out-of-pocket costs for American families. Under the proposed formula, the new methodology would increase the maximum annual out-of-pocket limit for 2026 to $10,600 for self-only coverage and $21,200 for other coverage, which would be a 15 percent increase compared to 2025 plan year limits.[17] An internal CMS memorandum discussing the policy under the first Trump Administration noted

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[15] *See* note 1 at 13002; *Id.* at 13003.

[16] Department of Health and Human Services, Center for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020,* 84 Fed. Reg. 17454.

[17] Health Affairs, *HHS Proposes To Restrict Marketplace Eligibility, Enrollment, And Affordability In First Major Rule Under Trump Administration (Part 1)* (Mar. 12, 2025) (https://www healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major).

that the methodology would cause "coverage losses, further premium increases, and market disruption."[18] This change would allow insurers to offer less comprehensive coverage than contemplated by the statute.

Taken together, these policies would increase costs for families to the tune of $900 more in out-of-pocket costs and $313 more in premiums annually—while kicking 80,000 people off of coverage altogether.[19]

Summary

This Proposed Rule will not only raise administrative costs and worsen coverage for people purchasing coverage on their own, but it will also raise insurance premiums for many Americans. Reducing tax credits, increasing excessive administrative burden by millions of hours, and rolling out new red tape will rip affordable health coverage away from millions of Americans. Therefore, we strongly urge you to immediately withdraw these policies that undermine the ACA, jeopardize access to health care, increase health care costs for American families, and make Americans sicker.

Sincerely,

Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

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

Richard E. Neal
Ranking Member
Committee on Ways and Means

[18] Memorandum from Seema Verma, Administrator, Centers for Medicare & Medicaid Services, to Secretary Azar, Department of Health and Human Services (Aug. 29, 2018) (Bates PalTX-004092-PalTX-004122).

[19] Center for Budget and Policy Priorities, Proposed ACA Marketplace Rule Would Raise Health Care Costs for Millions of Families (Apr. 1, 2025) (https://www.cbpp.org/research/health/proposed-aca-marketplace-rule-would-raise-health-care-costs-for-millions-of); *See* note 1 at 13019.

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
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ONE HUNDRED NINETEENTH CONGRESS
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May 28, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy:

We are alarmed by the devastating breadth of the indiscriminate and harmful layoffs across the Department of Health and Human Services (HHS). On March 27, 2025, you announced a massive reduction in force (RIF) of 10,000 agency employees in addition to the termination of the roles of another 10,000 public servants who had already been terminated or who had taken the deferred resignation program.[1] On April 1, 2025, we sent a letter asking for details on the planned RIF and proposed dismemberment of numerous HHS operating divisions.[2] You have not answered that letter. On April 11, three HHS staff provided a bipartisan briefing to Committee staff and health staff of Members on the Committee. This briefing was both late and lacking. The briefing, which was intended to provide information on the terminations of about 20,000 roles and the planned dismantling of HHS, was limited to one hour. In addition, we have been informed that on May 9, you or your staff provided a partisan briefing solely to Republican Committee staff. It is disappointing to see you view basic transparency and accountability such as briefing Congress on massive changes to HHS's structure and staffing as a partisan exercise. Congress and the American people deserve better.

Your actions will result in a 25 percent staffing cut at HHS and the near or complete elimination of entire programs that perform vital functions such as provision of health care for first responders and survivors of the 9/11 attacks, supporting independent living for seniors and

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[1] *RFK Jr. Plans 10,000 Job Cuts in Major Restructuring of Health Department*, The Wall Street Journal (Mar. 27, 2025); NPR, *Widespread firings start at federal health agencies including many in leadership* (https://www.npr.org/sections/shots-health-news/2025/04/01/g-s1-57485/hhs-fda-layoffs-doge-cdc-nih) (Apr. 1, 2025).

[2] Letter from Rep. Frank Pallone, Jr., Ranking Member, House Committee on Energy and Commerce, Rep. Diana DeGette, Ranking Member, Subcommittee on Health, House Committee on Energy and Commerce, and Rep. Yvette Clarke, Ranking Member, Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce, to Secretary Robert F. Kennedy, Jr., U.S. Department of Health and Human Services (Apr. 1, 2025).

individuals with disabilities, preventing HIV and sexually transmitted infections, food safety and lead prevention programing, and helping Americans in need afford their energy costs. Despite our numerous attempts to obtain information on employee terminations at the agencies under HHS, you have not provided Congress with a full accounting of the number of resignations, retirements, or layoffs that have been made as part of either the RIF or the termination of thousands of probationary employees in February.[3]

Due to the fact that the briefing was so limited and sought to address massive terminations and a seismic dismantling of HHS's structure, we still have considerable concerns and additional questions. Further, some of the questions that Democratic staff asked at the briefing did not receive clear or adequate answers. In some instances, information that we were provided at that briefing directly contradicted statements that you yourself have made publicly, and your staff was unable to explain the contradictions. We continue to insist that you come before our Committee to provide unrestricted and detailed testimony—beyond the annual budget hearing appearance—on HHS's plans regarding the layoffs and future plans for the Department under your leadership. We are already seeing that staffing cuts of mission critical positions and proposed elimination of whole operating divisions have damaged our nation's responsiveness to public health functions.

In the absence of more information and given the fact that these terminations and program elimination decisions were carried out far from public view by unidentified officials, it is unclear whether HHS complied with all laws and regulations in implementing the RIF. We also do not believe the Department has the unilateral authority to make the proposed changes to the structure of HHS without the approval of Congress. The staff briefing on April 11 did not provide any information on the authorities that HHS believes allow it to dismantle its agencies so dramatically.

Congress is entitled to receive more information directly from you as Secretary of HHS on how the Department is justifying and assessing the impact of the personnel and organizational changes you are making. The cuts create real consequences in our communities as the result of the hasty and reckless manner in which this process is being approached. For example:

- The elimination of the lead poisoning office at the Centers for Disease Control and Prevention (CDC) abandons local health officials in Milwaukee who had been working with federal lead experts for months on detecting lead exposure and eliminating lead paint in the city's schools after doctors started seeing elevated lead levels in children's blood.[4] Without federal support, progress on this operation that has a profound impact on children's health will be unnecessarily delayed and disrupted.

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[3] CBS, *Thousands of probationary federal health agency workers fired by letter this weekend. Here's what it said.* (https://www.cbsnews.com/news/thousands-of-probationary-federal-health-agency-workers-fired-by-letter-this-weekend/) (Feb. 15, 2025).

[4] CNN, *A city responding to a lead crisis in schools reached out to the CDC for help. The agency's lead experts were just fired* (https://www.cnn.com/2025/04/02/health/milwaukee-lead-crisis-schools-cdc-cuts/index.html) (Apr. 3, 2025)

- Deep staff cuts to the CDC Fire Fatality Investigation and Prevention Program cuts off local fire departments from requesting federal researchers' assistance in studying firefighter deaths to help avoid similar incidents for firefighters across the country.[5] These program cuts have also stalled a congressionally mandated study of cancer rates for firefighters that had already registered tens of thousands of participants.[6]

- The CDC Division of Violence Prevention has reportedly lost a critical number of staff, some of whom are responsible for dispersing federal funding for sexual violence prevention programs at the state and local levels.[7] Disruption of funding will harm local organizations that serve domestic violence and sexual assault survivors, which are dependent on federal financial support.[8]

- The National Institutes of Health (NIH) has cut the staff associated with the 30-year-old Safe to Sleep initiative, which provides resources to parents and health care providers on how to protect infants from unintentional suffocation.[9]

- Local organizations are worried that the elimination of the Administration for Community Living (ACL) and field office closures will hinder the continued delivery of Meals on Wheels for seniors and disabled individuals who depend on this vital food assistance.[10]

- The termination of the entire staff at the Low Income Home Energy Assistance Program (LIHEAP) jeopardizes the government's ability to send funds to assist low-income families to help them afford energy costs to heat and cool their homes.[11]

Congress needs more information about HHS's decisions and process that will likely have harmful effects on the health and safety of the American people. It is outrageous that HHS has not been much more transparent. Please provide complete responses to the questions in the Committee's previous letter dated April 1, 2025, for which we have thus far received no response, and the questions below about the RIF and proposed future changes at HHS by June 11, 2025.

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[5] ProPublica, *Trump Laid Off Nearly All the Federal Workers Who Investigate Firefighter Deaths* (https://www.propublica.org/article/trump-cuts-firefighter-deaths) (Apr. 21, 2025).

[6] *Id.*

[7] NPR, *HHS guts sexual violence prevention division, leaving local efforts adrift* (https://www.npr.org/2025/04/08/nx-s1-5349529/hhs-layoffs-sexual-assault-rape-prevention) (Apr. 8, 2025).

[8] *Id.*

[9] NPR, *Trump cuts baby 'Safe to Sleep' team. Here's what parents should know* (https://www.npr.org/2025/05/05/nx-s1-5383871/trump-cuts-safe-sleep-sids-baby) (May 5, 2025).

[10] *Trump Cuts Threaten Agency Running Meals on Wheels*, The New York Times (Apr. 30, 2025).

[11] *Entire Staff Is Fired at Office That Helps Poorer Americans Pay for Heating*, The New York Times (Apr. 2, 2025).

HHS Reduction in Force

1. Have all employees identified for termination as part of the RIF plan announced on March 27, 2025, been notified?

2. Are any additional RIFs at HHS planned?

3. At the congressional staff briefing by HHS staff on April 11, staff were told that operating division leadership in consultation with career staff "made all of the determinations" about who would be terminated under the RIF in order to meet a target to reduce HHS to 90 percent of fiscal year 2019 levels. The briefers also said that operating division leaders had five opportunities to review RIF plans during the development process and that DOGE "advised" during the process. This assertion by HHS staff contradicts comments about the cuts made by NIH Director Jay Bhattacharya, who reportedly said during a town hall with NIH staff on May 19, 2025, "I've been quite upset about that. It would be nice to have had some say."[12]

    a. Provide a full explanation of the process and timing for development, review, and approval of the RIF plans.

    b. Provide all written guidance provided to operating division leaders and others involved in the RIF plan development, review, and approval process.

    c. Provide a list of individuals at each operating division who reviewed the RIF plan, including their names, titles, and whether they were serving in an acting capacity at the time. To the extent that multiple leaders reviewed the plan (including where there was a transition of leadership from an acting leader to a confirmed leader), please provide information on which leaders reviewed RIF plans during which time period.

    d. Who are the members of DOGE who "advised" during the process of developing the RIF plan at HHS? For each, please describe their role in the process.

4. You stated in a March 28, 2025, interview with NewsNation that "what Elon did with our agency is going to help our agency . . . he came in for the first time with a real org chart for the agency."[13] When asked at the April 11 briefing, your staff were unaware of what you meant by this. Please explain what Elon Musk's role was in creating a new

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[12] Politico Pro, *NIH director seeks to pep up shell-shocked staff* (https://subscriber.politicopro.com/article/2025/05/nih-director-seeks-to-pep-up-shell-shocked-staff-00357631) (May 19, 2025).

[13] Real Clear Politics, *Kennedy: By Every Metric By Which You Measure Public Health, It Has Decreased With The Increase In HHS Spending* (https://www.realclearpolitics.com/video/2025/03/28/kennedy_by_every_metric_by_which_you_measure_public_health_it_has_decreased_with_the_increase_in_hhs_spending.html) (Mar. 28, 2025).

organization chart for HHS and provide a copy of the organization chart that he provided to you.

5. At the briefing by HHS staff on April 11, congressional staff were told that the RIF was conducted properly, but the briefers did not provide meaningful detail as to how the process was conducted, including how the competitive areas and levels were defined, as required by federal regulations.[14]

    a. Provide a list of all competitive areas at HHS that were included in the RIF plan. For each competitive area, include in your response:

        i. The number of employees in each competitive area;

        ii. A list of the competitive levels identified in each competitive area with a description of the jobs that would be included at each level;

        iii. The number of employees terminated in each competitive area;

        iv. The job titles of employees terminated in each competitive area; and

        v. The total number of employees terminated from each operating division and office.

    b. Federal regulations require that "Descriptions of all competitive areas must be made readily available for review."[15] Likewise, Office of Personnel Management (OPM) guidance states that "Agencies must keep records when establishing or changing competitive areas and publish descriptions or make them readily available for review by employees and OPM."[16]

        i. To the extent not provided in response to 5.a., please provide the list of all competitive areas relevant to the HHS RIF and descriptions of those areas.

        ii. Please indicate whether these descriptions were published, and, if so, on what date and where.

        iii. If these descriptions were not published, explain why not and whether and how they were made available upon request.

            1. Please indicate what individual(s) were responsible for making the descriptions available.

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[14] 5 C.F.R. § 351.402.

[15] *Id.*

[16] U.S. Office of Personnel Management, *Competitive Areas in Reduction in Force (RIF)* (Mar. 2025).

2. Please confirm whether these descriptions have been provided upon request for review by employees.

c. Federal regulations require that competitive levels be established for purposes of a RIF.[17] Please confirm whether the HHS codes specified in the Appendix of HHS Instruction 351-1 were utilized for the RIF.[18] If a different list of codes was used, please provide that list.

d. Provide the list of all offices and programs where all personnel have been terminated.

i. For each of these current programs or offices where the entire staff has been terminated as part of the RIF, indicate whether the office, program, or functions in whole or in part will be transferred to a different location at HHS and what the new location is.

ii. Provide documentation that demonstrates the Department's analysis of which programs should be moved, curtailed, or eliminated, and what impact such action would have on public health services.

e. Provide the retention register(s) used for this RIF.

6. At the briefing on April 11, HHS staff also stated that groups of employees with the same departmental identification code had to be terminated as a group and any reinstatements would need to include all individuals with the same code in the same office. The HHS briefers also stated that reinstatements could occur up to June 2, 2025. Please explain the process by which HHS is identifying individuals, or groups of individuals, for whom RIF notices are being withdrawn.

7. On April 3, you stated that 20 percent of the workers terminated by the RIF would be reinstated and claimed that was "always the plan."[19] The HHS staff at the briefing stated that they were unaware of your comments and they could not confirm whether those statements were accurate.

a. Please indicate how many individuals have been offered reinstatement, how many have accepted the offer of reinstatement, and the HHS operating division and program in which they work.

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[17] 5 C.F.R. § 351.403

[18] U.S. Department of Health and Human Services, *HHS Instruction 351-1: Reduction in Force (RIF)* (https://www.hhs.gov/about/agencies/asa/ohr/hr-library/351-1/index html) (Dec. 22, 2020).

[19] NBC News, *RFK Jr. says 'it was always the plan' to reinstate 20% of HHS cuts* (https://www.youtube.com/watch?v=ACrXlS9SnNE&ab_channel=NBCNews) (Apr. 3, 2025).

b. Please describe the process by which the reinstatement of HHS employees will be carried out, including the degree to which operating division leaders are involved in that process.

8. It was reported that several former leaders at NIH were offered reassignments to positions in the Indian Health Service (IHS) in locations across the country.[20]

   a. How many employees across HHS were offered reassignments to IHS since April 1, 2025?

   b. Of the employees who were offered reassignment to IHS, how many of those employees have accepted the reassignment or have reassignment offers still pending?

   c. How many offers of reassignment have been made in each operating division of HHS and what are the titles of the employees who received the offers?

   d. How many offers of reassignment were accepted? Provide the operating division, office and title of each reassigned employee's prior and current position.

9. At the briefing on April 11, the briefers said that 18 percent of the layoffs eliminated "duplicative programs." What criteria were used to determine which programs were "duplicative" and what specific programs and jobs were eliminated for this reason?

10. On May 22, 2025, a federal judge granted a preliminary injunction blocking implementation of RIFs at several federal agencies, including HHS, while the case progresses in court.[21] Describe the steps that HHS is taking to ensure compliance with the court order.

11. Provide the Phase 1 and Phase 2 Agency RIF and Reorganization Plans that were due to OMB and OPM by March 13 and April 14, respectively, and the monthly progress report due on May 14, according to the February 27, 2025, guidance memo issued by OMB and OPM in accordance with President Trump's Executive Order *Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative*.[22]

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[20] NPR, *Widespread firings start at federal health agencies including many in leadership* (https://www.npr.org/sections/shots-health-news/2025/04/01/g-s1-57485/hhs-fda-layoffs-doge-cdc-nih) (Apr. 1, 2025).

[21] *Judge Extends Order Blocking Trump's Planned Mass Layoffs*, New York Times (May 23, 2025).

[22] U.S. Office of Management and Budget and U.S. Office of Personnel Management, *Guidance on Agency RIF and Reorganization Plans Requested by* Implementing The President's "Department of Government Efficiency" Workforce Optimization Initiative (https://www.opm.gov/policy-data-oversight/latest-memos/guidance-on-agency-rif-and-reorganization-plans-requested-by-implementing-the-president-s-department-of-government-efficiency-workforce-optimization-initiative.pdf) (Feb. 26, 2025); Executive Order No. 14210, 90 FR 9669 (Feb. 11, 2025).

Proposed Changes to HHS Structure

12. The proposed changes to HHS's structure, which have not been authorized by Congress, would appear to create situations where positions or reporting lines created by statute would be eliminated or interfered with. Please provide an explanation for how the proposed dismantling of certain positions and offices would comply with the law, including, but not limited to the following:

    a. The Assistant Secretary for Aging is Senate confirmed, and the underlying statute requires a "direct reporting relationship between the Assistant Secretary and the Secretary."[23] Please explain whether HHS is preserving the position of Assistant Secretary for Aging and their statutory reporting relationship to the Secretary.

    b. HHS's proposed reorganization recommends moving CDC's Agency for Toxic Substances and Disease Registry (ATSDR) to the Administration for a Healthy America.[24] However, 42 U.S.C. 9604 (i)(1) requires that the Administrator of the ATSDR—historically, the director of the CDC—report directly to the Surgeon General of the United States. Please explain how HHS's proposed plan complies with the law.

    c. Under 42 U.S.C. 300hh-10(a), the Assistant Secretary for Strategic Preparedness and Response reports directly to the HHS Secretary. However, the Department's restructuring transfers the Administration for Strategic Preparedness and Response to CDC.[25] Please explain how HHS's proposed plan complies with the law.

13. The proposed changes to HHS's structure include dismantling several operating divisions, some of which have specific statutory mandates to carry out certain programs.[26] Please provide an explanation for how the proposed dismantling of these operating divisions would comply with the law, including, but not limited to:

    a. The proposed changes include eliminating ACL, but several programs, including the National Institute on Disability, Independent Living, and Rehabilitation Research and the Independent Living Administration, are required by statute to be administered by ACL.[27] Please explain how these programs would be administered in compliance with the law without ACL.

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[23] 42 U.S.C. § 3011(a)

[24] U.S. Department of Health and Human Services, *Fact Sheet: HHS' Transformation to Make America Healthy Again* (https://www hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html) (accessed May 19, 2025).

[25] U.S. Department of Health and Human Services, *HHS Announces Transformation to Make America Healthy Again* (Mar. 27, 2025) (press release).

[26] *Id.*

[27] 29 U.S.C. § 762(a)(1); 29 U.S.C. § 791-1.

b. The Violence Against Women Act mandates CDC make funding available to state and territorial health departments as part of its Rape Prevention and Education (RPE) program.[28] It has been reported that entire teams focused on rape prevention at CDC's National Center for Injury Prevention and Control—which administer RPE grants—have been cut.[29] Please explain how HHS intends to make and manage these statutorily required grants.

Food and Drug Administration (FDA)

14. Staff terminations have challenged FDA's ability to meet statutorily mandated product review deadlines established under user fee agreements.[30] Since January 20, 2025, has FDA missed any deadlines for product reviews outlined in user fee programs for prescription drugs, generic drugs, medical devices, biosimilars, and over-the-counter monograph drugs? Please break out missed deadlines by product category.

15. Please provide the number of staff involved in product evaluation—including reviewers, inspectors, staff scientists, fellows, technicians, and administration staff—that have been terminated from each of the following agency centers:

    a. Centers for Biologics Evaluation and Research (CBER);

    b. Center for Devices and Radiological Health (CDRH);

    c. Center for Drug Evaluation and Research (CDER);

    d. Center for Tobacco Products (CTP); and

    e. Office of Regulatory Affairs (ORA).

16. HHS told the Government Accountability Office that it does not plan to extend the HHS Supply Chain Resilience and Shortage Coordinator position, which was responsible for coordinating efforts across HHS to address drug shortages.[31] Please explain how HHS intends to strengthen drug supply chains and prevent or address drug shortages without a cross-Department Coordinator.

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[28] 42 U.S.C. § 280b-1b.

[29] *Health groups urge RFK Jr. to reinstate injury center staff*, Roll Call (Apr. 14, 2025).

[30] Reuters, *Exclusive: FDA staff struggle to meet product review deadlines after DOGE layoffs* (https://www.reuters.com/business/healthcare-pharmaceuticals/fda-staff-struggle-meet-product-review-deadlines-after-doge-layoffs-2025-03-27/) (Mar. 27, 2025).

[31] Government Accountability Office, *HHS Should Implement a Mechanism to Coordinate Its Activities* (GAO-25-107110) (Apr. 9, 2025).

17. Were any staff in FDA's India and China offices responsible for conducting foreign drug manufacturing facility inspections terminated? Were any support staff at FDA who coordinate travel for these international inspectors terminated? If so, indicate how many inspectors and support staff and their offices.

18. It has been reported that FDA has paused the Food Emergency Response Network (FERN) Proficiency Testing Program, which tests quality of raw milk and other dairy products, due to staffing shortages at FDA's Moffett Center Proficiency Testing Laboratory, but planned on resuming once the program was transferred to another laboratory.[32] Have those testing efforts resumed? If so, what date did they resume and which laboratory is now conducting testing for raw milk and other dairy products?

19. It was also reported that FDA has paused testing for the presence of H5N1 virus and other pathogens in milk and cheese.[33] Have those testing efforts resumed? If so, what date did they resume?

National Institutes of Health

20. How many intramural NIH projects have been paused, stopped, or terminated due to HHS's termination of probationary employees, fellows, and staff pursuant to the RIF? Please identify the projects and their associated institute or center.

21. Have any patients been removed from care or had their care interrupted at the NIH Clinical Center due to reductions in physicians, nurses, pharmacists, administrators, or any other support staff? If so, identify the number of patients along with the study in which they were participating.

22. How many clinical trials have been paused, stopped, or terminated due to HHS's termination of probationary employees, fellows, and staff pursuant to the RIF? Please list the title of all such trials, their associated institute or center, and whether those trials were happening internally or extramurally.

Office for Civil Rights (OCR)

23. Of the staff that have been terminated, how many were charged with reviewing complaints related to violations of civil rights law based on race, religion, color, national origin, disability, age, or sex? Please also provide the number of pending civil rights-related complaints before OCR.

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[32] NBC Chicago, *FDA pauses milk quality testing program due to reduced capacity* (https://www.nbcchicago.com/news/local/fda-pauses-milk-quality-testing-program-reduced-capacity/3731394/) (Apr. 26, 2025).

[33] Reuters, *FDA suspends program to improve bird flu testing due to staff cuts* (https://www.reuters.com/business/healthcare-pharmaceuticals/fda-suspends-program-improve-bird-flu-testing-due-staff-cuts-2025-04-03/) (Apr. 3, 2025).

24. Of the staff that have been terminated, how many were charged with reviewing complaints related to violations of the Health Information Portability and Accountability Act's (HIPAA) Privacy Rule and/or Security Rule? Please also provide the number of pending HIPAA-related complaints before OCR.

Administration for a Healthy America (AHA)

25. Please produce HHS's plan for developing the leadership, budget, reporting structures, and staff selection for AHA.

26. Do you plan to seek congressional authorization to establish this new division? If not, what authority empowers HHS to create such a division without congressional approval?

27. What hiring authorities does HHS intend to use to staff AHA leadership?

If you have any questions about this request, please contact the Committee Democratic staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Diana DeGette
Ranking Member
Subcommittee on Health

Yvette Clarke
Ranking Member
Subcommittee on Oversight
and Investigations

cc: The Honorable Brett Guthrie
Chairman

The Honorable Earl “Buddy” Carter
Chairman
Subcommittee on Health

The Honorable Gary Palmer
Chairman
Subcommittee on Oversight and Investigations

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-3641
Minority (202) 225-2927

June 10, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Jayanta Bhattacharya, M.D., Ph.D.
Director
National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892

Dear Secretary Kennedy and Director Bhattacharya:

Yesterday, we received a letter signed by 342 National Institutes of Health (NIH) staff detailing unprecedented waste, abuse, and illegality at NIH. The letter also addresses the harmful consequences of these unprecedented actions on patients, NIH staff, research conducted at NIH, and America's ability to improve and save lives through scientific breakthroughs.[1] These courageous staff confirm our concerns with the numerous, senseless cuts and arbitrary changes that you and others in the Trump Administration have made at the Department of Health and Human Services (HHS) and NIH.

As the letter notes, Director Bhattacharya has repeatedly emphasized the importance of dissent and open scientific debate. We hope that this provides an opportunity to prove that this commitment to dissent is not just empty words. Director Bhattacharya's initial response that "respectful dissent in science is productive" is a promising start, and we hope that this remains the position of HHS and NIH.[2]

We also write to remind you that any attempt by HHS, NIH, or any other federal entity to retaliate against any of the letter's signatories would be illegal. The Whistleblower Protection

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[1] Stand Up for Science, *The Bethesda Declaration: A Call for NIH and HHS Leadership to Deliver on Promises of Academic Freedom and Scientific Excellence* (https://www.standupforscience.net/bethesda-declaration) (accessed June 9, 2025).

[2] *Trump Administration Live Updates: National Institutes of Health Workers Denounce 'Harmful' Policies*, The New York Times (June 9, 2025).

Act protects individuals like the signers of the Bethesda Declaration who provide information to Congress and others about gross mismanagement, gross waste of federal funds, abuse of authority, and danger to public health and safety.[3] Among other serious concerns, the letter describes instances where countless decades of scientific expertise is being lost by arbitrary cuts in a demonstration of gross mismanagement, federal dollars are being wasted by reckless cancellation of potentially life-saving research before it is completed, funding for critical collaboration with outside partners has been arbitrarily capped, and patients' lives are being put at risk by arbitrary and abrupt termination of clinical trials. It is clear from the letter and statements from signatories that they believe these actions to be gravely concerning at best and illegal at worst.[4] We agree.

The letter also states that the signatories have appealed to NIH leadership repeatedly without HHS or NIH leadership taking any corrective action. We hope that you will finally listen to the voices of those who have invested their expertise and, for some, much of their professional lives into making NIH the world-leading biomedical research institution that it is. It is crucial that you address the harms outlined in the letter and stop undermining the life-saving research taking place at NIH and at research institutions across the world.

We request that you provide your assurances in writing that neither you nor anyone at HHS or NIH will engage in any retaliatory action against these whistleblowers for their protected disclosures to Congress and the American public.

[3] 5 U.S.C. § 2302(a)(2)(D).

[4] *See* note 2.

We will be watching your actions closely and welcome any staff who feel that they have been retaliated against to contact Democratic Committee staff at (202) 225-2927 or ECDemTips@mail.house.gov.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Diana DeGette
Ranking Member
Subcommittee on Health

Yvette D. Clarke
Ranking Member
Subcommittee on Oversight
and Investigations

cc: The Honorable Brett Guthrie
Chairman

The Honorable Earl "Buddy" Carter
Chairman
Subcommittee on Health

The Honorable Gary Palmer
Chairman
Subcommittee on Oversight and Investigations

Congress of the United States

Washington, DC 20515

June 11, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Kennedy,

For over 60 years, in both Republican and Democratic Administrations, the Advisory Committee on Immunization Practices (ACIP) has played a pivotal role in keeping Americans healthy and safe. As Members of Congress, we are outraged at your decision to unilaterally remove all 17 individuals from ACIP on June 9th. As Secretary of Health and Human Services (HHS), your duty to this country is to enhance the well-being of all Americans and this decision will cost lives. Your decision to disband the ACIP, a committee of medical and public health experts whose sole focus is to develop vaccine recommendations, completely undermines ACIP's critical role and endangers this nation's public health.

On June 9th, in your opinion piece in the Wall Street Journal, you blame conflict of interests and a lack of curiosity as a rationale for removing this panel of experts from their roles.[1] Your statement belies the rigorous vetting process for ACIP members, including financial disclosures and a review of their previous work on clinical trials. ACIP members must recuse themselves from votes and discussions on vaccines they are studying, or on any other vaccines manufactured by companies that fund their research.[2] In fact, just this year the Centers for Disease Control and Prevention set up a public, searchable database allowing transparency for any conflicts of interest for voting ACIP members dating back to 2000.

These actions upend ACIP's thoughtful, evidence-based decision-making and will weave unfounded or disproven theories into what has traditionally been a science-based process trusted by our health care providers. Conducting immunization reviews takes months of deliberation and review of research, and your unilateral decision to abruptly end ACIP's existing work is detrimental. It has become abundantly clear that your intent is to sow doubt and fear in the American public that will cost lives. With an ongoing measles outbreak and the decline of routine child immunizations, we will see the spread of vaccine-preventable diseases across the country. Your politicization of vaccines has made American families less safe and will return the US to an era before mass vaccination prevented millions of infections and early deaths.

We demand that you reinstate the fired 17 members to ACIP and uphold your oath to the American people.

Sincerely,

[1] RFK Jr.: HHS Moves to Restore Public Trust in Vaccines - WSJ
[2] Advisory Committee on Immunization Practices, Policies and Procedures June 2022

Kim Schrier, M.D.
Member of Congress

Diana DeGette
Member of Congress

Jan Schakowsky
Member of Congress

Doris Matsui
Member of Congress

Kathy Castor
Member of Congress

Paul Tonko
Member of Congress

Yvette D. Clarke
Member of Congress

Raul Ruiz, M.D.
Member of Congress

Scott H. Peters
Member of Congress

Debbie Dingell
Member of Congress

Marc A. Veasey
Member of Congress

Robin L. Kelly
Member of Congress

Nanette Diaz Barragán
Member of Congress

Darren Soto
Member of Congress

Lori Trahan
Member of Congress

Lizzie Fletcher
Member of Congress

Alexandria Ocasio-Cortez
Member of Congress

Jake Auchincloss
Member of Congress

Troy A. Carter, Sr.
Member of Congress

Robert J. Menendez
Member of Congress

Kevin Mullin
Member of Congress

Greg Landsman
Member of Congress

Jennifer L. McClellan
Member of Congress

Maxine Dexter
Member of Congress

Nikki Budzinski
Member of Congress

Kelly Morrison
Member of Congress

Judy Chu
Member of Congress

Nydia M. Velázquez
Member of Congress

John B. Larson
Member of Congress

Deborah K. Ross
Member of Congress

Grace Meng
Member of Congress

Ritchie Torres
Member of Congress

Sean Casten
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Mike Quigley
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Frederica S. Wilson
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Sheila Cherfilus-McCormick
Member of Congress

Shri Thanedar
Member of Congress

Bennie G. Thompson
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Teresa Leger Fernández
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Emanuel Cleaver, II
Member of Congress

Nikema Williams
Member of Congress

Sharice L. Davids
Member of Congress

Chris Pappas
Member of Congress

Jim Himes
Member of Congress

Suzanne Bonamici
Member of Congress

Jim Costa
Member of Congress

John W. Mannion
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Becca Balint
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Andrea Salinas
Member of Congress

Bill Foster
Member of Congress

Linda T. Sánchez
Member of Congress

Rashida Tlaib
Member of Congress

Rick Larsen
Member of Congress

Melanie Stansbury
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George Latimer
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Angie Craig
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Jahana Hayes
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Delia C. Ramirez
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Lateefah Simon
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Suzan K. DelBene
Member of Congress

Dina Titus
Member of Congress

Ami Bera, M.D.
Member of Congress

Maggie Goodlander
Member of Congress

Stephen F. Lynch
Member of Congress

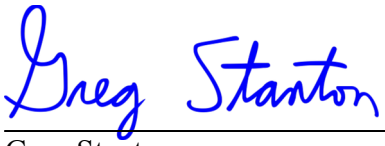
Robert Garcia
Member of Congress

Julie Johnson
Member of Congress

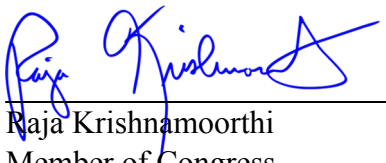
Joe Courtney
Member of Congress

Donald S. Beyer Jr.
Member of Congress

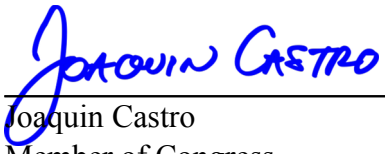
Chellie Pingree
Member of Congress



Greg Stanton
Member of Congress



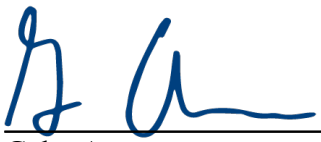
Raja Krishnamoorthi
Member of Congress



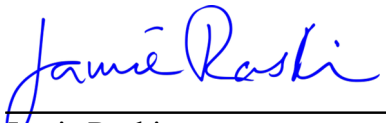
Joaquin Castro
Member of Congress



Eric Swalwell
Member of Congress



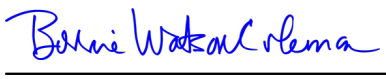
Gabe Amo
Member of Congress



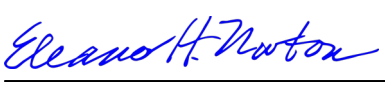
Jamie Raskin
Member of Congress



Chrissy Houlahan
Member of Congress



Bonnie Watson Coleman
Member of Congress



Eleanor Holmes Norton
Member of Congress



Bradley Scott Schneider
Member of Congress



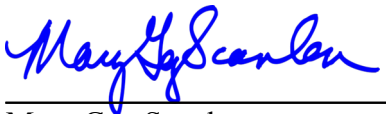
Mark DeSaulnier
Member of Congress



Marilyn Strickland
Member of Congress



Jill Tokuda
Member of Congress



Mary Gay Scanlon
Member of Congress

Madeleine Dean
Member of Congress

Sylvia R. Garcia
Member of Congress

Nancy Pelosi
Member of Congress

Julia Brownley
Member of Congress

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-3641
Minority (202) 225-2927

June 17, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Kennedy:

We write to request a prompt and honest explanation of the numerous errors and misrepresentations contained in *The MAHA Report: Make Our Children Healthy Again Assessment* (the "Report"), which was initially released on May 22 by the Presidential Commission to Make America Healthy Again (the "Commission"). As Chair of the Commission, you are quoted in a press release accompanying the Report as saying, "[w]e will follow the truth wherever it leads" and "uphold rigorous science."[1] Reporting and a review of the Report demonstrate, however, that it contains so many errors that cannot be accurately described as "following the truth" or upholding rigorous science. We therefore request information on your flawed process that led to the Report.

Shortly after the Commission released the Report, reporters from NOTUS published an article identifying numerous deeply concerning flaws with the sources cited in the Report, including mischaracterization of science, erroneous identification of authors and journals, and—most concerningly—outright fabrication of non-existent sources.[2] Subsequent reporting identified other flaws as well as clear hallmarks of the use of ChatGPT in the report.[3] Even after the Commission made some revisions, cited researchers objected that the revised version continues to mischaracterize their work.[4]

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[1] Department of Health and Human Services, *MAHA Commission Unveils Landmark Report Exposing Root Causes of Childhood Chronic Disease Crisis* (May 22, 2025) (press release).

[2] NOTUS, *The MAHA Report Cites Studies That Don't Exist* (May 29, 2025) (https://www notus.org/health-science/make-america-healthy-again-report-citation-errors).

[3] *White House MAHA Report May Have Garbled Science by Using AI, Experts Say*, The Washington Post (May 29, 2025).

[4] *See* note 2.

The White House sought to downplay the errors in the Report, calling them "formatting issues."[5] It is true that report is rife with what might be generously described as "formatting errors." For example, many citations in the original Report misidentified authors or incorrectly stated publication title or volumes. By way of illustration, two different people were cited in two different footnotes as the author of the article *How much recess should kids get?* Neither is the actual author of the article.[6]

There are far more significant errors, including the fact that several articles cited in support of the Report's assertions do not appear to exist at all. This includes:

- *Changes in mental health and substance use among US adolescents during the COVID-19 pandemic*;[7]
- *Direct-to-consumer advertising and the rise in ADHD medication use among children*;[8]
- *Direct-to-consumer advertising of psychotropic medications for youth: A growing concern*;[9]
- *Overprescribing of oral corticosteroids for children with asthma*;[10]
- *Titanium dioxide: Evolving regulatory classification and possible health implications in humans and the environment*; and[11]
- *Chronic stress and inflammation: The role of cytokines in metabolic diseases*.[12]

The fabrication of sources is not a question of "formatting" and instead indicates a fundamental failure in your and the Commission's process and conclusions. These issues alone call into question the integrity of the entire Report.

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[5] NBC News, *Trump Admin Corrects RFK Jr.'s MAHA Report After Citation Errors* (May 30, 2025) (https://www.nbcnews.com/health/health-news/trump-admin-corrects-rfk-jrs-maha-report-citation-errors-rcna209913).

[6] *The MAHA Report's AI Fingerprints, Annotated*, The Washington Post (May 29, 2025).

[7] Make America Healthy Again Commission, *Make Our Children Healthy Again Assessment* (May 22, 2025) (original version) (available at https://web.archive.org/web/20250522215748/https://www.whitehouse.gov/wp-content/uploads/2025/05/WH-The-MAHA-Report-Assessment.pdf).

[8] *Id.* at p.71 n.521.

[9] *Id.* at p.71 n.522.

[10] *Id.* at p.59 n.420.

[11] *Id.* at p.25 n.126.

[12] *Id.* at p.52 n.371.

Your failure to conduct meaningful research and careful review of the Report before its release is also demonstrated by many misrepresentations made about existing data and about conclusions drawn by cited sources. For example, one section of the Report cited to a study in support of the claim that therapy is as effective or more effective than medicine in treating mental health.[13] But one of the statisticians who wrote the cited source has explained that the study made no such comparison.[14]

These numerous, fundamental errors in the Report demonstrate a serious lack of scientific rigor and a flawed process designed to deliver conclusions that align with your personal views rather than the evidence. A review of the numerous errors found in the Report also raises the question of what extent AI tools were used to research and draft it without adequate oversight or policies to ensure accuracy. While you have said that you believe in "radical transparency," so far you have not explained how these egregious errors were included in the initial version of the Report or why you have allowed misstatements of scientific findings to remain in the current version of the Report.[15] And even where a fabricated source appeared in the original, you appear to have simply swapped in another source for the same assertion, demonstrating that you have conducted this process entirely backward by deciding conclusions first and then seeking out sources to justify your opinions.

To make matters worse, it appears that you walked back even the most meager efforts to notify readers of errors and changes to the Report. For example, the revised version of the Report available on May 29 identifies in several footnotes that citations were "corrected" or "updated."[16] But the version currently available online contains no such notations.[17]

The day after the release of the Report, President Trump issued an Executive Order entitled "Restoring Gold Standard Science," which states that there is a "loss of trust" in science, in part due to a "falsification of data."[18] The initial version of the Report contains what would undoubtedly constitute both "fabrication[s]" and "falsification[s]" under the terms of the Executive Order.[19] And authors of some of the articles still cited in the most recent version contend that their conclusions are still being misrepresented.[20] In other words, your Report fails

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[13] *Id.* at p.18.

[14] *See* note 2.

[15] *Id.*

[16] *See* Make America Healthy Again Commission, *Make Our Children Healthy Again Assessment* (May 27, 2025) (revised version) at p.7 n.2, p.25 n.126, p.26 n.136, p.27 n.159, and p.34 n.220 (available at https://web.archive.org/web/20250528190607/https://www.whitehouse.gov/wp-content/uploads/2025/05/WH-The-MAHA-Report-Assessment.pdf).

[17] *See* Make America Healthy Again Commission, *Make Our Children Healthy Again Assessment* (May 29, 2025) (current version).

[18] The White House. *Restoring Gold Standard Science* (May 23, 2025) (https://www.whitehouse.gov/presidential-actions/2025/05/restoring-gold-standard-science/).

[19] *Id.*

[20] *See* note 2.

to meet the basic standards of science, even by the terms laid out by the very Administration you work for.

In a post by the White House on X, you are quoted as stating that "Never in American history has the federal government taken a position on public health like this."[21] You are correct in that this is a uniquely embarrassing and flawed document on public health. In order to understand how this happened and ensure that you are more scientifically rigorous and vigilant going forward, we seek answers to a series of questions. We ask that you respond to the following questions by July 1, 2025:

1. Please confirm whether and to what extent AI tools were used in preparing the Report, including research, drafting, or revision.

    a. If so:

        i. Please list all AI tools that were used.

        ii. Please describe how each tool was used.

        iii. Please provide a complete list of prompts or other inputs used with these tools.

        iv. Please explain what process was followed to confirm the accuracy of the work product that resulted from the use of AI tools.

    b. If not:

        i. Please explain how you came to cite non-existent sources in the Report. If you contend that the original version of the Report did not cite to any non-existent sources, please provide copies of the following cited sources:

            1. *Changes in mental health and substance use among US adolescents during the COVID-19 pandemic*;

            2. *Direct-to-consumer advertising and the rise in ADHD medication use among children*;

            3. *Direct-to-consumer advertising of psychotropic medications for youth: A growing concern*;

            4. *Overprescribing of oral corticosteroids for children with asthma*;

[21] The White House (@WhiteHouse), X (May 23, 2025) (https://x.com/WhiteHouse/status/1925972794153550277).

5. *Titanium dioxide: Evolving regulatory classification and possible health implications in humans and the environment;* and

6. *Chronic stress and inflammation: The role of cytokines in metabolic diseases*

ii. Please explain why the term "oaicite," an apparent artifact of the use of OpenAI's ChatGPT, was included in footnotes 2 and 134.[22]

2. Please provide all policies or guidelines or other documentation regarding the process for conducting research, drafting, editing, and publishing reports that were applicable to the MAHA Report. This includes, but is not limited to, documentation relating to the use of AI, cite-checking or other quality assurance, and scientific integrity.

3. Please explain why only some changes to citations that have been made since the original version were notated, why the description of those revisions did not disclose that citations had been changed altogether (including where a source appears to have been altogether fabricated), and why those notations no longer appear in the current version of the Report. Please also explain how these decisions are consistent with your purported commitment to "radical transparency."

4. Please state whether further revisions to the Report are planned, particularly in light of comments made by researchers cited in the Report that their studies have been mischaracterized.

[22] *Make America Healthy Again Commission, Make Our Children Healthy Again Assessment* (May 22, 2025) (original version) (available at https://web.archive.org/web/20250522215748/https://www.whitehouse.gov/wp-content/uploads/2025/05/WH-The-MAHA-Report-Assessment.pdf) at p.7 n.2 and p.25 n.134; *White House MAHA Report May Have Garbled Science by Using AI, Experts Say,* The Washington Post (May 29, 2025).

If you have any questions about this request, please contact the Committee Democratic staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Ranking Member

Diana DeGette
Ranking Member
Subcommittee on Health

Yvette D. Clarke
Ranking Member
Subcommittee on Oversight
and Investigations

cc: The Honorable Brett Guthrie
Chairman

The Honorable Earl "Buddy" Carter
Chairman
Subcommittee on Health

The Honorable Gary Palmer
Chairman
Subcommittee on Oversight and Investigations

Congress of the United States

Washington, DC 20515

June 22, 2025

Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Kennedy:

We are alarmed by recent reporting that the Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) shared the personal information of millions of immigrants, and potentially their citizen family members, with the Department of Homeland Security (DHS) for immigration enforcement purposes.[1] We write to urge CMS to immediately cease any data sharing with DHS and to direct DHS to destroy any individually identifiable health information transmitted by CMS to DHS. We are particularly concerned that these latest actions will have a chilling effect and jeopardize access to services for those who rely on Medicaid and other public programs for lifesaving care, including the 5.5 million U.S. citizen children in mixed status families.[2]

Reporting from the Associated Press (AP) details new efforts by the Trump administration to access and share the private, personally identifiable information of individuals residing in the U.S. According to the AP, top advisors at HHS ordered the release of Medicaid enrollees' personally identifiable information, including names, addresses, and immigration status, to DHS despite nonpartisan CMS expert officials' reported concerns that the sharing of such data would raise considerable ethical concerns and could violate federal law, including the Social Security Act[3] and the Privacy Act of 1974. Data sharing efforts such as these have dubious legal authority, violate decades of precedent, and run counter to the confidentiality statements on many state Medicaid applications.[4] They also contradict CMS' own documents, which instruct health care assisters to "let consumers know that information they provide will

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[1] Kimberly Kindy and Amanda Seitz, "Trump administration gives personal data of immigrant Medicaid enrollees to deportation officials.," Associated Press, (updated June 14, 2025), https://apnews.com/article/medicaid-deportation-immigrants-trump-4e0f979e4290a4d10a067da0acca8e22.

[2] Matthew Lisiecki and Gerard Apruzzese, "Proposed 2024 Mass Deportation Program Would Socially and Economically Devastate American Families," Center for Migration Studies, (October 10, 2024), https://cmsny.org/publications/2024-mass-deportation-program-devastate-american-families-101024.

[3] For example, Sec. 1902(a)(7) of the Social Security Act requires state Medicaid agencies to provide "safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with… the administration of the plan" and certain other narrow uses.

[4] For example, *see* New York's application, which has the following confidentiality statement: "All of the information you provide on this application will remain confidential. The only people who will see this information are the Assistors and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your family members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information," https://www health ny.gov/forms/doh-4220_dd_access.pdf; California's application, which has the following privacy statement, "The personal and medical information you provide on it is private and confidential…We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to enroll you in a plan or program or to administer programs, and with other state and federal agencies as required by law," https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/2014_CoveredCA_Applications/ENG-CASingleStreamApp.pdf.

not be used by government agencies to enforce immigration laws or policies."[5] Further, 92 percent of Americans view data privacy as a right[6]—these actions risk irreparably eroding Americans' trust in federal and state agencies as good-faith stewards of their personal data.

Last month, CMS announced audits that it claimed were meant to increase "federal oversight" of state Medicaid agencies to ensure federal funds were not being used to provide health coverage to "individuals who are in the country illegally" and thus ineligible for comprehensive Medicaid benefits.[7] It appears that CMS has inappropriately and potentially unlawfully used that audit to obtain personally identifiable information and shared that data with DHS for purposes entirely unrelated to ensuring states are appropriately claiming federal funds.

As you are aware, federal law requires hospitals with emergency departments to provide a medical screening exam and stabilizing treatment to people with emergency medical conditions, regardless of their immigration status or ability to pay.[8] If the person seeking care is ineligible for Medicaid due to immigration status only, the hospital can seek reimbursement from Medicaid for the emergency services only.[9]

Federal funds are not available for non-emergency services for people who are undocumented.[10] As such, no state is permitted to utilize federal funds to provide full scope Medicaid benefits to undocumented individuals. Instead, some states[11] have opted to provide state-funded health benefits to individuals who do not qualify for any other form of health coverage, recognizing that access to reliable health care improves health outcomes, reduces overall costs, and strengthens access to care for all beneficiaries by reducing provider uncompensated care.[12] As reported by the AP, the Trump administration has targeted the immigrant residents of these states by sharing their personally identifiable information with DHS in violation of CMS' own policy, and potentially, federal law.

Given the significant impact this data sharing could have on the health of millions of Americans and the violations of privacy it raises, we request written responses to the following questions no later than Monday, July 21, 2025:

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[5] Center for Medicare & Medicaid Services, "Health Coverage Options for Immigrants," (July 2020) https://www.cms.gov/marketplace/technical-assistance-resources/health-coverage-options-immigrants.pdf.

[6] "Patient perspectives around data privacy," American Medical Association, (July 25, 2022), https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.

[7] CMS Increasing Oversight on States Illegally Using Federal Medicaid Funding for Health Care for Illegal Immigrants," Centers for Medicare & Medicaid Services, *press release* (May 27, 2025), https://www.cms.gov/newsroom/press-releases/cms-increasing-oversight-states-illegally-using-federal-medicaid-funding-health-care-illegal.

[8] 42 U.S. Code § 1395dd.

[9] 42 U.S.C. § 1396b(v).

[10] 8 U.S. Code § 1611.

[11] Fourteen states plus D.C. provide comprehensive state-funded coverage for children regardless of immigration status. These states include California, Colorado, Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. In addition, seven states (California, Colorado, Illinois, Minnesota, New York, Oregon, Washington) plus D.C. have also expanded fully state-funded coverage to some income-eligible adults regardless of immigration status.

[12] Akash Pillai, Drishti Pillai, and Samantha Artiga, "State Health Coverage for Immigrants and Implications for Health Coverage and Care," KFF, (May 1, 2024). https://www kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/; "Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024," Assistant Secretary for Planning and Evaluation, (June 7, 2024), https://aspe.hhs.gov/sites/default/files/documents/9376755db2480ad7288aaa5ec38f3d8c/improving-access-to-coverage.pdf.

1. Please detail any and all communication with state Medicaid officials regarding the Trump administration's efforts to obtain this data, including the exact information requested from state Medicaid agencies subject to the audit described in "SUBJECT: Ending Taxpayer Subsidization of Open Borders."[13] In addition:
    a. Please include the parameters outlining for which Medicaid applicants or enrollees CMS requested information (i.e., did CMS obtain data specifically on individuals for whom emergency Medicaid payments were made to hospitals, individuals who received state-funded health benefits, individuals who are lawfully present and eligible for Medicaid and/or Children's Health Insurance Program benefits);
    b. Please specify if such requested information included personally identifiable information such as name and address and, if so, what such information; and
    c. As of the date of your response, please specify which states have provided such information as well as which states have received inquiries.

2. Please provide copies of any data sharing agreements between CMS and any state for which CMS has provided data to DHS.

3. What, if any, data was requested from HHS by DHS and for what purpose?
    a. On what date did DHS request such data?

4. What, if any, data was shared by HHS with DHS and in what format?

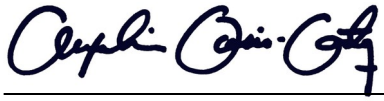
5. What legal authority, if any, is CMS citing for the release of this personally identifiable information to DHS?

6. Please share the below correspondence:
    a. Any and all communication from HHS and CMS to DHS regarding the transfer of this data.
    b. Any and all communication within HHS about sharing this data, including the memo prepared by CMS staff detailing their objections to the sharing of personal information of non-citizen enrollees.

7. Did HHS and DHS enter into a data sharing agreement or any other memorandum of understanding pertaining to the use of Medicaid data or resources for the purposes of immigration enforcement? If so, please provide a copy of that agreement. If not, please explain why the agencies did not enter into a data sharing agreement or other memorandum and describe what, if any, policies and practices are in place regarding the storage, retrievability, access controls, retention, and disposal of the data, as required by the Privacy Act of 1974.

[13] Centers for Medicare & Medicaid Services, letter to state Medicaid Directors on May 27, 2025, https://www.cms.gov/files/document/open-borders-eo-notification-states.pdf.

Sincerely,



Alexandria Ocasio-Cortez
Member of Congress



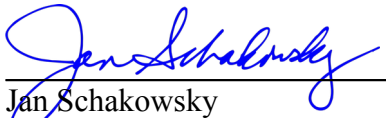
Diana DeGette
Member of Congress



Jesús G. "Chuy" García
Member of Congress



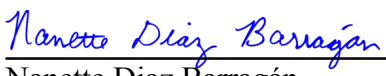
Lori Trahan
Member of Congress



Jan Schakowsky
Member of Congress



Debbie Dingell
Member of Congress



Nanette Diaz Barragán
Member of Congress



Robin L. Kelly
Member of Congress



Doris Matsui
Member of Congress



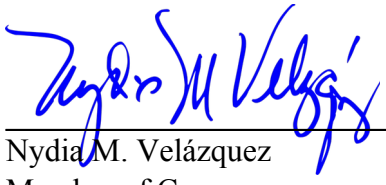
Adriano Espaillat
Chair
Congressional Hispanic Caucus



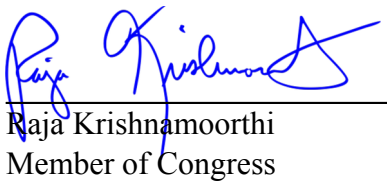
Eleanor Holmes Norton
Member of Congress



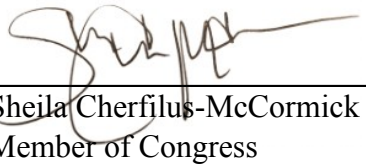
Delia C. Ramirez
Member of Congress



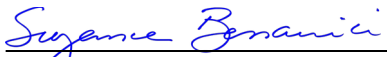
Nydia M. Velázquez
Member of Congress



Raja Krishnamoorthi
Member of Congress



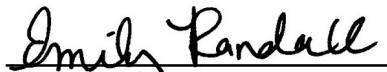
Sheila Cherfilus-McCormick
Member of Congress



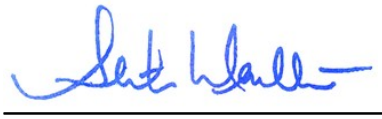
Suzanne Bonamici
Member of Congress



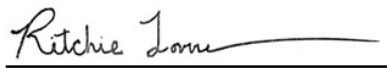
Rashida Tlaib
Member of Congress



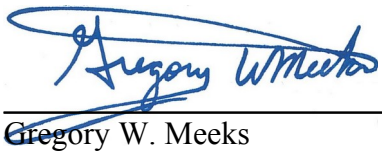
Emily Randall
Member of Congress



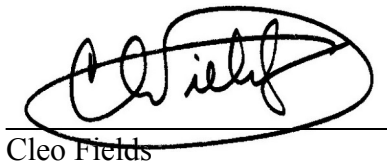
Seth Moulton
Member of Congress



Ritchie Torres
Member of Congress



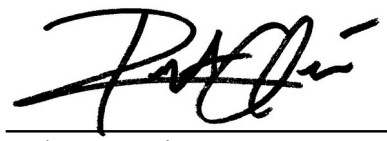
Gregory W. Meeks
Member of Congress



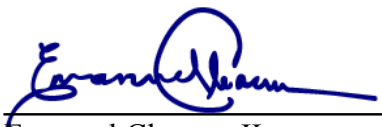
Cleo Fields
Member of Congress



Maxine Dexter
Member of Congress
Ranking Member,
Subcommittee on Oversight and Investigations



Robert Garcia
Member of Congress



Emanuel Cleaver, II
Member of Congress

Jill Tokuda
Member of Congress

Jerrold Nadler
Member of Congress

James P. McGovern
Member of Congress

Joaquin Castro
Member of Congress

Norma J. Torres
Member of Congress

Danny K. Davis
Member of Congress

Cc: Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

Congress of the United States

Washington, DC 20515

June 23, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Kennedy,

Over the past month, the Department of Health and Human Services (HHS) has issued contradictory and confusing guidance regarding COVID-19 vaccinations. These abrupt changes were made prior to the June 9th announcement in your opinion piece in the Wall Street Journal to fire all 17 active members of the Advisory Committee on Immunization Practices (ACIP), which had previously recommended shots for all Americans six months of age and older. Careful scientific review of vaccine safety and efficacy is essential, and the harmful release of inconsistent recommendations that lack scientific justification risks public and medical provider confusion, reduces access to vaccines, and ultimately endangers the nation's health.

On May 20th, the Food and Drug Administration (FDA) published a framework in the *New England Journal of Medicine* indicating that "… the FDA anticipates that it will be able to make favorable benefit-risk findings for adults over the age of 65 years and for all persons above the age of 6 months with one or more risk factors that put them at high risk for severe Covid-19 outcomes, as described by the CDC."[1] The framework lists pregnancy as a risk factor.

However, on May 27th you announced on your X account that COVID-19 vaccines for healthy children and healthy pregnant women had been removed from the CDC's recommended immunization schedule.[2] This announcement directly contradicted information on the CDC's website which recommended COVID-19 vaccination for pregnant women. Research shows evidence that pregnant women are more likely to become seriously ill from COVID-19 and more likely to need hospitalization, intensive care, or the use of a ventilator.[3] Thankfully, the CDC still maintains the recommendation for children in consultation with their providers, but it's incredibly concerning that pregnant women are removed. Further complicating this back-and-forth guidance, Food and Drug Administration (FDA) Commissioner Makary stated this change was made due to a "lack of data" for COVID-19 boosters, but the recommendation has been changed for primary vaccines as well.[4] Your decisions, seemingly on a whim, imperils the health of women and newborns who rely on maternal vaccinations for their own antibodies.

As justification for this radical shift in vaccination recommendations for pregnant women, HHS circulated a document to lawmakers that cited a study that confirmed "…the lack of association between SARS-CoV-2 vaccination and miscarriage, including after accounting for induced abortion."[5]. This misattribution of scientific literature to fit a predetermined decision to remove vaccine recommendations is incredibly dangerous and devalues the work of researchers to evaluate the safety and effectiveness of vaccines.

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[1] An Evidence-Based Approach to Covid-19 Vaccination | New England Journal of Medicine https://www nejm.org/doi/full/10.1056/NEJMsb2506929

[2] Secretary Kennedy on X: "Today, the COVID vaccine for healthy children and healthy pregnant women has been removed from @CDCgov recommended immunization schedule. https://x.com/seckennedy/status/1927368440811008138?s=46&t=kBbEX3mrEOJAU2F44vYIZQ

[3] COVID-19 Vaccination for Women Who Are Pregnant or Breastfeeding | COVID-19 | CDC https://www.cdc.gov/covid/vaccines/pregnant-or-breastfeeding.html#:~:text=When%20should%20I%20get%20the,at%20any%20point%20in%20pregnancy

[4] Full transcript of "Face the Nation with Margaret Brennan," June 1, 2025 - CBS News https://www.cbsnews.com/news/face-the-nation-full-transcript-06-01-2025/

[5] HHS justifies decision to stop recommending Covid shots during pregnancy with studies supporting the shots' safety - POLITICO

We are deeply concerned that these changes have been made without consultation from ACIP, contrary to your commitment to Chairman Cassidy to "maintain the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices without changes" while campaigning for the role of HHS Secretary.[6] Doubling down on your lie to Congress, you now write that ACIP "…has failed to scrutinize vaccine products given to babies and pregnant women" amongst other accusations.[7] It is our expectation that you will fully reinstate the fired ACIP members and that they will meet as scheduled on June 25th to discuss COVID-19 vaccination recommendations as noticed in the Federal Register.[8]

This rapid and inconsistent change in guidance may have broader consequences, such as whether insurance companies will pay for vaccines, whether they will be accessible to those who want them, and available to children through mandatory programs like the Vaccines for Children Program. It also injects unpredictability into the FDA regulatory process which can deter companies from investing in new products and pursuing new indications for existing products.

As members of Congress, we request a briefing from your staff on the justification for the recent changes to COVID-19 vaccination recommendations. We also request written responses to the following by July 15th, 2025:

1. Please provide the specific data you evaluated to justify your decision to change the CDC COVID-19 vaccination recommendations.
2. Pregnancy causes a state of relative immunocompromise compared to nonpregnant women. Given this, how should healthcare providers and patients distinguish "healthy pregnant women" from those who are at increased risk for severe infection?
3. Please provide analysis on the effect this new recommendation will have on insurance coverage and analysis of how many people would have to pay out-of-pocket if insurance is not required to cover COVID-19 vaccinations.
4. Please clarify whether the *Public Readiness and Emergency Preparedness Act* (PREP Act) declaration covers providers and pharmacists who administer vaccines to pregnant women now that the recommendation to vaccinate pregnant women has been removed.

Sincerely,

Kim Schrier, M.D.
Member of Congress

Mike Quigley
Member of Congress

Kevin Mullin
Member of Congress

[6] RFK Jr. to fire all members of the CDC's vaccine advisory committee - POLITICO
[7] RFK Jr.: HHS Moves to Restore Public Trust in Vaccines - WSJ
[8] 2025-10432.pdf

Paul Tonko
Member of Congress

Troy A. Carter, Sr.
Member of Congress

Angie Craig
Member of Congress

Nanette Diaz Barragán
Member of Congress

Emanuel Cleaver, II
Member of Congress

Darren Soto
Member of Congress

Doris Matsui
Member of Congress

Deborah K. Ross
Member of Congress

Jan Schakowsky
Member of Congress

Kathy Castor
Member of Congress

Jennifer L. McClellan
Member of Congress

Jimmy Panetta
Member of Congress

Diana DeGette
Member of Congress

Eleanor Holmes Norton
Member of Congress
Chair, Highways and Transit

Julie Johnson
Member of Congress

Dave Min
Member of Congress

Congress of the United States

Washington, DC 20515

April 9, 2025

Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Kennedy:

As members of the New York congressional delegation, we write regarding the Trump administration's recent attempt to rescind more than $11 billion in congressionally authorized funding from state and local health departments across the country. Under these cuts, New York state health departments will lose an estimated $400 million in critical health funding, with $100 million of that being pulled from the New York City Department of Health and Mental Hygiene alone.[1] These funds are used to monitor infectious disease outbreaks, provide mental health and substance use disorder treatment, and ensure access to other critical health services that New Yorkers rely on.

As a result of these actions, the New York State Department of Health has laid off more than 200 public health workers, including 50 full time staff and 168 public health fellows.[2] These fellows are part of the New York State Public Health Fellowship Corps, which was created to bolster New York's public health workforce and improve the state's ability to address future public health threats. In addition, at least 200 community-based organizations that provide mental health, maternal health, and other life-saving services have had their funding jeopardized.[3] Rescinding congressionally mandated funding is illegal and has already been blocked by a federal judge.[4] However, the administration is attempting to move forward with these cuts, regardless of the risks it creates for the health and safety of all Americans. Every single one of our constituents will be impacted by these actions.

Given the continued and unprecedented attacks on our nation's public health system, we request a meeting with you and your staff no later than April 22, 2025.

Sincerely,

Alexandria Ocasio-Cortez
Member of Congress

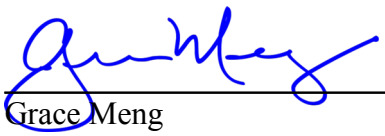
Jerrold Nadler
Member of Congress

1 "NYSACHO Statement on CDC Stop Work Orders and $400 Million in Cuts Threatening Public Health Emergency Response Across New York State," Press Release, New York State Association of County Health Officials (NYSACHO), (March 27, 2025), https://nysacho.org/wp-content/uploads/2025/03/NYSACHO-Press-Release-3-25-CDC-Stop-Work-Order-and-Cuts.pdf.

2 Caroline Lewis, "NY cuts more than 200 public health jobs following loss of federal funds," Gothamist, (April 3, 2025), https://gothamist.com/news/ny-cuts-more-than-200-public-health-jobs-following-loss-of-federal-funds.

3 "Attorney General Letitia James Sues Trump Administration for Slashing Vital Health Funding," Press Release, New York State Attorney General, (April 1, 2025), https://ag.ny.gov/press-release/2025/attorney-general-james-sues-trump-administration-slashing-vital-health-funding.

4 Jacob Rosen, Alexander Tin, "Federal judge temporarily blocks $11 billion in Trump administration's cuts to public health funding," CBS News, (April 3, 2025). https://www.cbsnews.com/news/trump-public-health-cuts-states-lawsuit/.



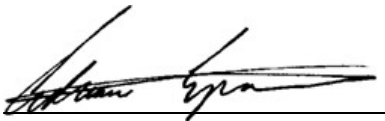
Grace Meng
Member of Congress



Hakeem Jeffries
Member of Congress



Paul Tonko
Member of Congress



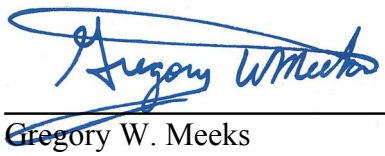
Adriano Espaillat
Member of Congress



Yvette D. Clarke
Member of Congress



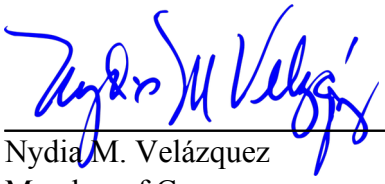
Patrick Ryan
Member of Congress



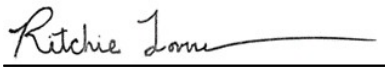
Gregory W. Meeks
Member of Congress



Dan Goldman
Member of Congress



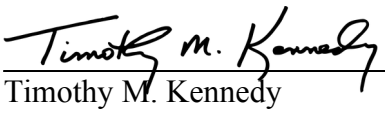
Nydia M. Velázquez
Member of Congress



Ritchie Torres
Member of Congress



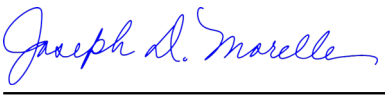
George Latimer
Member of Congress



Timothy M. Kennedy
Member of Congress



Josh Riley
Member of Congress



Joseph D. Morelle
Member of Congress

Thomas R. Suozzi
Member of Congress

John W. Mannion
Member of Congress

Laura A. Gillen
Member of Congress

DOGE begins to freeze health-care payments for extra review

DOGE is putting new curbs on billions of dollars in federal grants, requiring officials to manually review and approve payments that were previously routine.

April 17, 2025

By Dan Diamond, Carolyn Y. Johnson and Hannah Natanson

The U.S. DOGE Service is putting new curbs on billions of dollars in federal health-care grants, requiring government officials to manually review and approve previously routine payments — and paralyzing grant awards to tens of thousands of organizations, according to 12 people familiar with the new arrangements.

The effort, which DOGE has dubbed "Defend the Spend," has left thousands of payments backed up, including funding for doctors' and nurses' salaries at federal health centers for the poor. Some grantees are waiting on payments they expected last week.

The Trump administration is pushing to cut federal spending and crack down on grants that political officials say conflict with White House priorities.

DOGE, which stands for the Department of Government Efficiency, said the new initiative, which is being rolled out across parts of the Department of Health and Human Services, will force grantees and officials to justify spending and create transparency.

“Thanks to the great work by @HHSGov, for the first time ever, the American people will be able to see line-by-line payment descriptions & justifications — coming soon to the DOGE website,” the group posted on X last Saturday.

Typically, an organization that has been awarded a grant does not receive the funding up front. The money is held in a secure account managed by the government, and an organization will request “drawdowns” — tranches of money periodically throughout the year — to cover expenses such as salaries or research costs.

Under Defend the Spend, organizations must now include a justification for each transaction. Federal officials then review the justification before deciding whether to approve the payment.

The process has been abruptly instituted at the National Institutes for Health, the Administration for Children and Families, and other parts of HHS, with inconsistent instructions on how to proceed, said the people familiar with the arrangements, who, like others, spoke on the condition of anonymity because of fear of reprisal. They also described immediate backlogs in processing payments.

HHS said in a statement that the DOGE effort would not threaten “support for critical programs” and was intended to root out fraud and abuse. “The era of rubber stamping is over,” the HHS statement said.

Current and former federal officials said the process would create bottlenecks.

“Instead of cutting red tape, they are strangling grantees with it,” said Robert Gordon, who served as the HHS assistant secretary of financial resources during the Biden administration.

Some officials have been told that only Trump political appointees can sign requests to disburse funds, even if a career official has already approved it, adding an additional layer of review. The justification for each payment also must include an explanation of how the money will be used to advance Trump administration priorities, according to two employees in separate agencies who received high-level briefings on the process.

Federal officials also have been instructed to use a website run by DOGE to approve grant payments, according to an email sent by defendthespend@hhs.gov and obtained by The Washington Post.

NIH officials on Thursday were still determining who would approve grant payments at their agency and did not expect to finalize the process until next week, two NIH officials said.

Some outside organizations have been told their delayed payments are "in transit," but several federal officials said that is not true. It is unclear whether all the federal health-care grants will be approved and when.

"All funding is on hold," an NIH official told colleagues at a meeting on Thursday, according to audio obtained by The Post. "The bottom line is no one is getting any money right now. But they don't know they're not getting any money because it just says that it's 'in transit.'"

In the first months of the Trump administration, government officials have taken multiple steps to delay or halt federal grants. Those include slow-walking billions of dollars in research grants issued by agencies such as the NIH, and freezing or terminating grants to higher-education institutions, on the grounds that the universities did too little to combat antisemitism on campus, did too much to support transgender athletes or for other, indeterminate reasons.

DOGE engineers also recently inserted themselves into the government's long-established process to alert the public about potential federal grants and allow organizations to apply for funds. The group — which is backed by billionaire Elon Musk and stocked with young engineers and Musk allies — has said it is focused on cutting wasteful spending and making the government more efficient.

But the new initiative is creating holdups, staffers who award grants at the health agencies said in interviews. They described a hurried, uncertain process to roll out Defend the Spend, which involves fields added to Payment Management Services, a centralized system that processed nearly 500,000 transactions and more than $850 billion in payments last year. A DOGE engineer was given access to the system on Jan. 22 and was made an administrator, according to a Trump administration court filing last month.

At a meeting of grants management staff Wednesday, NIH officials explained that DOGE's process was instituted the previous Friday and that they would halt all payments until they had been through an extra layer of review, according to an NIH staffer.

The freeze had been put in place without any sort of formal announcement, leaving thousands of payment requests backed up and confusing organizations waiting for federal funds.

Catholic Charities of Fort Worth last week referred to the new requirements in a court filing that is part of its lawsuit against the Trump administration, saying it was "concerned" by the requests for additional information before drawing down funds. Catholic Charities of Fort Worth did not immediately respond to requests for comment.

Another grantee said they had requested funds in the last week but hadn't received them. An unsigned email told them to reach out to the agency.

"The payments are going through extra review," the email said.

Until this month, grantees had to provide progress reports and quarterly reports for federal review, but government staffers did not examine every single "drawdown" of funds requested, said one HHS employee.

Thousands of such "drawdowns" take place every day, the employee said. The DOGE system has imposed an extreme workload on government staff, the employee said.

Among those immediately suffering consequences are federal health centers, which provide services for low-income people and those who lack insurance, the employee said. Those centers rely on regular drawdowns for their operational expenses, such as doctors' and nurses' salaries and basic medical supplies.

If the funding delay continues much longer, the situation will grow dire for such centers, imperiling their ability to assist the poor, the employee said.

What readers are saying

The comments express strong criticism of the "Defend the Spend" initiative by DOGE, viewing it as a harmful measure that undermines federal health-care grants. Many commenters argue that the initiative is a deliberate attempt to cut funding for essential health services,... Show more

This summary is AI-generated. AI can make mistakes and this summary is not a replacement for reading the comments.

HEALTH & SCIENCE

The MAHA Report Cites Studies That Don't Exist

The Trump administration's "Make America Healthy Again" report misinterprets some studies and cites others that don't exist, according to the listed authors.



(Jacquelyn Martin/AP)

By Emily Kennard and Margaret Manto

May 29, 2025 05:36 AM Updated: May 29, 2025 07:52 PM

Health Secretary Robert F. Kennedy Jr. says his "Make America Healthy Again" Commission report harnesses "gold-standard" science, citing more than 500 studies and other sources to back up its claims. Those citations, though, are rife with errors, from broken links to misstated conclusions.

Seven of the cited sources don't appear to exist at all.

Epidemiologist Katherine Keyes is listed in the MAHA report as the first author of a study on anxiety in adolescents. When NOTUS reached out to her this week, she was surprised to hear of the citation. She does study mental health and substance use, she said. But she didn't write the paper listed.

"The paper cited is not a real paper that I or my colleagues were involved with," Keyes told NOTUS via email. "We've certainly done research on this topic, but did not publish a paper in JAMA Pediatrics on this topic with that co-author group, or with that title."

More on the MAHA Report

- The MAHA Report Has Been Updated With Fresh Errors
- The MAHA Report Cites a Paper Criticized as 'Junk Science' on Pesticides
- The MAHA Report Has Been Updated to Replace Citations That Didn't Exist
- Democrats Say MAHA Report Inconsistencies Show Kennedy Isn't Fit to Lead HHS
- The White House Blames 'Formatting Issues' for the MAHA Report's Citation Problems

It's not clear that anyone wrote the study cited in the MAHA report. The citation refers to a study titled, "Changes in mental health and substance abuse among US adolescents during the COVID-19 pandemic," along with a nonfunctional link to the study's digital object identifier. While the citation claims that the study appeared in the 12th issue of the 176th edition of the journal JAMA Pediatrics, that issue didn't include a study with that title.

As the Trump administration cuts research funding for federal health agencies and academic institutions and rejects the scientific consensus on issues like vaccines and gender-affirming care, the issues with its much-heralded MAHA report could indicate lessening concern for scientific accuracy at the highest levels of the federal government.

The Department of Health and Human Services did not respond to a request for comment on the report's citation inconsistencies prior to publication of this story.

The anxiety study wasn't the only one the report cites that appears to be mysteriously absent from the scientific literature. A section describing the "corporate capture of media" highlights two studies that it says are "broadly illustrative" of how a rise in direct-to-consumer drug advertisements has led to more prescriptions being written for ADHD medications and antidepressants for kids.

The catch? Neither of those studies is anywhere to be found. Here are the two citations:

Shah, M. B., et al. (2008). Direct-to-consumer advertising and the rise in ADHD medication use among children. Pediatrics, 122(5), e1055- e1060.

Findling, R. L., et al. (2009). Direct-to-consumer advertising of psychotropic medications for youth: A growing concern. Journal of Child and Adolescent Psychopharmacology, 19(5), 487-492.

Those articles don't appear in the table of contents for the journals listed in their citations. A spokesperson for Virginia Commonwealth University, where psychiatric researcher Robert L. Findling currently teaches, confirmed to NOTUS that he never authored such an article. The author of the first study doesn't appear to be a real ADHD researcher at all — at least, not one with a Google Scholar profile.

In another section titled, "American Children are on Too Much Medicine – A Recent and Emerging Crisis," the report claims that 25% to 40% of mild cases of asthma are overprescribed. But searching Google for the exact title of the paper it cites to back up that figure — "Overprescribing of oral corticosteroids for children with asthma" — leads to only one result: the MAHA report.

The corticosteroids study's supposed first author, pediatric pulmonologist Harold J. Farber, denied writing it or ever working with the other listed authors. He pointed to similar research he's conducted, but said that even if the MAHA report cited that study correctly, its conclusions are "clearly an overgeneralization" of the findings.

"It is a tremendous leap of faith to generalize from a study in one Medicaid managed care program in Texas using 2011 to 2015 data to national care patterns in 2025," Farber said in an email.

Spread across the footnotes of the 73-page document, those missing papers are listed alongside dozens of citations with more mundane errors like broken links, missing or incorrect authors and wrong issue numbers.

NOTUS also found serious issues with how the report interpreted some of the existing studies it cites.

In one section about mental health medication, which Kennedy has railed against for years, the report cites a review paper it claims shows that therapy alone is as or more effective than psychiatric medicine. But one of that paper's statisticians told NOTUS that conclusion doesn't make sense, given their study didn't even attempt to measure or compare therapy's effectiveness as a mental health treatment.

"We did not include psychotherapy in our review. We only compared the effectiveness of (new generation) antidepressants against each other, and against placebo," Joanne McKenzie, a biostatistics professor at an Australian university, said in an email.

Another paper, which the report says shows "antipsychotic prescriptions for children increased by 800% between 1993 and 2009," actually found an eight-fold increase from 1995 to 2005.

Another medical researcher whose work was cited in a section about how screen time affects children's sleep told us the MAHA report mischaracterized her study.

"The conclusions in the report are not accurate and the journal reference is incorrect. It was not published in Pediatrics. Also, the study was not done in children, but in college students," Mariana G. Figueiro emailed NOTUS. She added that she even had more relevant research the authors could have used: "I was not aware of the choice, or else I would have suggested one of the other ones."

The Trump administration commissioned the report to investigate the root causes of chronic illnesses in the U.S. From exposure to pesticides and microplastics to cell phone radiation and food coloring, the report points to many potential culprits — and claims it offers "a clear, evidence-based foundation for the policy interventions, institutional reforms, and societal shifts needed to reverse course." The commission is also scheduled to release a "Make Our Children Healthy Again Strategy" report in August.

Kennedy has enthusiastically promoted the report, calling it a "milestone" in a post on X after its release.

"Never in American history has the federal government taken a position on public health like this," Kennedy wrote.

UPDATE: White House press secretary Karoline Leavitt and Health and Human Services spokesperson Emily Hilliard later acknowledged some of the citation inconsistencies but dismissed them as formatting issues.

"Minor citation and formatting errors have been corrected, but the substance of the MAHA report remains the same — a historic and transformative assessment by the federal government to understand the chronic disease epidemic afflicting our nation's children," Hilliard told NOTUS in a statement. "Under President Trump and Secretary Kennedy, our federal government is no longer ignoring this crisis, and it's time for the media to also focus on what matters."

The administration updated the MAHA report to remove the seven references to reports that do not exist.

—

Emily Kennard and Margaret Manto are NOTUS reporters and Allbritton Journalism Institute fellows.

Have tips? You can reach Margaret on Signal at margaretmanto.61 and Emily at emilykennard.24.

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HEALTH & SCIENCE

The MAHA Report Has Been Updated to Replace Citations That Didn't Exist

An updated version of the report replaces citations, after the White House blamed errors on "formatting."



(Aaron Schwartz/Sipa USA via AP)

By Margaret Manto

May 29, 2025 04:54 PM

The White House is downplaying the "Make America Healthy Again" Commission report's citation issues, even as it scrambles to fix them.

A NOTUS investigation published Thursday found that at least seven of the report's citations appeared to not actually exist. The White House publicly blamed any problems with the report on "formatting issues."

Hours later, a new version of the MAHA report was published on the White House website with all seven of those citations replaced — five with completely different references and two with references to real studies written by the same authors of the nonexistent earlier citations.

While the replacement references all appear to be to real sources, it's not immediately clear whether they all support the claims the report is making.

The study included in the original report supposedly written by epidemiologist Katherine Keyes, for example, was replaced with a link to an article from KFF Health News on a similar topic.

The two nonexistent studies linking direct-to-consumer advertising to the rise in prescription medication use in children were replaced with links to a 2013 New York Times article about ADHD medications and a 2006 study titled, "Trends in the Use of Psychotropic Medications Among Adolescents, 1994 to 2001."

And the mysterious study by pediatric pulmonologist Harold J. Farber titled "Overprescribing of oral corticosteroids for children with asthma"? It was replaced by one of Farber's real publications, a study titled "Oral Corticosteroid Prescribing for Children With Asthma in a Medicaid Managed Care Program."

The new version of the report also swapped citations that NOTUS identified as being misinterpreted in the original. A study that was originally cited to back up the report's claim that psychotherapy can be as effective as psychotherapeutic drugs in the short term was replaced with another study after one of the first study's authors told NOTUS that their research didn't actually include psychotherapy as one of its conditions.

But even as changes take place behind the scenes, members and representatives of the Trump administration have continued to insist they still have faith in Health Secretary Robert F. Kennedy Jr.'s vision of "gold-standard science."

"Minor citation and formatting errors have been corrected, but the substance of the MAHA report remains the same — a historic and transformative assessment by the federal government to understand the chronic disease epidemic afflicting our nation's children," Health and Human Services spokesperson Emily Hilliard told NOTUS in a statement. "Under President Trump and Secretary Kennedy, our federal government is no longer ignoring this crisis, and it's time for the media to also focus on what matters."

Another administration source stood by the report. "Citation issues happen all the time," they told NOTUS. "The bulk of the report is still factually accurate — nothing changes in the report."

And at a White House press conference Thursday afternoon, press secretary Karoline Leavitt said that the White House still has "complete confidence in Secretary Kennedy and his team at HHS" and that the citation errors don't negate the substance of the report.

But, Leavitt added, she couldn't comment on whether HHS used AI tools when drafting the MAHA report. HHS also didn't provide any comment on whether its staff used AI.

—

Margaret Manto is a NOTUS reporter and an Allbritton Journalism Institute fellow. Violet Jira contributed reporting for this story.

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HEALTH & SCIENCE

The MAHA Report Has Been Updated With Fresh Errors

One psychologist who is newly cited in the report said the updated reference misconstrues his research.



(John McDonnell/AP)

By Margaret Manto and Emily Kennard

May 30, 2025 03:08 PM

The Trump administration's clean up of the "Make America Healthy Again" Commission's hallmark and error-riddled report is opening new questions about how the report's authors drew some of its sweeping conclusions about the state of Americans' health.

At least 18 of the original report's citations have been edited or completely swapped out for new references since NOTUS first revealed the errors Thursday morning. While some of the original

report's inconsistencies have been changed, a few of the new updated citations continue to misinterpret scientific studies.



One study NOTUS identified as misinterpreted in the original report was intended to support the claim that psychotherapy is more effective for children than medication for treating mental health concerns. That study was swapped out with a new "systematic overview" authored by psychologist Pim Cuijpers, who told NOTUS via email that MAHA's new citation is also wrong.

Cuijpers said his referenced study doesn't cover psychiatric medications in children at all — the research was focused on adults. The citation is located in a section of the MAHA report titled, "American children are highly medicated – and it's not working."

"Treatments of depression in adolescents have a different efficacy than treatments in adults, so they cannot be compared, and this reference is therefore not usable in adolescents," said Cuijpers, one of Amsterdam's most-cited psychologists. "It also fails to state that the combination of therapy and antidepressants is superior to therapy or antidepressants alone."

He added that there is no evidence that psychotherapy is more effective than antidepressants in adolescents.

He also took issue with the report's claim that "antidepressant prescription rates in teens increased by 14-fold between 1987 and 2014."

"It is strange to say that," he said. "Modern antidepressants were developed in the late 1980s. So it can also be said that these drugs were simply used for the adolescents who could benefit from them."

More on the MAHA Report

- The MAHA Report Cites a Paper Criticized as 'Junk Science' on Pesticides
- The MAHA Report Has Been Updated to Replace Citations That Didn't Exist
- Democrats Say MAHA Report Inconsistencies Show Kennedy Isn't Fit to Lead HHS
- The White House Blames 'Formatting Issues' for the MAHA Report's Citation Problems

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HHS did not immediately respond to a request for comment on the report's changes.

The seven studies cited in the original report identified by NOTUS as nonexistent were all replaced with other studies or news articles. But some sources that NOTUS didn't flag as nonexistent or otherwise problematic in its initial review were swapped out, including a citation on a line about screen use disrupting melatonin production in children.

The original cited study ("Exposure to room light before bedtime suppresses melatonin onset and shortens melatonin duration in humans") was exchanged for another ("Digital media and sleep in childhood and adolescence"). NOTUS hasn't yet identified a clear reason for the switch, but it's possibly because the original study cited only looks at how ambient lighting affects melatonin in adults.

Trump administration officials have so far downplayed the seriousness of the issues in the MAHA report. White House press secretary Karoline Leavitt called them "formatting issues" and said the White House still has full confidence in Secretary Robert F. Kennedy Jr. And an HHS press secretary told NOTUS in an email late Thursday that "minor citation and formatting errors have been corrected."

A batch of errors was corrected sometime between 10:15 a.m. and 3:28 p.m. Thursday, according to versions of the document archived by the Wayback Machine. But even the process by which the MAHA report was updated doesn't meet the normal standards of making corrections to scientific papers, according to epidemiologist David Michaels.

“It is a basic practice of scientific journals to note when corrections are made,” Michaels said.

Thursday’s changes were also not the report’s first update. Earlier this week, WhiteHouse.gov hosted a version called “Microsoft Word - WH - The MAHA Report - 1PM_Updated_5.24_10AM_DPC_5.26_6PM_5.27_6PM_CLEAN,” which noted within five citations that specific changes, like fixing hyperlinks and incorrect author listings, were made on Tuesday.

But as reporters found more inaccuracies within the report on Thursday, the White House stopped denoting changes and removed references to past corrections. Officials continued to update the report throughout the night to remove AI chatbot fingerprints and other errors, according to The Washington Post.

Another “correction” to address a nonexistent study cited in the original is still misstating the credited researcher’s conclusion, he told NOTUS.

The report initially cited a pulmonologist (though not a real paper he contributed to) to support the claim that “an estimated 25-40% of mild cases” of asthma are overprescribed drugs.

Pulmonologist Harold J. Farber acknowledged he did find overprescription in a very limited study on one Medicaid-managed care program in Texas, which used data from 2011 to 2015. But at the time, he rejected the idea that those results were at all generalizable before the report was updated.

Farber outlined those concerns for NOTUS' first story on the citations, saying using that specific study of his to generalize about national asthma-care patterns would require a "tremendous leap of faith."

But now, after an update, the MAHA report cites that Medicaid-managed care program study in Texas to say that there is "evidence of overprescription of oral corticosteroids for mild cases of asthma" — attempting to paint a national picture about asthma care that Farber doesn't believe is nuanced or accurate.

"Our challenge in asthma is that there is both over-prescribing and under-prescribing. In the 1990s, under-treatment and under-recognition of asthma were common," Farber told NOTUS via email. "The challenge is to right-size, not too much and not too little. You don't want to throw out the baby with the bath water."

Another correction was to fix a citation for a study that was attributed to incorrect authors — citation 337, which was, until Thursday night, attributed to "Barros, R. M., Silver, E. J., & Stein, R. E. K. (2011). Recess, physical education, and elementary school student outcomes. Economics of Education Review, 30(6), 1358–1364."

Now, it's attributed to "Barros, R. M., Silver, E. J., & Stein, R. E. (2009). School recess and group classroom behavior. Pediatrics, 123(2), 431–436. https://doi.org/10.1542/peds.2007-2825." The bibliographic information is correct — but the study still fails to support the report's claim that "since the 1970s, recess and physical education (PE) have steadily declined."

The study says it simply "compares the group classroom behavior of children receiving daily recess with that of children not receiving daily recess," focusing on just 8-to 9-year-old children.

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Margaret Manto and Emily Kennard are NOTUS reporters and Allbritton Journalism Institute fellows.

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FAH STATEMENT | MEDICAID | FAH POLICY BLOG TEAM

“A death knell to critical hospital services” – FAH Statement Following Passage of House Budget Reconciliation Bill

MAY 22, 2025

Washington, D.C. — The Federation of American Hospitals’ (FAH) President and CEO, Chip Kahn, released the following statement after the House passed the budget reconciliation bill, *H.Con.Res.14*:

“For months, Americans and the local hospitals who serve them have sent a clear warning to House leadership: don’t slash Medicaid and threaten health care access for communities across the country – in other words, ‘do no harm.’ The House budget reconciliation bill fails this test with devastating Medicaid cuts – including caps on provider taxes and state-directed payments – that will hand tie states’ abilities to fund their Medicaid programs, cause millions of Americans to lose coverage, and be a death knell to critical hospital services and entire communities’ access to care.

“There is still time to take heed and turn this ship. As the budget reconciliation process progresses, we look forward to working with lawmakers to advance policies that protect local hospitals and Americans’ health care by safeguarding Medicaid and extending the enhanced tax credits that millions of hardworking Americans rely on.”

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FAH STATEMENT | TAX CREDITS | MEDICAID | FAH POLICY BLOG TEAM

“The Senate just made a bad bill worse” – FAH Reacts to Senate Finance Committee’s Reconciliation Text

JUNE 16, 2025

The Federation of American Hospitals’ President and CEO, Chip Kahn, released the following statement after the Senate Finance Committee released its budget reconciliation text:

“The Senate just made a bad bill worse. The Senate’s slashes to important state Medicaid programs will further threaten access to care for millions of hardworking Americans. Rural communities across the country will be the hardest hit, with struggling hospitals compelled to face difficult decisions about what services to cut. It’s imperative Senators take a detour on this text and reject its deepening of the House cuts already on the table.

“Senators cannot let their local hospitals shutter services or close their doors. Now is the time to stand up for hardworking patients, push back on these draconian reductions, and protect Americans’ access to 24/7 care.”

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ARTICLE • EXPOSE THE HEIST: POWER AND POLICY IN UNPRECEDENTED TIMES

Alleged Kickbacks Further Expose Medicare Advantage Corruption

May 13, 2025
By Brandon Novick



CEPR CENTER FOR ECONOMIC AND POLICY RESEARCH

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Around the same time as the Trump Administration decided to more than double the increase in the payment rate to health insurance companies in Medicare Advantage (MA) compared to what the Biden Administration had proposed, the Department of Justice (DOJ) has taken legal action against some of the largest actors in the program. An alleged scheme of illegal kickbacks and discrimination against people with disabilities highlights the failure of privatized Medicare to introduce an efficient market that benefits patients. It has, however, enabled corporate manipulation and profiteering to succeed at the expense of taxpayer money.

Earlier this month, the DOJ) filed a complaint accusing three of the largest insurance companies within the MA program along with three of the largest insurance brokers of violating the False Claims Act. Allegedly, Humana, Elevance Health (formerly known as Anthem), and Aetna (owned by CVS) paid illegal kickbacks to three insurance brokers – eHealth and its affiliate GoHealth along with SelectQuote – in exchange for directing seniors to enroll in their plans.

Health insurance is often very complex; therefore, many people who have to purchase individual plans on the private market request help from insurance broker organizations. As Medicare Advantage is privatized Medicare, where different companies offer thousands of different plans, many seniors look to brokers for help. There are many details people have to consider when looking at plans that brokers supposedly help analyze: are certain doctors and providers in a plan's network, does a plan cover specific prescription medication, what are the various costs (deductibles, coinsurance, copayments, out-of-pocket limits)?

Yet, insurance brokers predominantly make money from the sales they deliver to insurance companies (i.e. getting people to enroll in their plans). To prevent kickbacks prohibited under the federal Anti-Kickback Statute, the Centers for Medicare and Medicaid Services (CMS) requires brokers to act in the best interest of patients and limits the compensation MA insurers can provide to brokers.

However, stating the law and enforcing it are different, and the DOJ complaint documents how Humana, Elevance Health, and Aetna allegedly hid illegal kickbacks to brokers by disguising them as administrative fees. The DOJ quotes meeting notes and discovered statements from insurance company and broker employees alike. For example, one employee of eHealth wrote that Aetna's payment method was "not even a little compliant. . . . I'm pretty sure if Aetna got audited by cms, they'd be fuc[**]ed." In sworn testimony, Aetna's executive director of the Strategic Sales Channel John Sowell said:

“[T]he partners [i.e., brokers] put us in a pay for performance mindset. The cost of securing business, therefore supporting business, went up year over year. Other carriers were paying them earlier. And the only way to participate and to have a seat at the table was to support them with marketing funds.”

Seniors already have to navigate the complexities between thousands of different plans from various insurers. The integrity of brokers is also in question with the corrupting influence of alleged insurance company kickbacks.

What We Already Knew About Medicare Advantage

The DOJ lawsuit follows previous actions in Congress, such as a November 2022 report by the Senate Finance Committee documenting deceptive marketing practices by brokers, such as overselling benefits in MA plans and targeting vulnerable consumers such as those with cognitive impairments. In October 2023, the Committee held a hearing on the same topic.

In March 2025, ranking member Senator Ron Wyden (D-OR) released a report finding that MA plans increased spending on “agents and brokers fees and commissions” from $2.4 billion to $6.9 billion from 2018 to 2023. The report complements the DOJ’s lawsuit, by noting how insurance companies have found loopholes around CMS’s cap on payments to brokers for enrollment services through inflated administrative costs.

Kickbacks to insurance brokers further debunk the idea that Medicare Advantage unleashes the benefits of a free market to Medicare. Rather than seniors choosing the best plans in a transparent, competitive marketplace, large insurance companies use their economic power to push their plans on seniors regardless of whether they are actually the most beneficial. This obstacle adds to the existing barriers for beneficiaries that brokers are supposedly here to help navigate: choosing from thousands of plans with complex differences between them.

Patient Discrimination

Medicare Advantage insurers do not just get more taxpayer money by enrolling more people; they profit from inflating how sick seniors in their plans are, and then spending as little as possible on covering health care. Indeed, the Medicare Payment Advisory Commission (MedPAC) has found that the MA program has not only never saved taxpayers money compared to traditional Medicare, but taxpayers have overpaid hundreds of billions of dollars to insurers. For 2025, MedPAC estimates that insurers will reap $84 billion in overpayments. Building on this estimate, the Committee for a Responsible Federal Budget estimates $1.2 trillion in overpayments from 2025-2034. For reference, $1.2 trillion is over $300 billion more than the government would

save if congressional Republicans succeed in their plan to cut Medicaid spending by up to $880 billion

The two dominant ways that Medicare Advantage companies steal taxpayer money are upcoding and favorable selection. CMS pays insurers through capitation, or per-person payments based on how sick they supposedly are. Upcoding refers to when insurers use false or irrelevant diagnoses to make their enrollees seem sicker, inflate their risk score, and ultimately increase the amount of money CMS pays to cover them. Favorable selection is simply the process of insurance companies seeking to enroll healthier patients so that they don't actually have to spend as much covering their health care costs. The less insurers spend, the more taxpayer dollars they keep.

While Medicare Advantage companies publicly deny any wrongdoing, the DOJ complaint reveals alleged behavior that clearly reflects favorable selection. More specifically, Aetna and Humana used their illegal kickback arrangements to pressure brokers to enroll fewer disabled people in their plans, viewing them as more costly to cover. For example, the DOJ alleges that Humana filtered out calls, rejected leads, and strategically altered "the broker's marketing methods to avoid enrolling beneficiaries with disabilities."

Aside from the fact that discriminating against beneficiaries with disabilities is illegal, it shines a bright light on the real motivations of health insurance companies. All the advertising and statements by corporate officials claiming to care about making people healthy are pure public relations. These companies want to spend as little as possible on fulfilling their purpose – covering health care – so they can keep more as profits, and they have been very successful. Insurance companies reap significantly higher profits in Medicare Advantage than other types of health coverage. For example, gross margins in MA were $1,982 per enrollee in 2023 compared to $1,048 in the individual market, $910 in the group market, and $753 in Medicaid managed care.

Taxpayers fund Medicare Advantage because Congress decided – especially since the 1982 Tax Equity and Fiscal Responsibility Act – to funnel money from the traditional Medicare program to private insurance companies as part of an effort to introduce competitive markets and lower spending. The Medicare program covers people under the age of 65 with qualifying disabilities along with many seniors with disabilities. Avoiding coverage of this key population for the sake of profit demonstrates a clear break between the purpose of Medicare and the goals of health insurance companies.

'Make America Healthy Again' report cites nonexistent studies: authors

BY BILL MCCARTHY
THU MAY 29 2025 11:36:53 GMT-0400

- Noah Kreski, a Columbia University researcher listed as an author of a paper on adolescent anxiety and depression during the Covid-19 pandemic, told AFP the citation is "not one of our studies" and "doesn't appear to be a study that exists at all."

At least four of the studies cited in a flagship White House report on children's health do not exist, authors listed in the document told AFP Thursday, casting doubt on the paper outlining US Health Secretary Robert F. Kennedy Jr.'s agenda.

The highly anticipated "Make America Healthy Again" (MAHA) report was released on May 22 by the presidential commission tasked with assessing drivers of childhood chronic disease.

But it includes broken citation links and credits authors with papers they say they did not write.

White House Press Secretary Karoline Leavitt described the mishaps as "formatting issues" during a press briefing Thursday and said the report will be updated to address them.

"It does not negate the substance of the report," said Leavitt, who expressed confidence in Kennedy and his team, and insisted that their work was "backed on good science."

The errors were first reported Thursday by NOTUS, a US digital news website affiliated with the nonprofit Allbritton Journalism Institute.

Noah Kreski, a Columbia University researcher listed as an author of a paper on adolescent anxiety and depression during the Covid-19 pandemic, told AFP the citation is "not one of our studies" and "doesn't appear to be a study that exists at all."

The citation includes a link that purports to send users to an article in the peer-reviewed medical journal JAMA, but which is broken.

Jim Michalski, a spokesman for JAMA Network, said it "was not published in JAMA Pediatrics or in any JAMA Network journal."

Columbia University epidemiologist Katherine Keyes, who was also listed as an author of the supposed JAMA study, told AFP she does research on the topic but does not know where the statistics credited to her came from, and that she "did not write that paper."

"I would be happy to send this information to the MAHA committee to correct the report, although I have not yet received information on where to reach them."

'Totally fabricated'

Guohua Li, another Columbia University professor apparently named in the citation, said the reference is "totally fabricated" and that he does not even know Kreski.

AFP also spoke with Harold Farber, pediatrics professor at Baylor College of Medicine, who said the paper attributed to him "does not exist" nor had he ever collaborated with the co-authors credited in the MAHA report.

Similarly, Brian McNeill, spokesperson for Virginia Commonwealth University, confirmed that professor Robert Findling did not author a paper the report says he wrote about advertising of psychotropic medications for youth.

A fourth paper on ADHD medication was also not published in the journal Pediatrics in 2008 as claimed in the MAHA report, according to Alex Hulvalchick, media relations specialist for the journal's publisher, the American Academy of Pediatrics.

'Rife with misinformation'

The Department of Health and Human Services (HHS) declined to comment, referring AFP's questions to the White House.

At her briefing, Leavitt declined to answer how the report was produced and whether artificial intelligence tools may have been used to craft it, directing those questions back to HHS.

The Democratic National Committee blasted the report as "rife with misinformation" in a Thursday press release, saying Kennedy's agency "is justifying its policy priorities with studies and sources that do not exist."

Kennedy was approved as health secretary earlier this year despite widespread alarm from the medical community over his history of promoting vaccine misinformation and denying scientific facts.

Since taking office, he has ordered the National Institutes of Health to probe the causes of autism -- a condition he has long falsely tied to the measles, mumps, and rubella (MMR) vaccine.

The report's chronic disease references appear to nod to that same disproven theory, discredited by numerous studies since the idea first aired in a late 1990s paper based on falsified data.

It also criticizes the "over-medicalization" of children, citing surging prescriptions of psychiatric drugs and antibiotics, and blaming "corporate capture" for skewing scientific research.

mgs-bmc/sst

UNITEDHEALTH GROUP

UnitedHealth Group Reports 2024 Results

- ***Revenues of $400.3 Billion Grew 8% Year-Over-Year***
- ***Domestic Consumers Served by UnitedHealthcare Grew 2.1 Million***
- ***Value-Based Care Patients Served by Optum Grew 600,000***
- ***Cash Flows from Operations were $24.2 Billion or 1.6x Net Income***
- ***Full Year, Fourth Quarter Net Earnings were $15.51, $5.98 Per Share***
- ***Full Year, Fourth Quarter Adjusted Net Earnings were $27.66, $6.81 Per Share***
- ***Company Affirms 2025 Performance Outlook***

(January 16, 2025) UnitedHealth Group (NYSE: UNH) reported full year and fourth quarter 2024 results reflecting diversified growth in serving people more extensively at Optum and UnitedHealthcare.

“The people of UnitedHealth Group remain focused on making high-quality, affordable health care more available to more people while making the health system easier to navigate for patients and providers, positioning us well for growth in 2025,” said Andrew Witty, chief executive officer of UnitedHealth Group.

UnitedHealth Group affirmed the 2025 performance outlook established in December 2024, including revenues of $450 billion to $455 billion, net earnings of $28.15 to $28.65 per share, adjusted net earnings of $29.50 to $30.00 per share and cash flow from operations of $32 billion to $33 billion.

UNITEDHEALTH GROUP

Quarterly and Annual Financial Performance
(in billions, except percentages)

	Three Months Ended			Year Ended		
	Dec 31, 2024	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**	**Dec 31, 2024**	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**
Revenues	$100.8	$100.8	$94.4	$400.3	$400.5	$371.6
Earnings from Operations	$7.8	$8.3	$7.7	$32.3	$34.4	$32.4
Net Margin	5.5%	5.9%	5.8%	3.6%	6.1%	6.0%

- UnitedHealth Group's 2024 revenues grew $28.7 billion or 8% year-over-year to $400.3 billion, driven primarily by serving people more comprehensively across the enterprise. Full year 2024 earnings from operations were $32.3 billion. Adjusted earnings from operations of $34.4 billion exclude the cyberattack direct response costs and South American impacts.

- The full year medical care ratio was 85.5% compared to 83.2% in 2023. The increase was primarily due to previously discussed items, including the revenue effects of CMS's Medicare funding reductions, member mix and timing of Medicaid redeterminations. Factors cited on the company's third quarter earnings call, including increased hospital coding intensity and specialty medication prescribing, continued at similar levels in the fourth quarter and are reflected in the company's 2025 outlook. Days claims payable of 47.0 compared to 47.4 in third quarter 2024 and 47.9 at year end 2023. The company did not have any favorable earnings impacting medical reserve development in the fourth quarter.

- The full year 2024 operating cost ratio of 13.2% compared to 14.7% in 2023, reflecting gains from business portfolio refinement and strong improvement in operating efficiencies and consumer experiences. The business portfolio refinement, including strategic transactions, will enhance growth opportunities and contributed about 80 basis points, nearly half at Optum Health with the remainder split between UnitedHealthcare and Optum Insight.

- Cash flows from operations for the full year were $24.2 billion, or 1.6 times net income. During 2024, the company returned over $16 billion to shareholders through dividends and share repurchases. Return on equity of 23.7% in the fourth quarter, reflected the company's consistent, broad-based earnings and efficient capital structure.

UnitedHealthcare provides health care benefits globally, serving individuals and employers, and Medicare and Medicaid beneficiaries. UnitedHealthcare is dedicated to improving the value customers and consumers receive by improving health and wellness, enhancing the quality of care received, simplifying the health care experience and reducing the total cost of care.

Quarterly and Annual Financial Performance
(in billions, except percentages)

	Three Months Ended			Year Ended		
	Dec 31, 2024	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**	**Dec 31, 2024**	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**
Revenues	$74.1	$74.1	$70.8	$298.2	$298.4	$281.4
Earnings from Operations	$3.0	$3.0	$3.1	$15.6	$16.2	$16.4
Operating Margin	4.0%	4.1%	4.4%	5.2%	5.4%	5.8%

- UnitedHealthcare full year revenues of $298.2 billion increased $16.8 billion or 6% year-over-year. Operating earnings were $15.6 billion.
- The number of consumers served with domestic commercial benefits grew by 2.4 million in 2024, reflecting strong customer response to the company's innovative offerings which enhance transparency and consumer choice. In 2025, one in four of our largest fee-based employer customers are offering such plans.
- The number of people served by the company's offerings for seniors and people with complex needs grew to 9.4 million due to product designs tailored to meet the specific needs of individuals and families with limited economic resources and who are underserved.
- People served by the company's state-based community offerings moderated as expected to 7.4 million due to the now concluded Medicaid eligibility redeterminations process, partially offset by new and expanded customer relationships. UnitedHealthcare expanded with state customers including Michigan, Idaho, Nevada and Georgia in 2024, providing momentum the company expects will lead to a return to growth in people served in 2025.

Optum

The Optum health services businesses serve the global health care marketplace, including payers, care providers, employers, governments, life sciences companies and consumers. Using market-leading information, analytics and technology to yield clinical insights, Optum helps improve overall health system performance by optimizing care quality, reducing care costs and improving the consumer experience.

Quarterly and Annual Financial Performance
(in billions, except percentages)

	Three Months Ended			Year Ended		
	Dec 31, 2024	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**	**Dec 31, 2024**	**Dec 31, 2024 (Adj)**	**Dec 31, 2023**
Revenues	$65.1	$65.1	$59.5	$253.0	$253.0	$226.6
Earnings from Operations	$4.8	$5.2	$4.6	$16.7	$18.2	$15.9
Operating Margin	7.4%	8.0%	7.7%	6.6%	7.2%	7.0%

- Optum full year revenues of $253 billion grew $26.3 billion or 12% year-over-year, led by Optum Rx and Optum Health. Operating earnings were $16.7 billion and adjusted operating earnings were $18.2 billion. Adjusted operating earnings exclude costs to support the Change Healthcare direct response efforts.

- Optum Health revenues grew to $105.4 billion, driven by growth in patients served under value-based care arrangements and continued expansion of the types and level of care provided. At the end of 2024, Optum Health served 4.7 million people with value-base care and expects to grow to serve an additional 650,000 patients in 2025.

- Optum Insight revenues were $18.8 billion, with the 1% year-over-year decline reflecting the business disruption effects of the cyberattack, which were $867 million. Operating earnings were $3.1 billion and adjusted operating earnings, which exclude cyberattack direct response costs, were $4.4 billion. The revenue backlog grew by $700 million over last year, largely due to new health system partnerships.

- Optum Rx revenues increased 15% in 2024 due to growth in new clients as well as expanded relationships with existing clients. Optum Rx continued to advance its comprehensive scope of pharmacy services offered, including specialty and community-based pharmacies. Adjusted scripts grew to 1.62 billion, compared to 1.54 billion last year.

About UnitedHealth Group

UnitedHealth Group (NYSE: UNH) is a health care and well-being company with a mission to help people live healthier lives and help make the health system work better for everyone through two distinct and complementary businesses. Optum delivers care aided by technology and data, empowering people, partners and providers with the guidance and tools they need to achieve better health. UnitedHealthcare offers a full range of health benefits, enabling affordable coverage, simplifying the health care experience and delivering access to high-quality care. Visit UnitedHealth Group at www.unitedhealthgroup.com and follow UnitedHealth Group on LinkedIn.

Earnings Conference Call

As previously announced, UnitedHealth Group will discuss the company's results, strategy and future outlook on a conference call with investors at 8:45 a.m. Eastern Time today. UnitedHealth Group will host a live webcast of this conference call from the Investor Relations page of the company's website (www.unitedhealthgroup.com). Following the call, a webcast replay will be on the Investor Relations page through January 30, 2025. This earnings release and the Form 8-K dated January 16, 2025, can also be accessed from the Investor Relations page of the company's website.

Non-GAAP Financial Information

This news release presents non-GAAP financial information provided as a complement to the results provided in accordance with accounting principles generally accepted in the United States of America ("GAAP"). A reconciliation of the non-GAAP financial information to the most directly comparable GAAP financial measure is provided in the accompanying tables found at the end of this release.

Forward-Looking Statements

The statements, estimates, projections, guidance or outlook contained in this document include "forward-looking" statements which are intended to take advantage of the "safe harbor" provisions of the federal securities laws. The words "believe," "expect," "intend," "estimate," "anticipate," "forecast," "outlook," "plan," "project," "should" and similar expressions identify forward-looking statements. These statements may contain information about financial prospects, economic conditions and trends and involve risks and uncertainties. Actual results could differ materially from those that management expects, depending on the outcome of certain factors including: our ability to effectively estimate, price for and manage medical costs; new or changes in existing health care laws or regulations, or their enforcement or application; cyberattacks, other privacy/data security incidents, or our failure to comply with related regulations; reductions in revenue or delays to cash flows received under government programs; changes in Medicare, the CMS star ratings program or the application of risk adjustment data validation audits; the DOJ's legal action relating to the risk adjustment submission matter; our

ability to maintain and achieve improvement in quality scores impacting revenue; failure to maintain effective and efficient information systems or if our technology products do not operate as intended; risks and uncertainties associated with our businesses providing pharmacy care services; competitive pressures, including our ability to maintain or increase our market share; changes in or challenges to our public sector contract awards; failure to achieve targeted operating cost productivity improvements; failure to develop and maintain satisfactory relationships with health care payers, physicians, hospitals and other service providers; the impact of potential changes in tax laws and regulations; increases in costs and other liabilities associated with litigation, government investigations, audits or reviews; failure to complete, manage or integrate strategic transactions; risk and uncertainties associated with the sale of our remaining operations in South America; risks associated with public health crises arising from large-scale medical emergencies, pandemics, natural disasters and other extreme events; failure to attract, develop, retain, and manage the succession of key employees and executives; our investment portfolio performance; impairment of our goodwill and intangible assets; failure to protect proprietary rights to our databases, software and related products; downgrades in our credit ratings; and our ability to obtain sufficient funds from our regulated subsidiaries or from external financings to fund our obligations, reinvest in our business, maintain our debt to total capital ratio at targeted levels, maintain our quarterly dividend payment cycle, or continue repurchasing shares of our common stock.

This above list is not exhaustive. We discuss these matters, and certain risks that may affect our business operations, financial condition and results of operations, more fully in our filings with the SEC, including our reports on Forms 10-K, 10-Q and 8-K. By their nature, forward-looking statements are not guarantees of future performance or results and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Actual results may vary materially from expectations expressed or implied in this document or any of our prior communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. We do not undertake to update or revise any forward-looking statements, except as required by law.

# # #

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UNITEDHEALTH GROUP
Earnings Release Schedules and Supplementary Information
Year Ended December 31, 2024

- Condensed Consolidated Statements of Operations
- Condensed Consolidated Balance Sheets
- Condensed Consolidated Statements of Cash Flows
- Revenues by Business - Supplemental Financial Information
- Earnings by Business - Supplemental Financial Information
- People Served and Performance Metrics - Supplemental Financial Information
- Reconciliation of Non-GAAP Financial Measures

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(in millions, except per share data; unaudited)

	Three Months Ended December 31,		Year Ended December 31,	
	2024	2023	2024	2023
Revenues				
Premiums	$76,483	$73,228	$308,810	$290,827
Products	13,475	11,311	50,226	42,583
Services	9,298	8,709	36,040	34,123
Investment and other income	1,551	1,179	5,202	4,089
Total revenues	100,807	94,427	400,278	371,622
Operating costs				
Medical costs	67,035	62,231	264,185	241,894
Operating costs	12,494	13,339	53,013	54,628
Cost of products sold	12,464	10,194	46,694	38,770
Depreciation and amortization	1,041	974	4,099	3,972
Total operating costs	93,034	86,738	367,991	339,264
Earnings from operations	7,773	7,689	32,287	32,358
Interest expense	(1,003)	(830)	(3,906)	(3,246)
Gain (loss) on sale of subsidiary and subsidiaries held for sale	21	—	(8,310)	—
Earnings before income taxes	6,791	6,859	20,071	29,112
Provision for income taxes	(1,007)	(1,184)	(4,829)	(5,968)
Net earnings	5,784	5,675	15,242	23,144
Earnings attributable to noncontrolling interests	(241)	(220)	(837)	(763)
Net earnings attributable to UnitedHealth Group common shareholders	$5,543	$5,455	$14,405	$22,381
Diluted earnings per share attributable to UnitedHealth Group common shareholders	$5.98	$5.83	$15.51	$23.86
Adjusted earnings per share attributable to UnitedHealth Group common shareholders (a)	$6.81	$6.16	$27.66	$25.12
Diluted weighted-average common shares outstanding	927	935	929	938

(a) See page 7 for a reconc at on of non-GAAP measures.

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED BALANCE SHEETS
(in millions; unaudited)

	December 31, 2024	December 31, 2023
Assets		
Cash and short-term investments	$29,113	$29,628
Accounts receivable, net	22,365	21,276
Other current assets	34,301	27,533
Total current assets	85,779	78,437
Long-term investments	52,354	47,609
Other long-term assets	160,145	147,674
Total assets	$298,278	$273,720
Liabilities, redeemable noncontrolling interests and equity		
Medical costs payable	$34,224	$32,395
Short-term borrowings and current maturities of long-term debt	4,545	4,274
Other current liabilities	65,000	62,385
Total current liabilities	103,769	99,054
Long-term debt, less current maturities	72,359	58,263
Other long-term liabilities	19,559	17,484
Redeemable noncontrolling interests	4,323	4,498
Equity	98,268	94,421
Total liabilities, redeemable noncontrolling interests and equity	$298,278	$273,720

UNITEDHEALTH GROUP
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(in millions; unaudited)

	Year Ended December 31,	
	2024	**2023**
Operating Activities		
Net earnings	$15,242	$23,144
Noncash items:		
Depreciation and amortization	4,099	3,972
Deferred income taxes and other	(3,657)	(750)
Share-based compensation	1,018	1,059
Loss on sale of subsidiary and subsidiaries held for sale	8,310	—
Net changes in operating assets and liabilities	(808)	1,643
Cash flows from operating activities	24,204	29,068
Investing Activities		
Sales and maturities of investments, net of purchases (purchases, net of sales and maturities)	525	(1,777)
Purchases of property, equipment and capitalized software	(3,499)	(3,386)
Cash paid for acquisitions and other transactions, net	(13,408)	(10,136)
Loans to care providers - cyberattack	(9,033)	—
Repayment of care provider loans - cyberattack	4,514	—
Other, net	374	(275)
Cash flows used for investing activities	(20,527)	(15,574)
Financing Activities		
Common share repurchases	(9,000)	(8,000)
Dividends paid	(7,533)	(6,761)
Net change in short-term borrowings and long-term debt	14,660	4,280
Other, net	(1,639)	(1,048)
Cash flows used for financing activities	(3,512)	(11,529)
Effect of exchange rate changes on cash and cash equivalents	(61)	97
Increase in cash and cash equivalents, including cash within businesses held for sale	104	2,062
Less: cash within businesses held for sale	(219)	—
Net (decrease) increase in cash and cash equivalents	(115)	2,062
Cash and cash equivalents, beginning of period	25,427	23,365
Cash and cash equivalents, end of period	$25,312	$25,427

UNITEDHEALTH GROUP
REVENUES BY BUSINESS - SUPPLEMENTAL FINANCIAL INFORMATION
(in millions; unaudited)

		Optum				
	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Total Optum (a)	UnitedHealth Group Consolidated (a)
Three Months Ended December 31, 2024						
Total revenues	$74,132	$25,660	$4,781	$35,774	$65,101	$100,807
Business disruption impacts - cyberattack (c)	$—	$—	$120	$—	$120	$120
Three Months Ended December 31, 2023						
Total revenues	$70,808	$24,534	$4,785	$31,166	$59,495	$94,427
Year Ended December 31, 2024						
Total revenues	$298,208	$105,358	$18,757	$133,231	$252,957	$400,278
South American impacts	220	—	—	—	—	220
Adjusted revenues (b)	$298,428	$105,358	$18,757	$133,231	$252,957	$400,498
Business disruption impacts - cyberattack (c)	$—	$—	$867	$—	$867	$867
Year Ended December 31, 2023						
Total revenues	$281,360	$95,319	$18,932	$116,087	$226,635	$371,622

UnitedHealthcare Revenues
(in millions; unaudited)

	Employer & Individual (E&I)			Medicare & Retirement	Community & State	Total UnitedHealthcare
	Domestic	Global	Total E&I			
Three Months Ended December 31, 2024						
Total revenues	$19,019	$775	$19,794	$34,188	$20,150	$74,132
Three Months Ended December 31, 2023						
Total revenues	$17,030	$2,402	$19,432	$32,394	$18,982	$70,808
Year Ended December 31, 2024						
Total revenues	$74,489	$3,667	$78,156	$139,482	$80,570	$298,208
Year Ended December 31, 2023						
Total revenues	$67,187	$9,307	$76,494	$129,862	$75,004	$281,360

(a) Optum and consolidated revenues for the three months ended December 31, 2024 and 2023 include Optum eliminations of $1,114 and $990; and corporate eliminations of $38,426 and $35,876, respectively. Optum and consolidated revenues for the year ended December 31, 2024 and 2023 include Optum eliminations of $4,389 and $3,703; and corporate eliminations of $150,887 and $136,373, respectively.

(b) See page 7 for description of non GAAP measures.

(c) Amounts represent reduced revenues due to business disruption.

UNITEDHEALTH GROUP
EARNINGS BY BUSINESS - SUPPLEMENTAL FINANCIAL INFORMATION
(in millions, except percentages; unaudited)

		Optum				
	UnitedHealthcare	Optum Health	Optum Insight	Optum Rx	Total Optum	UnitedHealth Group Consolidated
Three Months Ended December 31, 2024						
Earnings from operations	$2,973	$1,791	$1,270	$1,739	$4,800	$7,773
Direct response costs - cyberattack	9	—	420	—	420	429
Southern Americas impacts	55	—	—	—	—	55
Adjusted earnings from operations (b)	$3,037	$1,791	$1,690	$1,739	$5,220	$8,257
Total direct response costs - cyberattack (c)	$9	$—	$420	$—	$420	$513
Operating margin	4.0 %	7.0 %	26.6 %	4.9 %	7.4 %	7.7 %
Adjusted operating margin (b)	4.1 %	7.0 %	35.3 %	4.9 %	8.0 %	8.2 %
Business disruption impacts - cyberattack (d)	$—	$—	$120	$—	$120	$120
Total cyberattack impacts	$9	$—	$540	$—	$540	$633
Three Months Ended December 31, 2023						
Earnings from operations	$3,122	$1,691	$1,284	$1,592	$4,567	$7,689
Operating margin	4.4 %	6.9 %	26.8 %	5.1 %	7.7 %	8.1 %
Year Ended December 31, 2024						
Earnings from operations	$15,584	$7,770	$3,097	$5,836	$16,703	$32,287
Direct response costs - cyberattack	494 (a)	160 (a)	1,296	—	1,456	1,950
Southern Americas impacts	170	—	—	—	—	170
Adjusted earnings from operations (b)	$16,248	$7,930	$4,393	$5,836	$18,159	$34,407
Total direct response costs - cyberattack (c)	$494	$160	$1,296	$—	$1,456	$2,223
Operating margin	5.2 %	7.4 %	16.5 %	4.4 %	6.6 %	8.1 %
Adjusted operating margin (b)	5.4 %	7.5 %	23.4 %	4.4 %	7.2 %	8.6 %
Business disruption impacts - cyberattack (d)	$—	$—	$867	$—	$867	$867
Total cyberattack impacts	$494	$160	$2,163	$—	$2,323	$3,090
Year Ended December 31, 2023						
Earnings from operations	$16,415	$6,560	$4,268	$5,115	$15,943	$32,358
Operating margin	5.8 %	6.9 %	22.5 %	4.4 %	7.0 %	8.7 %

(a) Amounts primarily represent incremental medical costs for accommodations to support care providers.

(b) See page 7 for description of non GAAP measures.

(c) Amounts represent direct response costs incurred within the operating segments and at the parent (e.g., interest expense).

(d) Amounts represent reduced revenues due to business disruption. These amounts are not included within the adjustment to earnings from operations.

UNITEDHEALTH GROUP
PEOPLE SERVED AND PERFORMANCE METRICS - SUPPLEMENTAL FINANCIAL INFORMATION
(unaudited)

UnitedHealthcare Customer Profile

(in thousands)

People Served	December 31, 2024	September 30, 2024	December 31, 2023
Commercial - Domestic:			
Risk-based	8,845	8,900	8,115
Fee-based	20,885	20,830	19,200
Total Commercial - Domestic	29,730	29,730	27,315
Medicare Advantage	7,845	7,810	7,695
Medicaid	7,435	7,450	7,845
Medicare Supplement (Standardized)	4,335	4,340	4,355
Total Community and Senior	19,615	19,600	19,895
Total UnitedHealthcare - Domestic Medical	49,345	49,330	47,210
Commercial - Global	1,330	1,335	5,540
Total UnitedHealthcare - Medical	50,675	50,665	52,750
Supplemental Data			
Medicare Part D stand-alone	3,050	3,055	3,315

Optum Performance Metrics

	December 31, 2024	September 30, 2024	December 31, 2023
Optum Health Consumers Served (in millions)	100	104	103
Optum Insight Contract Backlog (in billions)	$32.8	$32.8	$32.1
Optum Rx Quarterly Adjusted Scripts (in millions)	422	407	400

Note: Un tedHea th Group served 146 m on un que nd v dua s across a bus nesses at December 31, 2024.

UNITEDHEALTH GROUP
RECONCILIATION OF NON-GAAP FINANCIAL MEASURES

Use of Non-GAAP Financial Measures

Adjusted net earnings per share, adjusted earnings from operations, adjusted operating margin, adjusted net margin and adjusted revenues are non-GAAP financial measures. Non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP. Adjustments made to these measures are as follows:

Intangible Amortization: Adjusted net earnings per share excludes intangible amortization from the relevant GAAP measure. As amortization fluctuates based on the size and timing of the Company's acquisition activity, management believes this exclusion presents a more useful comparison of the Company's underlying business performance and trends from period to period. While intangible assets contribute to the Company's revenue generation, the intangible amortization is not directly related. Therefore, the related revenues are included in adjusted earnings per share.

South American Impacts: Adjusted net earnings per share and adjusted net margin excludes the effects of various international transactions, including the loss on sale of our Brazilian operations that was completed on February 6, 2024, the loss on our remaining South American operations being classified as held for sale and certain other non-recurring matters impacting our South American operations. Adjusted earnings from operations, adjusted operating margin and adjusted revenues excludes the effects of certain non-recurring matters impacting our South American operations. As these matters are related to the Company's strategy to exit South America, the impact is not representative of the Company's underlying business performance and therefore management believes the exclusion presents a more useful comparison of the Company's underlying business performance and trends from period to period.

Direct Response Costs - Cyberattack: Adjusted net earnings per share, adjusted earnings from operations, adjusted operating margin and adjusted net margin excludes cyberattack direct response costs. Management believes the exclusion of costs incurred to investigate and remediate the attack, other direct and incremental costs incurred as a result of the cyberattack and incremental costs for accommodations to support care providers presents a more useful comparison of the Company's and its reportable segments' underlying business performance and trends from period to period.

Note: See pages 4 and 5 for reconciliation of GAAP amounts to adjusted revenues, adjusted earnings from operations and adjusted operating margin.

UNITEDHEALTH GROUP
RECONCILIATION OF NON-GAAP FINANCIAL MEASURES
(in millions, except per share data; unaudited)

Adjusted Net Earnings Per Share

	Three Months Ended December 31,		Year Ended December 31,		Projected Year Ended December 31,
	2024	2023	2024	2023	2025
Net earnings attributable to UnitedHealth Group common shareholders	$5,543	$5,455	$14,405	$22,381	$25,850 - $26,450
Intangible amortization	423	400	1,665	1,578	~1,625
Tax effect of intangible amortization	(103)	(100)	(408)	(392)	~(400)
Optum Rx impacts	24	—	8,459	—	—
Tax effect of Optum Rx impacts	27	—	(126)	—	—
Direct response costs - cyberattack	513	—	2,223	—	—
Tax effect of direct response costs - cyberattack	(116)	—	(519)	—	—
Adjusted net earnings attributable to UnitedHealth Group common shareholders	$6,311	$5,755	$25,699	$23,567	$27,075 - $27,675
Diluted earnings per share	$5.98	$5.83	$15.51	$23.86	$28.15 - $28.65
Intangible amortization per share	0.46	0.44	1.79	1.68	~1.75
Tax effect of intangible amortization per share	(0.11)	(0.11)	(0.44)	(0.42)	~(0.40)
Optum Rx impacts per share	0.03	—	9.11	—	—
Tax effect of Optum Rx impacts per share	0.03	—	(0.14)	—	—
Direct response costs - cyberattack per share	0.55	—	2.39	—	—
Tax effects of direct response costs - cyberattack per share	(0.13)	—	(0.56)	—	—
Adjusted diluted earnings per share	$6.81	$6.16	$27.66	$25.12	$29.50 - $30.00
Additional Information: Total Cyberattack Impacts					
Business disruption impacts (a)	$120	$—	$867	$—	$—
Tax effect of business disruption impacts (a)	(14)	—	(153)	—	—
Business disruption impacts, net of tax (a)	$106	$—	$714	$—	$—
Business disruption impacts per share (a)	$0.12	$—	$0.77	$—	$—
Total cyberattack impacts	$633	$—	$3,090	$—	$—
Tax effect of total cyberattack impacts	(130)	—	(672)	—	—
Total cyberattack impacts, net of tax	$503	$—	$2,418	$—	$—
Total cyberattack impacts per share	$0.54	$—	$2.60	$—	$—

(a) Amounts represent reduced revenues due to business disruption. These amounts are not included within the adjustment to net earnings.

Adjusted Net Margin

	Three Months Ended December 31, 2024	Year Ended December 31, 2024
Consolidated revenue	$100,807	$400,278
South American impacts	—	220
Adjusted consolidated revenues	$100,807	$400,498
Net earnings attributable to UnitedHealth Group common shareholders	$5,543	$14,405
South American impacts	24	8,459
Tax effect of South American impacts	27	(126)
Direct response costs - cyberattack	513	2,223
Tax effect of direct response costs - cyberattack	(116)	(519)
Adjusted net earnings attributable to UnitedHealth Group common shareholders for South American impacts and direct response costs	$5,991	$24,442
Net margin attributable to UnitedHealth Group common shareholders	5.5 %	3.6 %
Adjusted net margin attributable to UnitedHealth Group common shareholders for South American impacts and direct response costs	5.9 %	6.1 %

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

Hearing of the United States House Committee on Energy and Commerce

Subcommittee on Health

On

"The Fiscal Year 2026 Department of Health and Human Services Budget"

By

American Academy of Pediatric Dentistry (AAPD)

June 24, 2025

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

The American Academy of Pediatric Dentistry (AAPD) appreciates the opportunity to submit this statement for the record for the Subcommittee on Health of the House Energy and Commerce Committee's June 24, 2025, hearing on "The Fiscal Year 2026 Department of Health and Human Services Budget." The AAPD was founded in 1947 and is the leading national advocate dedicated exclusively to children's oral health, representing over 11,000 pediatric dentists across the U.S. Pediatric dentists provide care to millions of our nation's infants, children, adolescents, and persons with special health care needs, and are the primary contributors to professional education programs and publications on pediatric oral health.

The AAPD opposes the White House budgetary and programmatic changes to dental and oral health programs currently in place following staff firings and RIFs and Health and Human Services' (HHS) agency, department and office closures as well as additional budgetary changes proposed to adjust oral health offices and programs administered by federal agencies. **We call on the Subcommittee on Health and full Energy and Commerce Committee, Congress and the Administration to change course and take the following actions to immediately ensure access to oral health services for all of America's children:**

- **Support Title VII Pediatric Dental/General Dental Workforce and Faculty Development Programs that have been administered by the Health Resources and Services Administration**
- **Support Necessary Oral Health Public Health Measures – Access to Safe Levels of Fluoride and Healthy Nutrition**
- **Maintain Dental Programs and Chief Dental Officers Within Federal Health Agencies**

Support Title VII – Protecting and Expanding the Dental Workforce

Pediatric dentists are the backbone of the pediatric oral health care delivery system, helping to ensure all children have access to high quality comprehensive dental services. Access to dentists is especially critical for underserved populations that face health disparities.

Title VII, section 748 of the Public Health Service Act (PHSA) is up for re-authorization in 2025 and supports pediatric dentistry health care workforce education and training through grants to and contractual agreements with institutions to support predoctoral (dental school) education and post-doctoral residency programs and a Dental Faculty Loan Repayment Program (DFLRP), among other efforts. A dentist trainee learns advanced diagnostic and surgical procedures, along with unique care techniques and skills for dealing with children such as child psychology and behavior guidance; child development; and caring for patients with disabilities. Since children's oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists. The Title VII program is an essential resource in meeting the unmet oral health needs for many families and addressing the national shortage of pediatric dentists. The program serves to build a diverse, culturally competent health professions pipeline and a workforce that meets the needs of individuals in both rural and urban underserved communities. As we face nationwide shortages in the health professions, investment through Title VII programs in the dental workforces creates a robust network of providers who are trained to serve some of the most vulnerable patients in our country. Title VII provides pediatric dentistry training programs, supporting more dental and dental hygiene students to enter the field prepared to serve and support the unique needs of children in underserved communities throughout the country. In addition to directly supporting dental residency training and placement of dentists in underserved communities, the program also supports a dental faculty loan repayment program, incentivizing dental professionals to train future practitioners who are able to then meet the needs of underserved communities. The program may support loan repayment contracts over five years to recruit and retain faculty. Full-time faculty members are eligible for repayment of 10, 15, 20, 25 and 30 percent of their student loan balance (principal and interest) for each year of service while they provide dental care in an underserved community.

Recent reports indicate that 69 percent of graduates serve in medically underserved communities, with an additional 20 percent contributing to primary care settings, such as Federally Qualified Health Centers, following their completion of the oral health training program.

We urge the Committee to support the Title VII program's re-authorization in 2025, recognizing that the program is making an impact in the recruitment of dentists to serve underserved communities as well as developing new and needed pediatric and general practice dental faculty.

Support Necessary Oral Health Public Health Measures

Safe Community Water Fluoridation and Fluoridation Prescriptions and Products

Community water fluoridation has been lauded as one of the top 10 greatest public health achievements of the 20th century. The AAPD is alarmed by how it has recently become politicized and gravely misrepresented. Rhetoric and direct efforts at the federal level to cease the fluoridation of water supplies and availability of prescribed fluoride supplements – stripping that authority from local and state jurisdictions and physician and dentist prescribers – is wrong. On May 13, the FDA issued notice that it will pull fluoride supplements from the market effective October 2025, taking away a measure that dentists and physicians have long been able to use to help prevent dental caries.[1] HHS Secretary Robert Kennedy, Jr has also spoken against the fluoridation of community drinking water. The AAPD must emphasize that to dismiss safe water fluoridation means the administration will fail the American public as it relates to their oral health and significantly undercut its effort to address chronic disease by failing to recognize that oral disease is the number one chronic disease in America as well as failing to understand the connection between oral health and overall health and well-being, given oral disease's systemic connection to conditions like diabetes and cardiovascular disease.

The AAPD is extremely concerned about the misinformation being spread to the people of the United States and the consequences of the cessation of water fluoridation and safely prescribed fluoride supplements. Much of the recent discourse from the Trump administration is based on incomplete information and a false interpretation of studies that contain inaccurate information or significantly limited information, undermining their usefulness and accuracy.

The U.S. experienced massive reductions in the prevalence of tooth decay in the years that followed its introduction in the 1950s and 1960s. Most people in the U.S. today have never seen nor personally experienced the severity of tooth decay that exists without fluoride. With an abrupt departure from water fluoridation and other fluoride access, our nation would undoubtedly experience a rapidly rising incidence of decay.

It's important that the Subcommittee understand that the U.S. does not have capacity in the oral health workforce to support the emergency, surgical, and restorative dental needs that would result from skyrocketing dental decay. There would be increased pain and suffering, and more missed school and work.

In its almost century long use, water fluoridation and the use of fluoride supplements has been studied widely and the benefits safety validated. Community water fluoridation and prescribed fluoride supplements remain the only ways to ensure that all people – especially those who are at greatest risk for dental disease and who have the fewest resources to maintain their oral health – can reap its cavity-preventing benefits. Dental teams, physicians, other health care professionals, and public health officials work together with patients and families to identify the various sources of fluoride being consumed or used and determine if they are sufficient for

[1] Food and Drug Administration (FDA). May 13, 2025. FDA Begins Action To Remove Ingestible Fluoride Prescription Drug Products for Children from the Market | FDA.

preventing cavities while not leading to issues like fluorosis. The AAPD remains committed to fluoride in water and the safe prescribing of fluoride supplements as a way to reach those most in need and to protect our nation's children, and we support continued research that can inform and update its optimal level over time.

As a nation, we have so much more work to do to ensure all people can get the dental care they need and achieve optimal oral health. Community water fluoridation and the safe prescribing of fluoride supplements has been a proven safe, effective, equitable way of helping us work toward that goal in the United States.

The AAPD urges the Committee to encourage and support continued program efforts at the CDC to support states and local communities with accurate data and information concerning safe community water fluoridation. We likewise urge the Committee to request that the FDA halt any effort to pull agency-approved safe supplements from the market this year.

Child Nutrition

We have an epidemic of dental caries in many of our youngest children. Poor diet and low overall health literacy affect these disparities. Dentists observe children with diets high in sugar and refined carbohydrates and without the benefit of early preventive care, contributing to early childhood caries.

Improving access to nutritious foods and reducing the consumption of sugary beverages is critical for children most at risk for dental decay, particularly those from low-income households. Diets high in sugar and low in essential nutrients like calcium, phosphorus, and vitamin D contribute significantly to the development of cavities and other oral health problems, creating a vicious cycle where malnutrition and dental disease reinforce each other. Research shows that undernourished children from low-income families have a higher risk of dental caries, especially when their diets are also high in sugar.

Innovative efforts that leverage HHS programs like Head Start and Women Infants and Children (WIC) and also collaborate with the National School Lunch Program (NSLP) and the Supplemental Nutrition Assistance Program (SNAP) to promote healthier food choices, along with efforts to improve oral health literacy among families, can help break this cycle. School-based and community programs that engage parents, educators, and health professionals have proven effective in increasing children's knowledge about oral health, boosting healthy habits, and improving access to preventive care.

By integrating nutrition education and oral health promotion into HHS programs like Head Start and WIC and in collaboration with other food nutrition programs run through the U.S. Department of Agriculture like SNAP and NSLP, we can address both the root causes and consequences of poor oral health in vulnerable populations. The AAPD encourages efforts to support funding for each of these programs and support to establish innovative programming to improve oral health awareness and access to more nutritious options that improve oral health and well-being.

Maintain Dental Programs and Officers Within Federal Health Agencies

Centers for Disease Control and Prevention (CDC) – Division of Oral Health

For decades, the CDC Division of Oral Health has administered critically important federal dental public health programs and activities that successfully prevent cavities, gum disease, and other serious oral health conditions. The Division has provided vital support for state and territorial health departments to monitor oral disease across populations and implement evidence-based oral health interventions. The CDC Division has been responsible for supporting state health departments to develop, maintain, and support oral health programs benefitting low-income children. The Division of Oral Health has developed infection control guidelines to protect dental patients and funded specialty training for dental public health professionals and supported public education campaigns to encourage good oral hygiene. Additionally, the Division has supported public health data systems to support the use of preventive oral health services. This data is used to measure the nation's progress in advancing the public's oral health.

The AAPD urges the Committee to reauthorize and staff the CDC Oral Health program. The program is essential in the effort to prevent cavities, gum disease, and other painful and serious conditions by supporting dental education, data collection, school-based sealant care for low-income children, workforce development, and research into gaps in patient care.

Centers for Medicare and Medicaid Services

Recognizing that dental health is vital to overall health, in 2003, CMS appointed its first-ever Chief Dental Officer (CDO) to work across CMS centers and offices, a position re-established in the CMS Office of the Administrator in 2021. Today the CDO supports the agency in advancing its oral health programs and policies through all of the health care marketplaces the agency oversees. There has been a tremendous effort undertaken by CMS to address oral health coverage and access during the CDO's tenure. CMS has worked to ensure medically necessary dental coverage is covered under Medicare and has taken strong steps toward improving access to dental surgeries for Medicare and Medicaid-eligible patients in an effort to reduce ER visits for dental health concerns and improve health and well-being.

The role is likewise essential for supporting the CMS Administrator and broader agency leadership in understanding how programmatic and policy changes impact U.S. dental businesses and oral health care delivery for beneficiaries under Medicare, Medicaid, CHIP and in the exchange marketplace. The CDO serves as a key bridge between medical and dental care for CMS leadership and states, enhancing coordination across CMS programs. This coordination and insight will be essential in support of the MAHA Initiative.

The AAPD requests that the Chief Dental Officer continue to serve in the office of the CMS Administrator and work with agency and HHS leadership to support oral health programs within Medicare, Medicaid, CHIP and the state exchange marketplace.

Health Resources and Services Administration

As referenced earlier, HRSA has been responsible for managing the Title VII dental workforce and faculty loan repayment programs up for reauthorization in 2025. To support these programs throughout the agency, HRSA has had a Chief Dental Officer (CDO). The Trump Administration eliminated this position this year without explanation, leaving an immense voice in the coordination of all dental-related programs within the agency.

The AAPD emphasizes that dental loan repayment programs and scholarships that incentivize dental professionals to serve in rural and other underserved areas are critically important to building the dental workforce pipeline throughout the U.S. It is essential that these programs continue and grow and have the support of a Chief Dental Officer to coordinate and manage the programs.

National Institutes of Health – National Institute of Dental and Craniofacial Research (NIDCR)

The AAPD strongly supports the work of the National Institute of Dental and Craniofacial Research (NIDCR) and urges Committee efforts to support NIDCR as a separate and unique institute within NIH. As the largest institution in the world exclusively dedicated to researching ways to improve dental, oral, and craniofacial health, NIDCR has been instrumental in advancing scientific discovery and public health. Its contributions include breakthroughs in pain biology and management, reducing opioid use, addressing temporomandibular disorders (TMD), regenerative medicine, and the development of early diagnostics and HPV vaccine efficacy for oral and pharyngeal cancers. These investments have directly improved oral health and overall health for millions of Americans and contributed to broader systemic health outcomes.

The AAPD asks that the Committee support NIDCR as a separate and independent institute within NIH and not risk the loss of dedicated funding for oral health and craniofacial research or the loss of expertise and research innovation that comes from targeted oral health research efforts.

Conclusion

The AAPD looks forward to working with the Subcommittee and full Committee to advance and address these important programs, issues and challenges. From working to ensure that every child in America – no matter where they live or their circumstances - has a dental home, to strengthening our dentist and dental team workforce to reauthorizing oral health programs and strengthening oral health positions and resources that are critical to our oral health programmatic infrastructure, we stand ready to work with you. For questions or further discussion, please contact AAPD's government relations representative, Julie Allen at Julie.allen@powerslaw.com or 202-494-4115.

ACOG
The American College of Obstetricians and Gynecologists

News Releases | May 27, 2025

ACOG Statement on HHS Recommendations Regarding the COVID Vaccine During Pregnancy

The following is a statement from Steven J. Fleischman, MD, FACOG, president of the American College of Obstetricians and Gynecologists (ACOG):

"ACOG is concerned about and extremely disappointed by the announcement that HHS will no longer recommend COVID-19 vaccination during pregnancy. As ob-gyns who treat patients every day, we have seen firsthand how dangerous COVID-19 infection can be during pregnancy and for newborns who depend on maternal antibodies from the vaccine for protection. We also understand that despite the change in recommendations from HHS, the science has not changed. It is very clear that COVID-19 infection during pregnancy can be catastrophic and lead to major disability, and it can cause devastating consequences for families. The COVID-19 vaccine is safe during pregnancy, and vaccination can protect our patients and their infants after birth.

"In fact, growing evidence shows just how much vaccination during pregnancy protects the infant after birth, with the vast majority of hospitalized infants less than six months of age—those who are not yet eligible for vaccination—born to unvaccinated mothers.

"Following this announcement, we are worried about our patients in the future, who may be less likely to choose vaccination during pregnancy despite the clear and definitive evidence demonstrating its benefit. We are concerned about access implications and what this recommendation will mean for insurance coverage of the COVID-19 vaccine for those who do choose to get vaccinated during pregnancy. And as ob-gyns, we are very concerned about the potential deterioration of vaccine confidence in the future."

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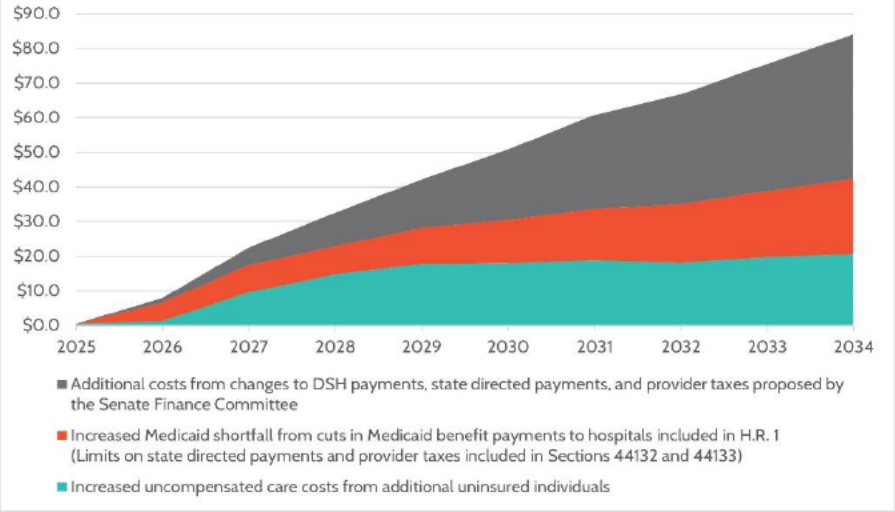
ADDITIONAL HOSPITAL UNCOMPENSATED CARE COSTS PROJECTED UNDER PROPOSED SENATE REVISIONS TO H.R. 1

ROB NELB MPH

The proposed Medicaid policy changes included in the Senate Finance Committee's budget reconciliation bill are projected to increase hospital uncompensated care costs by at least **$84.0 billion in 2034**, which is $41.7 billion more than the amount projected under the House-passed One Big Beautiful Bill Act (H.R. 1).

Between 2025 and 2034, we find that both proposed cuts in Medicaid payments and additional costs for uninsured individuals will add **$443.4 billion to hospitals' uncompensated care costs over the ten-year period** (Figure 1). More than two-thirds of the added costs come from cuts in payments for benefits provided to eligible Medicaid beneficiaries, which increase hospitals' Medicaid shortfall.

FIGURE 1. PROJECTED INCREASE IN UNCOMPENSATED CARE COSTS FOR HOSPITALS UNDER H.R. 1, 2025–2034 (BILLIONS)



Note: DSH is disproportionate share hospital. Analysis does not include the effects of the additional number of uninsured individuals expected under the Senate Finance Committee proposed changes.

Source: America's Essential Hospitals. 2025. Analysis of CBO Cost Estimates and Economic Baseline.

UNPAID COSTS OF CARE FOR ELIGIBLE MEDICAID PATIENTS

In 2023, hospitals reported a $27.5 billion Medicaid shortfall.[1] Medicaid shortfall refers to the difference between a hospital's cost of care for Medicaid patients and the payment that it receives for these services.

Two provisions in the proposed reconciliation bill that cut payments for benefits provided to eligible Medicaid beneficiaries will have the largest effect on hospitals' Medicaid shortfall.

Cuts to state directed payments (SDPs) reverse policies established during President Trump's first administration and set a new limit that is generally lower than hospitals' costs of care. The House-passed bill would

freeze existing SDPs at current levels, but the Senate Finance Committee-proposed bill would also cut payments in at least 34 states that currently make SDPs benchmarked to the average commercial rate (ACR). These ACR-based SDPs, including many approved during President Trump's first administration, help keep rural hospitals open; reduce infant and maternal mortality; and improve care quality, value, and access.[2]

The bill also cuts provider taxes, a permissible financing mechanism that most states use to ensure adequate payments to hospitals. Section 44132 of H.R. 1 places a moratorium on provider taxes, and the Senate Finance Committee-proposed bill would cut funding in at least 18 states that have expanded Medicaid and currently have hospital taxes above 3.5% of hospitals' patient revenue.[3]

We estimate that these two provisions would lower Medicaid payments to hospitals by at least $63.4 billion in 2034 and $300.6 billion over the ten-year period from 2025 to 2034. The proposed cuts to SDPs will not be fully phased in until 2036, at which point they would cut an additional $7 billion per year from hospitals compared to 2034 payment levels.

UNCOMPENSATED CARE COSTS FOR UNINSURED INDIVIDUALS

In 2023, hospitals reported $41.4 billion in unpaid costs of care for uninsured individuals on Medicare cost reports. CBO estimates that H.R. 1 will increase the number of uninsured individuals by 10.9 million in 2034, which is 34% higher than the CBO baseline. As a result, the bill is expected to increase hospital uncompensated care costs by $20.6 billion in 2034 and $136.3 billion over the ten-year period from 2025 to 2034.

The Senate Finance Committee bill would further increase the number of uninsured individuals, but data are not available at this time to model these effects. Most notably, the bill expands the number of people who will be subject to work requirements, which are expected to increase the number of people disenrolled from Medicaid for procedural reasons. In addition, the new proposal to limit taxes may result in states rolling back coverage since many states have used these long-standing, permissible financing mechanisms to finance Medicaid expansions.

Medicaid currently pays for some hospital uncompensated care costs through the Medicaid disproportionate share hospital (DSH) program. However, because DSH funding is capped by federal allotments, the uncompensated costs added by this bill will not be offset by other sources. H.R. 1 proposed to delay pending DSH allotment reductions, but the Senate Finance Committee proposal would remove this policy, adding $8 billion a year in federal DSH cuts for hospitals beginning Oct. 1, 2025.

EFFECTS ON ESSENTIAL HOSPITALS

Cuts of this magnitude would disproportionately harm essential hospitals and the communities that they serve. Essential hospitals are dedicated to high-quality care for all, including those who face social and financial barriers to care. About three-quarters of the patients they serve are uninsured or enrolled in Medicare or Medicaid. Although essential hospitals account for just 5% of hospitals nationally, we estimate that they would bear approximately 25% of the added hospital unpaid costs of care. This would amount to an additional $20.8 billion in cuts to essential hospitals in 2034 and $110.3 billion over the ten-year period from 2025 to 2034.

In 2022, essential hospitals reported $22.7 billion in unpaid costs of care, which included $10.4 billion in uncompensated care for uninsured individuals and $12.4 billion in under-reimbursed care from government payers, such as Medicaid. As a result of these costs, essential hospitals reported operating margins of negative 9%.[4] When the cuts proposed by the Senate Finance Committee are fully implemented, hospital margins will be at least 5 percentage points lower, meaning that essential hospitals would have operating margins of negative 14%, which would further threaten their ability to provide access to life-saving services in their communities.

Essential hospitals are particularly important sources of care in rural communities. Two-thirds of our member hospitals provide care in rural areas, including access to primary and specialty care that are not otherwise available.[5]

DATA SOURCES AND METHODOLOGY

Baseline levels of uncompensated care were estimated using CBO's January 2025 economic baseline projections and June 2024 baseline projections for Medicaid and the number of uninsured individuals.[6]

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These baseline estimates include projected increases in the number of uninsured individuals due to the expected expiration of enhanced subsidies for the health insurance marketplace as of Dec. 31, 2025.

The effects of H.R. 1 on Medicaid shortfall were estimated using CBO's estimates of H.R. 1 as passed by the House of Representatives on May 22, 2025.[7] We used the most recent approved preprints published on CMS's website to estimate that 82% of the proposed cuts to SDPs would be borne by hospitals. We estimated that 65% of the costs of the proposed moratorium on provider taxes would affect hospitals based on prior analysis from the Medicaid and CHIP Payment and Access Commission and data from CMS' National Health Expenditure Accounts.[8,9]

The additional costs of proposed cuts to SDPs added by the Senate Finance Committee were estimated based on America's Essential Hospitals' analysis of SDPs approved as of February 2025. This estimate likely underestimates the effect of the proposed cuts because several additional states have recently submitted proposals to use the ACR benchmark to make SDPs that advance their state quality and access goals.

The additional costs of the proposed limits on provider taxes were estimated using estimates from CBO and the Paragon Institute about the effects of lowering the provider tax hold harmless threshold to 3.5%.[10] To estimate the share of cuts applied to expansion states, we used data from the Kaiser Family Foundation survey of state Medicaid officials and Medicare cost report data about taxable hospital revenue in each state.[11]

The effects of H.R. 1 on uncompensated care costs for uninsured individuals were estimated using CBO's preliminary estimates of Subpart D, Part I of the budget reconciliation recommendations of the House Energy and Commerce Committee and adjusted based on CBO's final analysis of H.R. 1 as passed by the House of Representatives.[12] Our estimates of the costs of care per uninsured individual were determined using data from Medicare cost reports. Our analysis did not include the additional uncompensated care costs that would result from the expiration of enhanced premium tax credits. A recent analysis suggests that this change could result in $103 billion in payment cuts to hospitals between 2025 and 2034.[13]

The effect of proposed cuts on essential hospitals was estimated based on essential hospitals' share of Medicaid payments and hospital uncompensated care.

Endnotes

[1] American Hospital Association (AHA). Letter to Congressional Leadership on Potential Medicaid, EPTC Policy Changes. April 29, 2025. https://www.aha.org/lettercomment/2025-04-29-aha-letter-congressional-leadership-potential-medicaid-eptc-policy-changes. Accessed June 2, 2025.

[2] SDPs are a tool that many states use to offset low Medicaid payment rates in managed care. SDPs allow states to ensure that Medicaid payments to managed care plans are directed to providers who are helping to advance state access and quality goals. Additional information is available in our policy brief Behind the Numbers: How State Directed Payments Support Essential Hospitals. *America's Essential Hospitals*. April 2025. https://essentialhospitals.org/wp-content/uploads/2025/04/How-State-Directed-Payments-Support-Essential-Hospitals.pdf. Accessed June 18, 2025.

[3] Section 44134 makes additional changes to provider tax requirements, but the effects of this change are excluding from this analysis since the Centers for Medicare & Medicaid Services (CMS) has already proposed to make similar changes through regulation.

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[11] Burns, A. E Hinton, et al. 5 Key Facts About Medicaid Provider Taxes. Kaiser Family Foundation. March 2025. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/. Accessed June 18, 2025.

[12] Congressional Budget Office. Preliminary estimate of Energy & Commerce, Subtitle D, Part I. May 2025. https://d1dth6e84htgma.cloudfront.net/E_and_C_Markup_Subtitle_D_Part_I_5_12_25_4628d60c2a.pdf. Accessed June 2, 2025.

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RFK Jr. plugs ag reform on Capitol Hill amid talk of role with Trump

09/25/24 6:09 AM

By Philip Brasher (/proxy?q=https%3A%2F%2Fwww.agri-pulse.com%2Fauthors%2F1-philip-brasher)

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Former Independent candidate for president Robert F. Kennedy, Jr. speaks at a campaign event for Republican presidential nominee former President Donald Trump, Saturday, Sept. 14, 2024, in

Glendale, Arizona. (AP Photo/Ross D. Franklin)

Robert F. Kennedy Jr. and some allies in his "Make America Healthy Again" movement are trying to get a toehold on Capitol Hill even as the food and agriculture industry worries about what role he could play in a second Donald Trump administration.

RFK Jr. got a standing ovation at the outset of a four-hour, standing-room roundtable hosted Monday by Sen. Ron Johnson, R-Wis., in the Kennedy Caucus Room of the Russell Senate Office Building, made famous by the Watergate hearings.

Kennedy was joined by the brother-and-sister duo of Calley and Casey Means, prominent critics of U.S. agricultural policy and the health care industry, plus a collection of podcasters and bloggers.

Also making an appearance at the event was Idaho GOP Sen. Mike Crapo, who is in line to chair the Senate Finance Committee next year if Republicans win control of the Senate. The committee oversees Medicare and Medicaid as well as tax and trade policy.

“For 19 years, solving the childhood, chronic disease crisis has been the central goal of my life, and for 19 years, I have prayed to God every morning to put me in a position to end this calamity,” Kennedy said. “I believe we have the opportunity for transformational, bipartisan change to transform American health.”

Also Monday, Rep. Chip Roy, a Texas Republican who serves on the House Rules Committee, said in a post on X that he met with Kennedy, Calley Means, Tennessee GOP Sen. Bill Hagerty and Rep. Tom Massey, R-Ky., along with Jordan Peterson, a Canadian psychologist and best-selling author popular in conservative circles. Peterson also participated in the Senate roundtable.

Casey Means also hosted a meeting Monday morning with congressional and Senate staffers.

Kennedy’s potential role in a Trump administration remains a mystery, although he has said he is part of Trump’s transition team. Kennedy said in an interview Sept. 17 with Tucker Carlson (/proxy?q=https%3A%2F%2Fx.com%2FTuckerCarlson%2Fstatus%2F1836087721468534869) that Trump has asked him “to help unravel the capture of the agencies by corrupt influence” and to “help him end the childhood disease epidemic.”



Senate roundtable featuring RFK Jr.

Kennedy went on, “I don’t have a post for myself. I know that I’m going to be deeply involved in helping to choose the people who can run FDA, NIH and CDC in a way that restores public health.” Kennedy added that he would “bring in people to run those agencies like Calley Means, like Casey Means.”

When Carlson remarked, “They have nightmares about that,” apparently referring to industry, Kennedy responded, "And they should."

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At the Senate roundtable, Kennedy also cited USDA as a villain.

“The FDA, the USDA and CDC are all controlled by giant for-profit corporations,” he claimed. “Their function is no longer to improve and protect the health of Americans. Their function is to advance the mercantile and commercial interests of the pharmaceutical industry and the food industry that has transformed them into sock puppets for the industry they're supposed to regulate.”

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Food companies begin steps on RFK Jr. goal of removing dyes (/proxy?q=https%3A%2F%2Fwww.agri-pulse.com%2Farticles%2F22856-food-companies-begin-steps-on-rfk-jr-goal-of-removing-dyes)
RFK Jr. eyes SNAP restrictions on ultra-processed foods (/proxy?q=https%3A%2F%2Fwww.agri-pulse.com%2Farticles%2F23043-rfk-jr-eyes-snap-restrictions-on-ultra-processed-foods)
Trump says he'll invest in 'modern' agricultural techniques, cites RFK Jr. concerns (/proxy?q=https%3A%2F%2Fwww.agri-pulse.com%2Farticles%2F21593-trump-says-hell-invest-in-modern-agricultural-techniques)
Calley Means made similar claims, specifically mentioning the dietary guidelines revision process, which he asserted is unduly influenced by industry. Means also called for restricting what kinds of foods can be purchased with SNAP benefits, an idea championed, unsuccessfully so far, by the chairman of the House Ag Appropriations Subcommittee, Rep. Andy Harris, R-Md.

At the roundtable and later on X, Calley Means also delivered a direct message to congressional staffers who he said are “working to impress your future bosses at the pharmaceutical companies, the hospitals, the insurance companies … We are coming for you.” His X post added: “Corrupt congressional healthcare staffers are destroying the country. We see you.”

During the Senate roundtable, some agriculture sectors were spared from criticism: meat and poultry as well as organic production. Much of the criticism is aimed instead at the use of pesticides and the broad and ill-defined category of “ultraprocessed” foods

Podcaster Mikhaila Fuller

,
who promotes a plant-free ketogenic diet, declared at the roundtable, “The ecological war on meat needs to end,” an apparent reference to environmentalists' concerns about the carbon footprint of



Rep. Chip Roy posted on X with RFK Jr.

animal agriculture.

Crapo, who was invited to speak at the roundtable, talked about how he had shed weight by reducing carbohydrates in his diet.

“I’m hopeful we can get a focus on addressing the government’s part” in the health conditions discussed at the meeting, Crapo said, also indicating he favors expanding health savings accounts.

He didn’t say how rules for the accounts should be liberalized, but a major complaint aired at the meeting is that doctors aren’t reimbursed for alternative medicine.

After the meeting, Crapo used a post on X (/proxy?q=https%3A%2F%2Fx.com%2FMikeCrapo%2Fstatus%2F1838363395935920175) to thank Johnson and Calley Means for inviting him to the roundtable that “included many inspiring people working toward a healthier America.”

Calley Means' call for restricting SNAP purchase choices is one of the few MAHA ideas that has been tested in Congress but so far has found little traction. Harris has put a pilot program for SNAP restrictions in each of the last two spending bills for USDA but the provision was killed in negotiations on the final version of the fiscal 2024 legislation. A similar provision he put in the draft FY25 bill was stripped out in committee.

The top Republican on the Senate Ag Committee, John Boozman of Arkansas, told *Agri-Pulse* Tuesday he doesn’t think the food and agriculture sectors have to worry about Kennedy’s influence.

“That is a voice,” Boozman said, referring to Kennedy, “but Congress gets to decide.”

Mike Beam, the secretary of agriculture in Kansas, expressed confidence to *Agri-Pulse* that farm groups can overcome any MAHA-promoting critics in Washington.

“I have quite a bit of confidence that, no matter who is elected, that we will be able to unify behind, you know, a strong economic agriculture, we seem to have done that in the past, and I have the opinion that we'll be able to do so again, regardless of who's in the White House,” he said on the sidelines of the National Association of State Departments of Agriculture annual meeting in Indianapolis this week.

For more news, go to Agri-Pulse.com (/proxy?q=https%3A%2F%2FAgri-Pulse.com).

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AHA Statement on House Reconciliation Legislation

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Rick Pollack
President and CEO
American Hospital Association

May 21, 2025

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is sharing our concerns about the One Big Beautiful Bill Act (OBBBA) that is being considered on the House floor this week.

Our hospitals and health systems have significant concerns regarding the harmful Medicaid and Health Insurance Marketplace provisions currently included in the bill. The sheer magnitude of the level of reductions to the Medicaid program alone will impact all patients, not just Medicaid beneficiaries, in every community across the nation. Hospitals — especially in rural and underserved areas — will be forced to make difficult decisions about whether they will have to reduce services, reduce staff and potentially consider closing their doors. Other impacts could include longer waiting times to receive care, more crowded emergency departments, and hospitals not being able to invest in technology and innovations for clinical care.

In particular, the Medicaid legislative proposals severely restrict the use of legitimate state funding resources and supplemental payment programs, including provider taxes and state directed payments, under the guise of eliminating waste, fraud and abuse. We reject this notion as these critical, legitimate and well-established Medicaid financing programs are essential to offset decades of chronic underpayments of the cost of care provided to Medicaid patients. These new policies are estimated to decimate federal support for the Medicaid program by more than $700 billion over 10 years and will displace health care coverage for millions of Americans, moving them from insured to uninsured status.

In addition to jeopardizing access to patient care and services, these abrupt policy changes would upend state government budgets and threaten the viability of the health care system to provide essential services to this population. Since these changes are effective immediately upon enactment of the legislation, states will have little or no time to prepare for the significant financial impact on state budgets.

Given the substantial reduction in Medicaid payments and cuts to the Health Insurance Marketplaces, including allowing the enhanced premium tax credits to expire, millions will lose health care coverage. Therefore, the AHA urges the House to reject efforts to dismantle these vital programs in the OBBBA and preserve health care access for our nation's vulnerable and working families.

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AHA Statement on Senate Finance Committee Bill

Rick Pollack
President and CEO
American Hospital Association

June 16, 2025

We continue to review the Senate Finance Committee's proposal. However, it appears that the provisions further undermine the ability for hospitals to provide care to Medicaid patients. This bill moves in the wrong direction.

The magnitude of Medicaid reductions and changes to health insurance marketplaces will shift millions of Americans from insured to uninsured status.

Additionally, the proposal further erodes the legitimate use of provider taxes and state directed payment programs that help bridge the gap of chronic and historic Medicaid underpayments.

These harmful proposals will impact access to all patients who are served by our nation's hospitals and health systems. These cuts will strain emergency departments as they become the family doctor to millions of newly uninsured people. Finally, the proposal will force hospitals to reconsider services or potentially close, particularly in rural areas.

As the Senate continues its deliberation, we urge consideration of the far-ranging negative consequences to our nation's patients and hospitals.

###

About the AHA

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org (https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Flink.mediaoutreach.meltwater.com%2Fls%2Fclick%3Fupn%3Du001.7kr010ACWZRfM3MOuCoTb4j1A7dsWuFv5c9nef7CCBE-3D0MS9_d2RbcZlH1cPr8T71lfy9-2Baax-2F-2BEajmJ1xBQdwzrxSfXYrczhBuOKN0y9-2Fz7LWn8-2BDbxbRMmISA8VWYgeVYMYLehFbJjjJrsDU061vryWib5OgupGu7XbukALgR8dzkZgAerndJsPeGXqyTrI-2FcEwMKNevSigEQ8Jz2owcxsV-2FqFwrAAqGoSdhL2JMlC6trqiOfu-2Bn9zNmJYlQgWXk5BmQPlh7So3re-2BlUqAbZO4l9B-2BBjwEGbugJlBrXlbXlr8aC5C3-2Bnaa1c714-2BPfplYRv0jHTgTXDJPjhkpJRDfgap7u0j1k8tTV 0W-2BgFftMxg1uvHCMYmO9TGB1Eta77ps9XshXfP-2FnjYXdXr9HBjsYVJOdgAaiYJU-2FhKLEDVEzjPnB&data=05%7C02%7Cbteicher%40aha.org%7C6ab3ed06e5c344cc42d208dd8c9caeb6%7Cb9119340beb74e5e84b23cc18f7b36a6%7C

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Statement for the Record of the ALS Association on
Fiscal Year 2026 Funding for the
National Institutes of Health and Centers for Disease Control and Prevention

United State House of Representatives, Energy and Commerce Subcommittee on Health Hearing
"Department of Health and Human Services FY2026 Budget"

ALS (amyotrophic lateral sclerosis), or more commonly referred to as Loug Gehrig's Disease impacts over 30,000 Americans today and tens of thousands of family caregivers who provide support to their loved ones every day.

ALS is a severe disease that progressively damages the nervous system, affecting muscles needed for movement, speech and breathing, ultimately resulting in death. Once diagnosed, the average life expectancy of an individual living with ALS is approximately two to five years.

Annual costs related to ALS, including direct medical care and indirect expenses like lost income, exceed $1 billion in the United States. Studies funded by the Department of Defense (DOD), Veterans Affairs (VA), and National Institutes of Health (NIH) found that veterans of the United States Armed Forces are more likely to be diagnosed with ALS than people who did not serve in the military.

ALS cases are expected to increase by over 69% by 2040.[1] This is why the ALS Association is determined to make ALS a livable disease while also searching for a cure. The ALS Association is the leading philanthropic funder of ALS research worldwide. Since the Ice Bucket Challenge launched in 2014, we have invested over $155 million into ALS research. Today, more than 150 studies in 15 countries are being supported by our private investments. A cure for ALS can only occur with the collaboration of both private and public funding.

There is currently no cure for ALS. Biomedical research is at a critical point in making ALS a livable disease. Reductions in ALS research funding would significantly hinder decades of progress towards improving the lives of those affected by ALS. For example, research has indicated that both genetic and environmental factors may contribute to the development of ALS. Further research on ALS in relation to genetics and environmental toxins is critical to preventing and ending ALS.

Medical technology advancements, biomarkers, and novel treatments are opening new research opportunities. Gene therapy and stem cell treatments are being studied for their potential to slow disease progression and restore muscle strength. New brain computer interface technology is enabling people with ALS to communicate with their loved ones. It is imperative for government agencies, researchers, medical professionals, and organizations, such as the ALS Association to collaborate, leverage advancements, and convert them into pioneering novel treatments.

The Fiscal year 2026 Presidential Discretionary Budget request eliminates the National ALS Registry and Biorepository at the Centers for Disease Control and Prevention (CDC). This program was created by Congress in 2008 with the bipartisan passage of the *ALS Registry Act*, P.L. 110-373. This program has been instrumental in providing scientists biospecimens used for foundational and clinical trial research.

[1] Arthur, K., Calvo, A., Price, T. *et al.* Projected increase in amyotrophic lateral sclerosis from 2015 to 2040. *Nat Commun* 7, 12408 (2016). DOI: 10.1038/ncomms12408

Currently, the biospecimens are being used in 35 active studies and 28 federally funded research projects. In addition, the Registry currently holds epidemiological data of 23,000 ALS patients, the largest database in the world, to support risk factor analysis to prevent ALS. The elimination of the National ALS Registry and Biorepository would:

- Delay clinical trials
- Delay new therapies
- Delay a cure
- Delay prevention interventions
- Delay new discoveries of genetic links to ALS
- Delay new diagnostic tools
- Eradicate decades of data and samples from loved ones who are currently living with ALS and loved ones we have lost to ALS

The elimination of the CDC ALS National Registry and Biorepository would stop the progress the United States has made in preventing and finding a cure for ALS.

Research funded by NIH has played a critical role in advancing our understanding and treatment of ALS. Progress has been made towards making ALS a manageable condition. For instance, NIH-funded grants supported essential preclinical toxicology and efficacy studies, which were required for the investigational new drug application (IND) for an antisense oligonucleotide (ASO) that ultimately became Qalsody (tofersen).[2] Recent confirmatory studies have demonstrated that Qalsody stabilizes ALS and results in significant preservation of function, with indications of sustained improvement in neurological function in some patients.[3] These findings represent a substantial advancement in the expected outcomes of ALS treatment and provide hope that effective treatments will soon be accessible to all individuals living with ALS.

Sustained investments in public research are vital for improving the management and treatment of ALS. Any reduction in public funding at the NIH, CDC, or other publicly supported ALS research programs could significantly hinder medical advancements in the study of ALS. Each ALS research initiative funded by the U.S. government is crucial to contributing to the broader ALS research continuum and adds value to the overarching goal of advancing our understanding of the disease. The aim is to make ALS livable rather than a fatal disease, until it is cured.

Here are more examples of how NIH funded research is moving our nation closer to a cure for ALS:

1. **Identification of *SOD1* as the first gene to cause familial ALS** (1993) – Robert Brown, Massachusetts General Hospital
2. **Identification of TDP-43 aggregates as a key pathological feature in ALS and FTD** (2006) – Virginia Man-Yee Lee, University of Pennsylvania Perelman School of Medicine
3. **Linking *C9orf72* to ALS** (2012) – Bryan Traynor, Neuromuscular Diseases Research Unit, National Institute on Aging, National Institutes of Health

[2] Campbell et al (2018). Antisense oligonucleotides extend survival and reverse decrement in muscle response in ALS models. The Journal of Clinical Investigation. DOI: 10.1172/JCI99081

[3] Smith et al (2025). Tofersen treatment leads to sustained stabilization of disease in SOD1 ALS in a "real-world" setting. Ann Clin Transl Neurol, 70(3), 333-345. DOI: 10.1002/acn3.52264

4. **Better understanding of the role of nuclear pore damage in the accumulation of TDP-43** (2021) – Jeffrey Rothstein; Johns Hopkins University School of Medicine
5. **Validation of neurofilament light chain (NfL) as a biomarker for ALS** (2024) – Michael Benatar, University of Miami, Miller School of Medicine

ALS research at NIH not only increases our understanding of the disease that will lead to a cure, but it also provides access to critical therapies for people living with ALS not qualified for clinical trials. ALS clinical trials typically require participants to be in the early stages of the disease. This criterion excludes approximately 60% of people since the average time to diagnosis is a year and a half. The *Accelerating Access to Critical Therapies (ACT) for ALS Act*, P.L. 117-79, overwhelmingly passed by Congress, authorizes NIH to disseminate expanded access grants allowing for access to investigational drugs for people living with ALS who are not eligible for clinical trials and collect relevant data on the drug's efficacy.

A veteran living with ALS recently testified at a Senate forum and illustrated what NIH funding means to him, his family and the 30,000 people living with ALS today.

> "The National Institutes of Health (NIH) and other federal agencies have been critical in funding groundbreaking research that offers hope to thousands of individuals like me, including by providing access to experimental treatments for ALS. The expanded access drug I am taking could not only extend my life but could serve as a pathway to making ALS a livable disease.
>
> But now funding cuts and reductions to funding at NIH and other research agencies threaten to derail decades of progress right when we are at the tipping point of finally finding a cure and at the minimum, making ALS a livable disease.
>
> But to be clear, this isn't just about me. It's about everyone impacted by ALS now and in the future. ALS costs our nation over one-billion dollars a year. Investing in a cure is not only fiscally responsible, but very simply, good public policy.
>
> I urge Congress to reject these harmful cuts to NIH and support the funding necessary to make ALS a livable disease until we cure it. My life, all our lives, and our economy depend on it."

The ALS Association urges Congress to prevent cuts to ALS research programs at the NIH and CDC. This would harm people living with ALS and impact our role as a world leader in ALS research. By making strategic investments in ALS research at NIH and the CDC, we can increase the number of clinical trials and decrease the incidence of new ALS cases. Together, these investments will enable us to change the trajectory of this disease and bring more effective treatments to all Americans with ALS, ultimately making ALS a livable disease. A healthy America includes a world without ALS.

The ALS Association stands ready to support your efforts and provide any additional information you may need to ensure ALS research is funded and protected with the urgency it deserves.

ASAM American Society of Addiction Medicine

NEWS

ASAM: Sweeping Medicaid Reforms Could Weaken America's Addiction Treatment Efforts, Pose a National Security Threat

May 13, 2025

Download



To save lives and undermine the influence of drug cartels, ASAM urges Congress to exempt addiction-related treatment services from cost-sharing mandates and reject burdensome work requirements

Rockville, MD (May 13, 2025) - In response to Sunday's release of the House Energy & Commerce Committee's bill text to reform Medicaid funding, Stephen M. Taylor, MD, M

DFAPA, DFASAM, president of the American Society of Addiction Medicine (ASAM), issued the following statement:

“ASAM firmly opposes any harmful Medicaid reforms which threaten to make lifesaving addiction treatment less accessible to Americans. Should the out-of-pocket costs of treatment services for low-income Americans with addiction exceed the price of legal or illicit addictive substances due to health insurance loss or new Medicaid requirements, we risk losing valuable ground in our addiction and recovery efforts.

In particular, we are greatly concerned that proposals to impose cost-sharing requirements on Medicaid Expansion enrollees – including those with substance use disorders – could make addiction-related treatment services even more costly than cheaper tobacco products, alcohol, and illicit drugs. Further, while we deeply appreciate the Committee’s exemption of people with a substance use disorder from the proposed work requirements, we maintain serious concerns over how this and other exemptions will be implemented. Time and energy spent on excessive bureaucratic red tape and surveillance could be better used to ensure that more Americans with low incomes can readily access and afford the medical care they need and deserve, including through programs like Medicaid Expansion.

Medicaid Expansion is a powerful weapon against addiction and the drug cartels, because it can reduce demand for illicit substances and help more Americans with addiction enter treatment. It must be protected, especially as we continue to lose tens of thousands of lives each year to the nation’s addiction and overdose crisis.”

# # #

About the American Society of Addiction Medicine

The American Society of Addiction Medicine (ASAM), founded in 1954, is a professional medical society representing over 8,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction. For more information, visit www.ASAM.org.

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POLITICS

Top RFK Jr. aide attacks US health system while running company that promotes wellness alternatives



In this image from video provided by C-SPAN, Calley Means, a key adviser to Health and Human Services Secretary Robert F. Kennedy Jr., speaks during a news conference where the HHS and FDA announced plans to ban petroleum-based food dyes, in Washington, on April 22, 2025. (C-SPAN via AP)

By MATTHEW PERRONE

Updated 9:54 AM EDT, June 10, 2025

WASHINGTON (AP) — Calley Means has built a following within the "Make America Healthy Again" movement by railing against the failings of the U.S. health system, often pinning the blame on one issue: corruption.

Means, a top aide to Health Secretary Robert F. Kennedy Jr., was hired as a White House adviser in March. He has used that perch to attack the nation's leading physician groups, federal agencies and government scientists, claiming they only protect their own interests in the nation's $4.9 trillion-a-year industry.

In recent interviews, speeches and podcasts he has called the American Medical Association "a pharma lobbying group," labeled the Food and Drug Administration "a sock puppet of industry," and said federal health scientists have "overseen a record of utter failure."

Means, however, has his own financial stake in the sprawling health system. He's the co-founder of an online platform, Truemed, that offers dietary supplements, herbal remedies and other wellness products. Some of the vendors featured on Truemed's website are supporters of Kennedy's MAHA movement, which downplays the benefits of prescription drugs, vaccines and other rigorously tested medical products.

Kennedy has pledged to run the Department of Health and Human Services with "radical transparency," but Means has never had to publicly disclose his own financial details or where exactly they intersect with the policies he's advancing.

"It reeks of hypocrisy," said Dr. Reshma Ramachandran, a health researcher at Yale University. "In effect, he is representing another industry that is touting nonregulated products and using his platform within the government to financially benefit himself."

In a written statement, Means said his government work has not dealt with matters affecting Truemed and has focused on issues like reforming nutrition programs and pressuring companies to phase out food dyes.

"Pursuing these large-scale MAHA goals to make America healthy has been the sole focus in my government work," Means said.

Truemed helps users take tax-free money out of their health savings accounts, or HSAs, to spend on things that wouldn't normally qualify as medical expenses, such as exercise equipment, meal delivery services and homeopathic remedies — mixtures of plants and minerals based on a centuries-old theory of medicine that's not supported by modern science.

The business model caught the attention of the IRS last year, which issued an alert: "Beware of companies misrepresenting nutrition, wellness and general health expenses as medical care."

Truemed co-founder and CEO, Justin Mares, said in a statement the company is "in full alignment" with IRS guidelines.

“Truemed enables patients to work with providers to use medical funds for root cause interventions like exercise and vitamin D to reverse disease under current law,” Mares said.

The full extent of Means’ potential conflicts — including his personal investments— are unclear because of his status as a special government employee.

Unlike presidential appointees and other senior officials, special government employees are temporary staffers who do not have to leave companies or sell investments that could be impacted by their work. Also, their financial disclosure forms are shielded from public release.

“It’s a big problem,” says Richard Painter, a former White House ethics lawyer under George W. Bush now at the University of Minnesota. Painter and other experts have raised alarms over a whirlwind of Trump administration actions to dismantle the government’s public integrity guardrails.

Still, part-time government employees are subject to the same law that bars all federal staffers from working on issues that could directly benefit their finances. When such cases arise, they must recuse themselves or risk criminal penalties.

Means regularly opines on matters before HHS, including rethinking the use of drugs for depression, weight loss, diabetes and other conditions. Recently he’s been promoting a new government report that calls for scaling back prescription medications in favor of exercise, dietary changes and other alternatives.

“If we rely less on our medical system, less on drugs, it necessitates the spiritual, cultural conversation about what we’re doing to our children’s bodies,” Means said in a recent podcast appearance.

Experts note that government ethics rules are intended to both prevent financial conflict violations, but also the appearance of such conflicts that might undermine public trust in government.

“If I were running the ethics office over at HHS, I sure as heck wouldn’t want anybody going around giving interviews and speeches about government matters that could have an effect on their own financial interests,” Painter said.

A rising star in the MAHA movement

Means’ rapid rise reflects the seeming contradictions within the MAHA movement itself, which urges followers to distrust both big corporations and the government agencies which regulate them.

Means rails against big pharma and food conglomerates, two industries that he says he spent years working for as a consultant in Washington.

Means has no medical training. A graduate of Harvard Business School, he previously ran a bridal gown startup with his wife. On Wednesday, he's scheduled to be the keynote speaker at FDA's annual science forum, according to a copy of the program shared with The Associated Press.

He traces his passion for health care reform to the death of his mother from pancreatic cancer in 2021. Shortly thereafter, Means and his sister, Dr. Casey Means, took psychedelics together and had "a mind-blowing, life-changing experience," which led them to co-author a wellness book, launch separate health startups and begin appearing on podcasts.

Casey Means was recently nominated to be surgeon general and has faced scrutiny over her qualifications, including an unfinished medical residency.

Asked about her nomination, President Donald Trump said: "Bobby thought she was fantastic," adding that he did not know her.

Meanwhile, her brother has stepped up his rhetoric for the MAHA agenda, recently declaring that Kennedy has "a spiritual mandate to reform our broken system."

While promoting the administration's accomplishments, Means does not shy away from plugging his own brand or those of his business partners.

When asked to offer health advice to listeners of a sports podcast, Outkick The Show, in April, Means said: "Read our book, 'Good Energy.'"

He also recommended blood tests sold by Function Health, which provides subscription-based testing for $500 annually. The company was cofounded by Dr. Mark Hyman, a friend of Kennedy and an investor in Truemed, which also offers Hyman's supplements through its platform. Casey Means is also an investor in Hyman's company.

"If you're sick, most likely you have some kind of nutrient deficiency, some kind of biomarker that you can actually then target with your diet and your supplements," Calley Means said.

Like dietary supplements, the marketing claims on laboratory tests sold by Hyman are not approved by the FDA. The agency has warned for years about the accuracy of such tests and tried to start regulating them under President Joe Biden.

Experts say MAHA entrepreneurs like Hyman are following a playbook common to the wellness industry: Identify a health concern, market a test to diagnose it and then sell supplements or other remedies to treat it.

“It ends up favoring these products and services that rest on flimsy grounds, at the expense of products that have actually survived a rigorous FDA approval process,” said Dr. Peter Lurie, a former FDA official who is now president of the Center for Science in the Public Interest.

Many of the items sold via Truemed, including sweat tents, cold plunge tanks and light therapy lamps, wouldn’t typically qualify as medical expenses under rules for HSAs, tax-free accounts created by Congress to manage medical costs.

The IRS generally states that HSA purchases must help diagnose, cure, treat, mitigate or prevent disease.

Truemed allows users to request a “letter of medical necessity” from a doctor, stating that the product in question could have medical value for them. Like other telehealth services, there’s usually no real-time communication with the patient. The physician reviews a “simple survey solution,” filled out by the Truemed user, according to the company’s website.

Industry representatives say customers should be careful.

“You need to be prepared to defend your spending habits under audit,” said Kevin McKechnie, head of the American Bankers Association’s HSA council. “Companies are popping up suggesting they can help you manage that process and maybe they can — so the debate continues.”

Americans have an estimated $147 billion in HSA accounts, a potential windfall for companies like Truemed that collects fees for transactions made using their platforms.

Means sees an even bigger opportunity — routing federal funds out of government programs and into more HSAs.

“The point of our company is to steer medical dollars into flexible spending,” Means told fitness celebrity Jillian Michaels, on her podcast last year. “I want to get that $4.5 trillion of Medicare, Medicaid, everything into a flexible account.”

Who benefits most from HSAs?

Means’ pitch for expanding HSAs echoes two decades of Republican talking points on the accounts, which were created in 2003 to encourage Americans in high-deductible plans to be judicious with their health dollars.

But HSAs have not brought down spending, economists say. They are disproportionately used by the wealthiest Americans, who have more income to fund them and a bigger incentive to lower their tax rate.

Americans who earn more than $1 million annually are the group most likely to make regular HSA contributions, according to an analysis by the nonprofit Center on Budget and Policy Priorities. More than half Americans with HSAs have balances less than $500.

Trump's "One Big Beautiful Bill" would further expand HSA purchases, making gym memberships and other fitness expenses eligible for tax-free spending. That provision alone is expected to cost the government $10 billion in revenue.

"These are really just tax breaks in the guise of health policy that overwhelmingly benefit people with high incomes," said Gideon Lukens, a former White House budget official during the Obama and Trump administrations, now with the Center on Budget and Policy Priorities.

Expanding HSA eligibility was listed as a goal for a coalition of MAHA entrepreneurs and Truemed partners, founded by Means, which lobbied Congress last year, according to the group's website.

Means said in a statement that the group focused only on broad topics like "health care incentives and patient choice — but did not lobby for specific bills."

In total, the HSA expansions in Trump's bill are projected to cost the federal government $180 billion over the next 10 years. As HSAs expand to include more disparate products and services, Lukens says the U.S. government will have fewer dollars to expand medical coverage through programs like Medicaid.

"We have a limited amount of federal resources and the question is whether we want to spend that on health and wellness products that may or may not be helpful for wealthy people," Lukens said.

The Bethesda Declaration: A Call for NIH and HHS Leadership to Deliver on Promises of Academic Freedom and Scientific Excellence

Dear Dr. Bhattacharya,

For staff across the National Institutes of Health (NIH), we dissent to Administration policies that undermine the NIH mission, waste public resources, and harm the health of Americans and people across the globe. Keeping NIH at the forefront of biomedical research requires our stalwart commitment to continuous improvement. But the life-and-death nature of our work demands that changes be thoughtful and vetted. We are compelled to speak up when our leadership prioritizes political momentum over human safety and faithful stewardship of public resources.

Many have raised these concerns to NIH leadership, yet we remain pressured to implement harmful measures. Today, we come directly to you. We include Secretary Kennedy and members of Congress who oversee NIH. We look forward to working with you and Department of Health and Human Services (HHS) leadership to maintain NIH as the world leader of biomedical research.

Our Shared Commitment to Academic Freedom

Academic freedom is a core scientific principle, and we deeply appreciate your public commitment to it at your confirmation hearing, in your April 24 statement on academic freedom, and in recent media interviews. You said: "I will establish a culture of respect for free speech in science and scientific dissent at the NIH," "Dissent is the very essence of science," and "...dissenting voices need to be heard and allowed." We hope you will welcome this dissent, which we modeled after your Great Barrington Declaration.

Our Concerns

This Administration has forced NIH, under your watch, to:

1) **Politicize research by halting high-quality, peer-reviewed grants and contracts**. Academic freedom should not be applied selectively based on political ideology. To achieve political aims, NIH has targeted multiple universities with indiscriminate grant terminations, payment freezes for ongoing research, and blanket holds on awards regardless of the quality, progress, or impact of the science. Based on political preferences and without input from NIH scientific staff or Congress, NIH is censoring critical research and programs addressing:

- **Health disparities.** U.S. Law (42 U.S.C. § 282) states that NIH *shall* "utilize diverse study populations, with special consideration to biological, social, and other determinants of health that contribute to health disparities." Yet, NIH has stigmatized and abruptly cut off funding for research mislabeled "Diversity Equity and Inclusion (DEI)." Achieving your stated goal to "solve the American chronic disease crisis" requires research addressing the social and structural drivers of health disparities.

- **COVID-19, long COVID, and immunization.** We still have much to learn about the health and social consequences of COVID-19 and our response. Such research is needed to reduce the risk of future pandemics, optimize pandemic response policies, and address the well-documented and debilitating consequences of long COVID.
- **Health impacts of climate change**. Substantial evidence shows human-driven climate change leads to higher rates of disease and death, such as asthma, heart disease, and stillbirths. Research is critical to find effective ways to reduce these and other health impacts of climate change.
- **Gender identity, sexual health, and the needs of intersex people in the U.S.** These topics deserve research attention, and NIH has a long tradition of supporting rigorous research in these fields.
- **Broad participation in biomedical research.** Robust research shows diverse teams outperform homogeneous ones. A broad workforce strengthens research capacity and supports globally competitive science. Due to misunderstanding of its workforce diversity programs, NIH terminated top-scoring grants to scientists from underrepresented backgrounds, while maintaining poorer-scoring grants from standard pathways, contrary to the merit-based system that makes NIH a global research leader.

Since January 20, 2025, NIH has terminated 2,100 research grants totaling around $9.5 billion and $2.6 billion in contracts. This undercuts long-standing NIH policies designed to maximize return on investment by working with grantees to address concerns and complete studies. Many terminations contradict federal regulations that mandate protections for research participants and require grant awards to specify potential termination reasons. These terminations:

- Throw away years of hard work and millions of dollars. Ending a $5 million research study when it is 80% complete does not save $1 million, it wastes $4 million.
- Shirk commitments to participants, who braved personal risk to give the incredible gift of biological samples, understanding that their generosity would fuel scientific discovery and improve health.
- Risk participant health. NIH trials are being halted without regard to participant safety, abruptly stopping medications or leaving participants with unmonitored device implants.
- Damage hard-earned public trust, counter to your stated goal to improve trust in NIH.

We urge you as NIH Director to restore grants delayed or terminated for political reasons so that life-saving science can continue.

2) **Interrupt global collaboration.** We would gladly work with you to improve existing systems to monitor awards with foreign components. But dissolving foreign collaborations while we await new procedures harms research participants and slows scientific discovery, cutting American scientists off from the global scientific community, preventing access to technologies only available abroad, and eliminating critical research that crosses political borders. ***We urge you as NIH Director to allow rigorously peer-reviewed research with vetted foreign collaborators to continue without disruption***.

3) **Undermine peer review.** Independent peer review is the bedrock of NIH science, directing scarce resources toward the most impactful research and ensuring credible findings that can lead to better health. Without independent peer review, we risk losing scientific integrity and public trust. NIH is ignoring peer review to cater to political whims, pulling applications prior to review and removing high-scoring grants from funding consideration. HHS has redirected this funding to unvetted projects, like the Taubenberger-Memoli vaccine project. ***We urge you as NIH Director to restore peer review and hold political appointees to the same standards as other scientists.***

4) **Enact a blanket 15% cap on indirect costs.** Until recently, indirect costs were negotiated using well-established criteria, accounting for critical research needs and very real costs, such as buildings, animal facilities, computers, libraries, and administrative support. The arbitrary 15% cap would hinder research, risk viability of universities and hospitals in states across the country, force universities to rescind graduate student positions, limit undergraduate research training, and damage the incredibly successful NIH-university partnerships that have improved health through scientific advances. ***We urge you as NIH Director to continue indirect rates that account for the research costs borne by academic institutions.***

5) **Fire essential NIH staff**. The cuts to talented, hardworking professionals and critical departments without thought to their purpose or need has slowed the pace of science, held up extramural grant and contract funding, made NIH less transparent and efficient, and put Clinical Center patients at risk. ***We urge you as NIH Director to reinstate the people who make NIH work.***

Delivering on your duty to obligate NIH funds

Combined, these actions have resulted in an unprecedented reduction in NIH spending that ***does not*** reflect efficiency but rather a dramatic reduction in life-saving research. Some may use the false impression that NIH funding is not needed to justify the draconian cuts proposed in the President's Budget. This spending slowdown reflects a failure of your legal duty to use congressionally appropriated funds for critical NIH research. Each day that NIH continues to disrupt research, your ability to deliver on this duty narrows.

Who We Are

We are workers from every Institute and Center at NIH. We are devoted to the NIH mission: to seek and apply fundamental knowledge "to enhance health, lengthen life, and reduce illness and disability." We share your stated goal of supporting impactful research that, as you said at your confirmation hearing, is "vital to our country's future and, indeed, the world's." We work hard every day to carefully steward public funds to drive impactful, cutting-edge research. We want to work together to maintain NIH's tradition of excellence.

On June 9, 2025, we sign this declaration in Bethesda, Maryland, U.S. In addition to the 92 named signers, we include 250 anonymous signers and speak for countless others at NIH who

share our concerns but who—due to a culture of fear and suppression created by this Administration—chose not to sign their names for fear of retaliation.

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Trump Pushes Holdout Republicans to Back Tax, Spending Deal (3)

May 20, 2025 5:41PM ET

- **The president spoke with House Republicans on Capitol Hill**
- **Trump urged moderate lawmakers to accept SALT caps**

(Updates with comments from SALT Caucus lawmakers beginning in the 12th paragraph.)

President Donald Trump on Tuesday warned House Republicans against making major changes to Medicaid as they negotiate a sweeping tax and policy package, according to lawmakers who attended the meeting.

Trump trekked to the Capitol as House Speaker Mike Johnson (R-La.) scrambles to pass sweeping legislation filled with many of the administration's domestic priorities, including extending the 2017 tax cuts and increasing defense and border spending.

One major sticking point has been a push by conservative hardliners for significant changes to Medicaid. Moderate Republicans fear deep cuts to Medicaid could cost them with voters who rely on the aid. Trump warned against making major revisions to Medicaid, according to two lawmakers who attended the meeting and spoke on condition of anonymity to talk about the private discussion

The president visited the House Republican Conference meeting Tuesday to rally support for passing the legislation this week. He used the session to to dial up the pressure on various holdouts across the House GOP conference ahead

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of a House Rules Committee meeting scheduled to convene at 1 a.m. Wednesday to take up the legislation.

The White House knows if Johnson loses more than three Republican votes, the bill would likely stall given unanimous Democratic opposition.

Trump was most adamant about tampering with Medicaid, using an expletive to instruct members to leave Medicaid alone, according to two people who were in the room.
The comment and Trump's tone surprised some GOP lawmakers who weren't expecting the president to be so forceful.

Leaving the meeting, Trump played down any rifts, telling reporters "this was a meeting of love."

Rep. Dusty Johnson (R-S.D.) after leaving the meeting said Trump is "frustrated with the pace of our progress."

"He made it pretty clear we need to quit screwing around and we need to get the one big, beautiful bill passed," Johnson added.

Trump took aim at House Republicans from high-tax, blue states, who have held up the bill in demand for raising the state and local tax (SALT) deduction, which has been capped at $10,000 since the 2017 tax law took effect.

The president said lawmakers in the SALT Caucus should accept an offer from GOP leaders to triple the cap to $30,000, according to a third lawmaker in the meeting. Trump singled out Rep. Mike Lawler (R-N.Y.), a leading critic of SALT, claiming he knew his district better than Lawler and that he wouldn't win re-election solely on SALT.

But Lawler and other SALT Caucus lawmakers said they were undeterred by the

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president's comments.

SALT Caucus members met with Johnson again Tuesday afternoon, but were not yet ready to support the bill. Rep. Nick LaLota (R-N.Y.) said they've made progress but weren't much closer to a deal.

"Some new and better numbers were discussed. We're still not there yet," LaLota said. "The president's involvement in conference this morning was positive."

Lots of No Votes

House Republican leadership wants the bill on the floor vote as soon as Wednesday, but Freedom Caucus Chairman Andy Harris (R-Md.) cast doubt on that timeline.

"We can get there, maybe not by tomorrow, but we can get there," Harris said. "The president I don't think convinced enough people that the bill is adequate the way it is."

If Republicans manage to strike a deal with the holdouts at Wednesday's Rules Committee meeting, House leaders will likely make the changes to the bill via a manager's amendment.

Rep. Ralph Norman (R-S.C.), a Freedom Caucus member who sits on the Rules Committee, didn't commit to supporting the bill but suggested Trump's remarks flipped some hardliners.

"He did a great job, we'll see," Norman said.

Trump also took issue with Rep. Thomas Massie (R-Ky.), a deficit hawk who has frequently bucked GOP leaders. Walking into the meeting, Trump claimed

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Massie doesn't understand how government works and "should be voted out of office."

Massie, who has already vowed to vote against the bill, said after the meeting Trump's remarks would likely flip several holdouts.

"They probably have the votes anyway to pass it. I think he was talking to the other people who've leaned no and trying to persuade them more than me," Massie said.

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ESTIMATED EFFECTS OF H.R. 1 ON HOSPITAL UNCOMPENSATED CARE COSTS

ROB NELB MPH

The proposed Medicaid policy changes included in the House-passed One Big Beautiful Bill Act (H.R. 1) are projected to increase hospital uncompensated care costs by at least **$42.4 billion in 2034, according to analysis of Congressional Budget Office (CBO) data**.

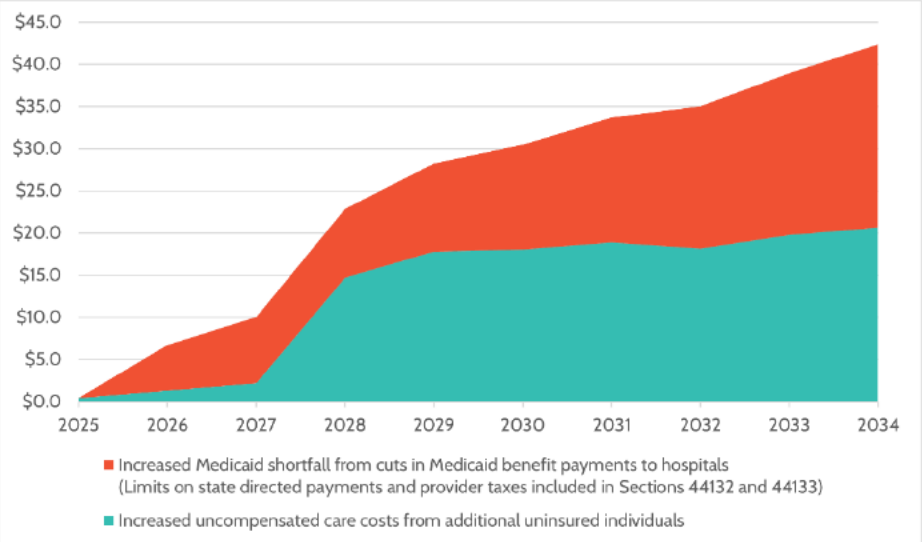
Overall, we find that both proposed cuts in Medicaid payments and additional costs for uninsured individuals will add to hospitals' uncompensated care costs over time (Figure 1). Lower Medicaid payment will make up an additional $21.7 billion in shortfalls in 2034.

Meanwhile, increased uncompensated care costs due to a growing number of uninsured individuals will contribute $20.6 billion in costs to hospitals in 2034.

UNPAID COSTS OF CARE FOR ELIGIBLE MEDICAID PATIENTS

In 2023, hospitals reported a $27.5 billion Medicaid shortfall.[1] Medicaid shortfall refers to the difference between a hospital's cost of care for Medicaid patients and the payment that it receives for these services.

FIGURE 1. PROJECTED INCREASE IN UNCOMPENSATED CARE COSTS FOR HOSPITALS UNDER H.R. 1, 2025–2034 (BILLIONS)



Note: Analysis does not include the effects of amendments made by the House Rules Committee, including provisions to move up the implementation date for Medicaid work requirements to Dec. 31, 2026.

Source: America's Essential Hospitals. 2025. Analysis of CBO Cost Estimates and Economic Baseline.

Medicaid shortfall is affected both by changes in Medicaid enrollment rates and changes in Medicaid payment levels. Two provisions in H.R. 1 that cut Medicaid provider payments will have the largest effect on hospitals' Medicaid shortfall:

- Section 44133 limits state directed payments (SDPs) to rates that are generally lower than hospitals' cost of care. It also freezes existing SDPs at current levels, which will limit states' ability to use this tool to continue

to close the gaps in payment between Medicaid and other payers.[2]

- Section 44132 places a moratorium on provider taxes, a permissible financing mechanism that most states use to ensure adequate payments to hospitals.[3]

We estimate that these two provisions will lower Medicaid payments to hospitals by at least $21.7 billion by 2034. Moreover, the effects of these cuts will likely compound over time because these proposed Medicaid payment freezes do not appear to fully keep up with inflation.

UNCOMPENSATED CARE COSTS FOR UNINSURED INDIVIDUALS

In 2023, hospitals reported $41.4 billion in unpaid costs of care for uninsured individuals on Medicare cost reports. CBO estimates that H.R. 1 will increase the number of uninsured individuals by 10.9 million in 2034, which is 34% higher than the CBO baseline. As a result, the bill is expected to increase hospital uncompensated care costs by $20.6 billion in 2034.

Medicaid currently pays for some hospital uncompensated care costs through the Medicaid disproportionate share hospital (DSH) program. However, because DSH funding is capped by federal allotments, and is also due to be significantly cut on Oct. 1, 2025, the uncompensated costs added by this bill will not be offset by other sources.

EFFECTS ON ESSENTIAL HOSPITALS

Cuts of this magnitude would disproportionately harm essential hospitals and the communities that they serve. Essential hospitals are dedicated to high-quality care for all, including those who face social and financial barriers to care. About three-quarters of the patients they serve are uninsured or enrolled in Medicare or Medicaid.

Although essential hospitals account for just 5% of hospitals nationally, we estimate that they would bear approximately 25% of the added hospital unpaid costs of care. This would amount to an additional $10.7 billion in cuts to essential hospitals in 2034.

In 2022, essential hospitals reported $22.7 billion in unpaid costs of care, which included $10.4 billion in uncompensated care for uninsured individuals and $12.4 billion in under-reimbursed care from government payers, such as Medicaid.

As a result of these costs, essential hospitals reported operating margins of negative 9%.[4] With cuts of the magnitude proposed by H.R. 1, essential hospitals face even more financial challenges, threatening their ability to provide access to life-saving services in their communities.

DATA SOURCES AND METHODOLOGY

Baseline levels of uncompensated care were estimated using CBO's January 2025 economic baseline projections and June 2024 baseline projections for Medicaid and the number of uninsured individuals.[5] These baseline estimates include projected increases in the number of uninsured individuals due to the expected expiration of enhanced subsidies for the health insurance marketplace as of Dec. 31, 2025.

The effects of H.R. 1 on Medicaid shortfall were estimated using CBO's estimates of H.R. 1 as passed by the House of Representatives on May 22, 2025.[6] We used the most recent approved preprints published on CMS' website to estimate that 82% of the proposed cuts to SDPs would be borne by hospitals. We estimated that 65% of the costs of the proposed moratorium on provider taxes would affect hospitals based on prior analysis from the Medicaid and CHIP Payment and Access Commission and data from CMS' National Health Expenditure Accounts.[7,8]

Our analysis focuses on the effects of Section 44132 and 44133 of H.R. 1 and does not include other provisions that could also affect Medicaid payment for hospitals. For example, proposed increases in Medicaid cost sharing included in Section 44142 are likely to lower Medicaid payments to providers who chose to continue caring for patients who cannot afford the new cost sharing obligations. In addition, our analysis did not consider other interaction effects, such as how cuts in state funding may affect states' ability to pay for Medicaid hospital services.

The effects of H.R. 1 on uncompensated care costs for uninsured individuals were estimated using CBO's preliminary estimates of Subpart D, Part I of the budget reconciliation recommendations of the House Energy and Commerce Committee and adjusted based on CBO's final analysis of H.R. 1 as passed by the House of Representatives.[9]

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In CBO's preliminary estimates, CBO assumed that the proposed Medicaid work requirements would take effect Jan. 1, 2029, but in the final version of H.R. 1 that passed the House of Representatives, work requirements would take effect Dec. 31, 2026.

The effect of proposed cuts on essential hospitals was estimated based on essential hospitals' share of Medicaid payments and hospital uncompensated care.

Endnotes

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2. SDPs are a tool that many states use to offset low Medicaid payment rates in managed care. SDPs allow states to ensure that Medicaid payments to managed care plans are directed to providers who are helping to advance state access and quality goals.

3. Section 44134 makes additional changes to provider tax requirements, but the effects of this change are excluding from this analysis since the Centers for Medicare & Medicaid Services (CMS) has already proposed to make similar changes through regulation.

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Democracy Dies in Darkness

CDC blindsided as RFK Jr. changes covid-19 vaccine recommendations

Agency officials were not aware that the HHS secretary was going to change the recommended vaccine schedule.

May 28, 2025



By Lena H. Sun

Health and Human Services Secretary Robert F. Kennedy Jr.'s surprise announcement Tuesday ending coronavirus vaccine recommendations for healthy children and pregnant women blindsided the agency that offers that advice, according to current and former federal health officials.

Officials at the Centers for Disease Control and Prevention are scrambling to understand Kennedy's decision, announced in a 58-second video on X on Tuesday morning, which took agency staff by surprise.



Podcast episode

RFK Jr.'s imprint on covid vaccines and public health

RFK Jr. is changing coronavirus vaccine recommendations. What will that mean for you?

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Five hours later, CDC officials received a one-page "secretarial directive," dated May 19 and signed by Kennedy, that contradicts some of what he said in his video, according to two current and one former health officials, who spoke on the condition of anonymity out of fear of retaliation.

In his tweet and video, Kennedy said he had unilaterally decided to override the current recommendation that everyone 6 months and older receive an annual coronavirus vaccination — including healthy pregnant women.

Officials at the CDC learned of that decision "when it was tweeted. People were scrambling to find out what it meant," one federal health official said. The letter was distributed to the CDC in the afternoon, causing more confusion because it was dated May 19, the official said.

In his video, Kennedy also said federal health officials had removed the previous recommendations from the agency website. But top CDC officials did not know of the decision at the time, according to one official, and as of Wednesday that removal still had not happened for the millions of people who rely on the site for health-care guidance.

The directive raises questions about who should be getting the vaccine because it refers to both healthy children and all children. "The CDC is directed to remove COVID-19 vaccines from the recommended Child and Adolescent Immunization Schedule by Age and recommended vaccines during pregnancy," the letter states.

"It's unclear," the official said.

In his video, Kennedy, who founded an anti-vaccine organization before joining the government, also said he was ending coronavirus shots for healthy pregnant women. But last week, top officials from the Food and Drug Administration outlined a new coronavirus vaccine policy in a New England Journal of Medicine article, approving shots only for those 65 and older and people with medical conditions that put them at high risk for severe illness. Pregnancy is listed as one of the conditions.

HHS spokesman Andrew Nixon said the directive provides that the vaccine should not be recommended for healthy children under 18 and should not be recommended for pregnant women. He did not address questions about the apparent contradictions between the directive, Kennedy's video and the New England Journal of Medicine article.

"Secretary Kennedy is taking urgent action to ensure the public's safety when it comes to COVID-19 vaccines," Nixon said in a statement.

As of Wednesday afternoon, the CDC website on immunization of children and adolescents under 18 continued to recommend one or more doses of coronavirus vaccine for those 6 months and older. The website for pregnant women continued to recommend an updated shot for those who are pregnant, breastfeeding an infant, trying to get pregnant now or might become pregnant in the future.

The bottom line, according to public health experts and agency officials, appears to be an effort by Kennedy and the Trump administration to further erode public trust in the CDC.

Paul Offit, director of the Vaccine Education Center at Children's Hospital of Philadelphia and a longtime pediatric infectious-diseases physician, said bypassing the CDC makes it more difficult for people to access the coronavirus vaccine. Current law requires insurance companies to cover the cost of CDC-recommended vaccines without charging out-of-pocket costs to consumers.

"They've made it much less insurable, and therefore this could make it much less available for people," Offit said. "It's a continued war against vaccines by our secretary of health and human services."

“His goal is to make vaccines less available, less affordable and more feared. That’s his goal, and this is what he’s doing,” Offit said.

The long-established process for vaccine approval in the United States involves the FDA and the CDC. The FDA is responsible for regulating vaccine use, including approving vaccines for safety and efficacy. Before a vaccine can be tested in people, researchers study its ability to produce an immune response in animals.

If it shows promising results, it moves forward to clinical trials for testing in people, which includes monitoring for side effects and determining how well the vaccine triggers an immune response. The FDA reviews that clinical trial data before its decision.

In some cases, the FDA’s vaccine advisory committee provides additional input at public hearings.

The CDC’s vaccine advisory panel of medical and public health experts — the Advisory Committee on Immunization Practices (ACIP) — develops recommendations for the use of vaccines approved by the FDA. To determine the public health benefit, the panel weighs safety and vaccine effectiveness, the seriousness of the vaccine-preventable disease and the number of people who would contract the disease if there were no vaccine.

After the ACIP recommends a vaccine, the CDC director must sign off for it to become official public health guidance.

The CDC has no permanent director, raising questions about who is empowered to sign off on vaccine recommendations. Susan Monarez, who had previously been acting director, is awaiting Senate confirmation.

Lauren Weber contributed to this report.

What readers are saying

The comments express strong disapproval of Robert F. Kennedy Jr.'s recent changes in vaccine recommendations, highlighting his lack of medical qualifications and perceived disregard for scientific consensus. Many commenters criticize his unilateral decision-making and fear the... Show more

This summary is AI-generated. AI can make mistakes and this summary is not a replacement for reading the comments.

Everyone Loves a Comeback

Paul Rivera needed a lung transplant. After others turned him down, only one hospital stepped in to help.

See Paul's Story »

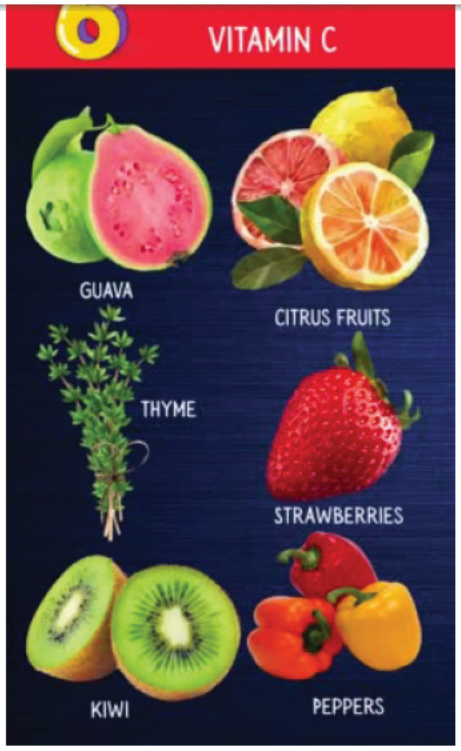
CDC Cancels Measles Help for Texas Schools Amid Staff Layoffs

By HealthDay | April 21, 2025

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HEALTHDAY



NOW PLAYING

Eat These 6 Foods f… These Are The Five… Surprising Foods Th… GLP-1s Should Be… Jessie J promises

MONDAY, April 21, 2025 (HealthDay News) — The U.S. Centers for Disease Control and Prevention (CDC) has canceled its plans to help Texas schools stop the rapid spread of measles.

The decision came after some CDC staff involved in this year's outbreak response were told they might lose their jobs, according to an agency employee.

CDC staff had planned to expand their work in Texas by offering on-site ventilation checks at schools, just like they had done in hospitals.

These visits help spot issues that could make it easier for viruses like measles to spread. As of April 18, the Texas department of health services has confirmed 597 cases of measles in 10 counties, and two children have died.

"Being on the ground allows us to actually look at the filters that are in place, look at the HVAC systems, how they're set up, how they're being used, how they're being monitored. And after seeing what we did, I'm glad we did," Dylan Neu, a biomedical engineer at the CDC's National Institute of Occupational Safety and Health (NIOSH), told *CBS News*.

spreading the virus instead of containing it.

In another hospital, a HEPA filter was installed in its plastic wrapping, making it pretty much useless.

"They might say in an interview, 'Yeah, we purchased HEPA filters. They've been running in the waiting room.' But if they're not actually out of the plastic bag, they're not doing what they think they're doing," Neu said to *CBS News*.

NIOSH, the CDC team that Neu works for, was largely dismantled earlier this month after U.S. Health and Human Services Secretary Robert F. Kennedy Jr. launched a massive round of layoffs.


A stranger gate-crashes the wedding of a couple leaving Everyone baffled
Learn More

Neu was notified on April 1 that he would likely be laid off by the end of June.

"This action is necessary to align our workforce with the agency's current and future needs and to ensure the efficient and effective operation of our programs," Neu's notice said.

"My current understanding is that I'll be working in the office until the end of this month, and then I'll be on 60 days administrative leave until June 30th, and then we'll be separated at that point," he said.

Because Neu could lose access to CDC systems while in the field, the agency decided not to send him to assess schools in Texas.

The layoffs are affecting more than just the measles response. Neu says NIOSH has also had to stop doing health hazard evaluations — where experts help workplaces investigate cancer clusters or other types of outbreaks, according to *CBS News*.

Neu said.

More information

Learn more about the CDC's National Institute for Occupational Safety and Health.

SOURCE: *CBS News*, April 18, 2025

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Join the Conversation

See Comments

Tags: government, measles

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SHOTS - HEALTH NEWS

RFK Jr. says COVID shots no longer recommended for kids, pregnant women

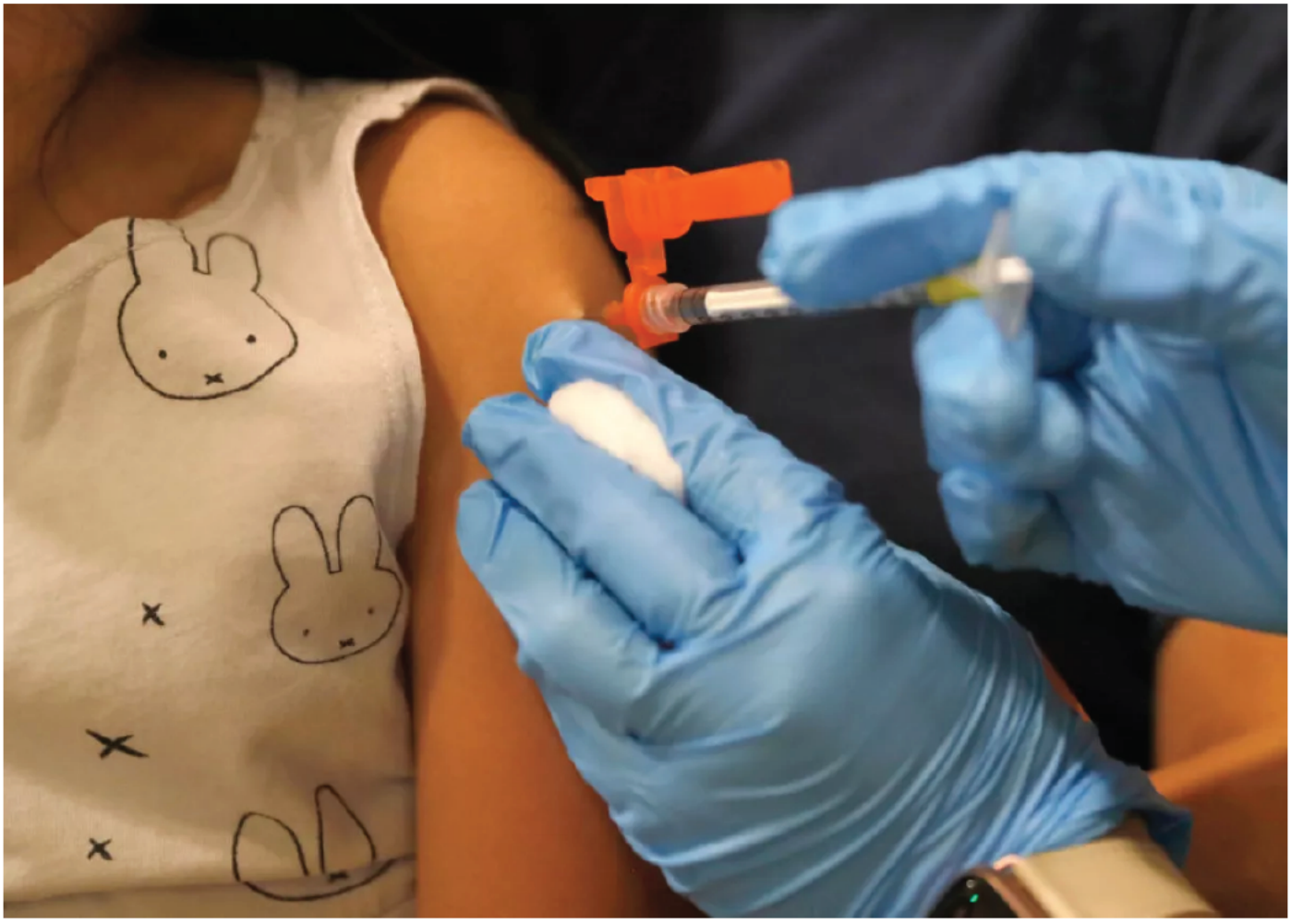
MAY 27, 2025 · 12:47 PM ET

HEARD ON ALL THINGS CONSIDERED



Rob Stein

3-Minute Listen PLAYLIST TRANSCRIPT



The CDC is removing recommendations that children and pregnant people get the COVID vaccine.

Jane Tyska/Digital First Media/Media News Group/Getty Images

The federal government has removed COVID-19 vaccines from the list of shots recommended for healthy pregnant women and children, federal health officials announced Tuesday.

"I couldn't be more pleased to announce that as of today the COVID vaccine for healthy children and healthy pregnant women has been removed from the CDC recommended immunization schedule," Health and Human Services Secretary Robert F. Kennedy Jr. announced in a video posted on X. "We're now one step closer to realizing President Trump's promise to make America healthy again."

The decision will make it much harder for parents to get their children vaccinated and for pregnant people to get the shots because insurance companies will likely no longer pay for them.

Sponsor Message





POLICY-ISH

A stricter FDA policy for COVID vaccines could limit future access

"Last year the Biden administration urged healthy children to get yet another COVID shot despite the lack of any clinical data to support the repeat booster strategy in children," Kennedy said.

In announcing the decision, Kennedy was flanked by Food and Drug Administration Commissioner Dr. Martin Makary and National Institutes of Health Director Dr. Jay Bhattacharya.

"It's common sense and it's good science," Bhattacharya said.

"There's no evidence healthy kids need it today and most countries have stopped recommending it for children," Makary added.

The decision was apparently made without the usual input from independent outside advisers. Although independent advisers have been reconsidering the COVID vaccine recommendations, the Center for Disease Control and Prevention's Advisory Committee on Immunization Practices isn't scheduled to meet until later this month to make a recommendation.

In response to questions on this issue, Department of Health and Human Services press secretary Vianca N. Rodriguez Feliciano shared the following statement:

"HHS and the CDC remain committed to gold standard science and to ensuring the health and well-being of all Americans—especially our nation's children."

Since the vaccines became available, the government has been recommending the shots for nearly everyone, including children and pregnant people. Although children don't tend to get seriously ill from COVID, some do, especially very young children, and pregnant women remain at high risk for serious complications from the virus.



PUBLIC HEALTH

Getting the COVID vaccine during pregnancy protects newborns from hospitalization

Vaccinating pregnant women also protects newborn babies, who can't get vaccinated themselves but are at very high risk for serious complications from the virus.

"It's really concerning," Dr. Sean O'Leary, who chairs the American Academy of Pediatrics' Committee on Infectious Diseases, told NPR. "I think it's going to be confusing not only for parents but also for public health professionals and medical professionals as well. This takes away choice."

Dr. Steven J. Fleischman, president of the American College of Obstetricians and Gynecologists said his organization is "extremely disappointed" by the removal of the recommendation for COVID shots during pregnancy.

"As ob-gyns who treat patients every day, we have seen firsthand how dangerous COVID infection can be during pregnancy and for newborns who depend on maternal antibodies from the vaccine for protection," he said in a statement. "The science has not changed. It is very clear that COVID infection during pregnancy can be catastrophic and lead to major disability."

The announcement comes a week after the administration made changes that could dramatically restrict the availability of the next round of COVID boosters. The government will now require additional testing for the vaccines to be approved for use by anyone other than people who are at high risk from COVID because they are age 65 or older or have risk factors for other health problems.

CHA Opposes H.R.1, The One Big Beautiful Bill

FOR IMMEDIATE RELEASE
May 22, 2025
Contact: Marie Johnson

WASHINGTON, DC — Today, Catholic Health Association of the United States (CHA) President and CEO Sr. Mary Haddad, RSM, issued the following statement on H.R. 1, The One Big Beautiful Bill.

"H.R. 1 would harm critical health and social safety-net programs that millions of Americans rely on to live with health, dignity, and security. The Catholic Health Association strongly opposes provisions like mandatory Medicaid work reporting requirements, restrictions on state tax authority, and changes to state-directed payment policies—all of which would lead to coverage losses for more than 10 million people who depend on Medicaid for essential care. These harmful proposals threaten the health and stability of the very communities we are called to serve.

We are also deeply concerned by the bill's failure to extend the Affordable Care Act's enhanced premium tax credits. Without action, five million Americans — including nearly two million living with chronic conditions — could lose their coverage, and millions more would face skyrocketing premiums and unaffordable care.

Proposed changes to the Supplemental Nutrition Assistance Program would further jeopardize food security for families already struggling to make ends meet,

compounding the health and economic burdens on low-income communities.
We urge the Senate to protect and strengthen the programs that uphold the dignity, health, and well-being of all, especially those most in need."

###

The Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry, representing the largest nonprofit provider of health care services in the nation.

- *1 in 7 patients in the U.S. is cared for in a Catholic hospital each day.*
- *Catholic health care, which includes more than 2,200 hospitals, nursing homes, long-term care facilities, systems, sponsors, and related organizations, serves the full continuum of health care across our nation.*

STATEMENT

CHA Opposes New Senate Finance Reconciliation Proposal

The bill includes provisions that would hurt health care for all children.

BOOKMARK

Published June 17, 2025 1 min. read

WASHINGTON, D.C. – As the Senate considers reconciliation, CHA President and CEO Matthew Cook released the following statement:

"The bill text released by Senate Finance last night is worse than what the House proposed and will be detrimental for children's health and hospitals across the nation. The Medicaid program continues to be vital to nearly half of children in the U.S. – without it, all children will struggle to get the care they need from hospitals that will be unequipped to treat them. We urge senators to champion American children, hospital workers, and families and oppose the Medicaid provisions in this proposal."

• • •

ACCESS TO CARE MEDICAID ADVOCACY

Contact Us

Elleni Almandrez
(202) 753-5364

STATEMENT

CHA Opposes Proposed Cuts to Medicaid Program

If enacted, these cuts would threaten health care access for millions of children.

BOOKMARK

Published May 12, 2025 1 min. read

WASHINGTON, D.C. – In response to the House Energy and Commerce Committee's proposed cuts to the Medicaid program, Children's Hospital Association President and CEO Matthew Cook released the following statement:

"The E&C committee's proposed cuts of $715 billion to the Medicaid program would be catastrophic for children and children's hospitals if passed into law. Nearly half of America's children rely on Medicaid and CHIP for their health care, and importantly, this proposal would threaten their access to critical pediatric care.

"Children's hospitals rely heavily on Medicaid reimbursement to provide high-quality care, and without a strong Medicaid program, children's hospitals will be forced to make tough decisions. Families often can't just go to their closest general hospital – children aren't little adults, and their health care needs aren't the same as their parents'.

"We urge Congress to protect and strengthen the Medicaid program for millions of children who rely on it by opposing these proposed cuts to children's health care access."

• • •

MEDICAID CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) ADVOCACY

Contact Us

Elleni Almandrez
(202) 753-5364

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

CMS Newsroom

Press Releases Apr 07, 2025

CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs

Administration

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Today, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Rate Announcement for the Medicare Advantage (MA) and Medicare Part D Prescription Drug Programs that finalizes the payment policies for these programs. This release — combined with the CY 2026 MA and Part D final rule that was released on April 4 — makes annual routine and technical updates to the MA and Part D programs.

The actions taken by CMS help protect beneficiaries and taxpayers from waste, fraud, and abuse, while also driving access to high-quality, affordable healthcare through Medicare Advantage. By finalizing these payment policies, CMS is ensuring that Medicare Advantage continues to offer access to critical services in an efficient, accountable manner, further strengthening the program's ability to serve beneficiaries.

Payments from the government to MA plans are expected to increase on average by 5.06% from 2025 to 2026. This is an increase of 2.83 percentage points since the CY 2026 Advance Notice, which is largely attributable to an increase in the effective growth rate. The method for setting the effective growth rate is set in statute and represents the average expected change in the benchmarks, used to determine payment for MA plans, based on the growth in Medicare per capita

costs. The effective growth rate is 9.04%, which is higher than the estimate of 5.93% in the CY 2026 Advance Notice. This change is primarily due to the inclusion of additional data on fee-for-service (FFS) expenditures, including payment data through the fourth quarter of 2024, which was not included on account of the early Advance Notice publication.

In CY 2024, CMS initiated a three-year, phased-in approach for removing the medical education costs — related to services MA enrollees receive — from the historical and projected expenditures supporting the FFS costs that are included in the growth rate calculations. For CY 2026, CMS will complete the phase-in of the technical adjustment by applying 100% of the adjustment for MA-related medical education costs.

CMS is also completing a three-year phase-in of improvements to the MA risk adjustment model that the agency finalized in the CY 2024 Rate Announcement, with the first year of the three-year phase-in starting with CY 2024. CMS is committed to expanding access to affordable, high-quality care through Medicare Advantage, while also implementing measures to safeguard beneficiaries and taxpayers from waste, fraud, and abuse. These ongoing improvements support a sustainable program that benefits both current and future Medicare recipients.

CMS is concurrently releasing the Final CY 2026 Part D Redesign Program Instructions that continue to implement the redesign of the Medicare Part D program. These instructions contain a detailed description of, and guidance related to, changes to the Part D drug benefit in place for CY 2026.

The CY 2026 MA and Part D Rate Announcement may be viewed at https://www.cms.gov/files/document/2026-announcement.pdf.

A fact sheet discussing the provisions of the CY 2026 Rate Announcement can be viewed at https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement

The Final CY 2026 Part D Redesign Program Instructions can be found at https://www.cms.gov/files/document/final-cy-2026-part-d-redesign-program-instruction.pdf.

A fact sheet discussing the provisions of the Final CY 2026 Part D Redesign Program Instructions can be viewed at https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions

Previous Newsroom Article

Next Newsroom Article

CMS.gov

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

7500 Security Boulevard, Baltimore, MD 21244

An official website of the United States government

COVID-19 Vaccines

COVID-19 vaccines are safe and effective. <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html>

COVID-19 vaccines are available to everyone 6 months and older. Getting vaccinated is the best way to help protect people from COVID-19. Get vaccinated if you haven't. If you are vaccinated, stay up to date with your COVID-19 vaccine.

- Find COVID-19 vaccine information from CDC <https://www.cdc.gov/covid/vaccines/>

How do I get a COVID-19 vaccine?

- Text your **zip code** to **438829**
- Call **1-800-232-0233** (TTY 1-888-720-7489)
- Message & Data rates may apply. Terms of Service <https://wwwn.cdc.gov/dcs/contactus/termsofservice>.
- Find a vaccine near you <http://vaccinefinder.org/search/>

COVID-19 Vaccine Development and Authorization

The federal government has been working since the pandemic started to develop, manufacture, and distribute safe and effective COVID-19 vaccines.

Years before the COVID-19 pandemic, scientists were already studying coronaviruses to find out how to protect against them. When the COVID-19 pandemic began, researchers were able to come up with vaccines for this new virus much faster because of work that was already happening.

FDA Authorization

The Food and Drug Administration (FDA) reviews and evaluates COVID-19 vaccines for quality, safety, and effectiveness. The FDA then issues Emergency Use Authorizations (EUAs) <https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained> for certain vaccines that meet rigorous, science-based standards. The FDA determines that these vaccines are safe and effective for public use.

CDC Recommendation

After the FDA authorizes the emergency use of a vaccine, an independent panel of medical and health experts called the Advisory Committee on Immunization Practices (ACIP) <https://www.cdc.gov/acip/about/role-in-vaccine-recommendations.html> provides recommendations and guidance to the Director of the Centers for Disease Control and Prevention (CDC) regarding the use of the vaccine.

FDA Approval

When the FDA approves a vaccine, it must undergo the agency's standard approval process <https://www.fda.gov/drugs/development-approval-process-drugs> for reviewing the quality, safety and effectiveness. The FDA's Center for Drug Evaluation and Research

conducts an analysis of the benefits and risks to ensure the vaccine meets the FDA's standards for approval.

COVID-19 Vaccine Milestones

October

October 3, 2023

FDA authorized the updated Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) for individuals ages 12 and older <https://www.fda.gov/news-events/press-announcements/fda-authorizes-updated-novavax-covid-19-vaccine-formulated-better-protect-against-currently>

September

September 11, 2023

FDA approved and authorized the emergency use of the updated Moderna and -BioNTech COVID-19 vaccines <https://www.fda.gov/news-events/press-announcements/fda-takes-action-updated-mrna-covid-19-vaccines-better-protect-against-currently-circulating> formulated to better protect against currently circulating variants

---

April

April 18, 2023

FDA amended the emergency use authorization to simplify the vaccination schedule for bivalent Moderna and Pfizer-BioNTech COVID-19 vaccines <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-changes-simplify-use-bivalent-mrna-covid-19-vaccines>

April 24, 2023

HHS Secretary issued a directive on simplified and expanded use of bivalent mRNA COVID-19 vaccines [PDF, 226 KB] </sites/default/files/secretarial-directive-simplified-expanded-bivalent-mrna-covid-19-vaccines.pdf>

December

December 8, 2022

FDA authorizes the emergency use of the updated (bivalent) Moderna and Pfizer COVID-19 vaccines for children ages 6 months and up <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-updated-bivalent-covid-19-vaccines-children-down-6-months>.

December 9, 2022

HHS Secretary issued a directive on bivalent vaccines for children starting at 6 months of age [PDF, 160 KB] </sites/default/files/secretarial-directive-pediatric-bivalent-covid-19-vaccine.pdf>

October

October 13, 2022

HHS Secretary issued a directive on bivalent COVID-19 vaccine booster doses for individuals ages 5 years and older [PDF, 166 KB] </sites/default/files/secretarial-directive-covid-19-bivalent-vaccine-boosters-younger-peds.pdf>.

September

September 2, 2022

HHS Secretary issued a directive on bivalent COVID-19 vaccine booster doses for individuals ages 12 years and older [PDF, 146 KB] </sites/default/files/secretarial-directive-covid-19-bivalent-vaccine-boosters.pdf>.

July

July 13, 2022

FDA authorized emergency use of Novavax COVID-19 Vaccine, Adjuvanted <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-emergency-use-novavax-covid-19-vaccine-adjuvanted> for individuals 18 years of age and older.

July 21, 2022

HHS Secretary issued a directive on the use of a two-dose Novavax COVID-19 Vaccine, Adjuvanted for persons ages 18 years and older [PDF, 120 KB] </sites/default/files/secretarial-directive-novavax-covid-19-vaccine.pdf>.

June

June 17, 2022

FDA authorized Moderna and Pfizer-BioNTech COVID-19 vaccines for children down to 6 months of age <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-moderna-and-pfizer-biontech-covid-19-vaccines-children>.

June 18, 2022

HHS Secretary issued a directive to expand eligibility of the Moderna COVID-19 vaccine for children 6 months through 5 years old and the Pfizer-BioNTech COVID-19 vaccine for children 6 months through 4 years old [PDF, 107 KB] </sites/default/files/secretarial-directive-on-pediatric-covid-19-vaccines.pdf>.

June 24, 2022

HHS Secretary issued a directive to expand eligibility of a two-dose series of the Moderna COVID-19 vaccine for children ages 6 years through 17 years, and an additional Moderna dose for children in that age group who are immunocompromised [PDF, 108 KB] </sites/default/files/secretarial-directive-additional-pediatric-covid-19-vaccines-6-17-yrs.pdf>.

May

May 17, 2022

FDA expanded eligibility for the Pfizer-BioNTech COVID-19 vaccine to allow a single booster dose for children 5 through 11 years of age <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-expands-eligibility-pfizer-biontech-covid-19-vaccine-booster-dose>.

May 23, 2022

HHS Secretary issued a directive to expand eligibility for a single booster dose to children ages 5 through 11 years and updated the recommendation of a second COVID-19 vaccine booster dose to certain populations [PDF, 157 KB] </sites/default/files/secretarial-directive-on-pediatric-and-second-booster-dose.pdf>.

March

March 29, 2022

CDC recommends additional boosters for certain individuals <https://www.cdc.gov/media/releases/2022/s0328-covid-19-boosters.html>.

January

January 10, 2022

HHS Secretary issued a directive to expand eligibility for children ages 12 through 15 years [PDF, 107 KB] </sites/default/files/secretarial-directive-on-availability-of-covid-19-vaccines.pdf> to receive a booster dose of the Pfizer COVID-19 vaccine, and to allow a third vaccine dose for immunocompromised children 5 through 11 years of age.

January 31, 2022

FDA approved the second COVID-19 vaccine <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-key-action-approving-second-covid-19-vaccine>, Spikevax (COVID-19 Vaccine, mRNA), which was previously known as Moderna COVID-19 Vaccine; the approved vaccine will be marketed as Spikevax for the prevention of COVID-19 in individuals 18 years of age and older.

December

December 10, 2021

HHS Secretary issued a directive to expand eligibility for adolescents ages 16 and 17 [PDF, 113 KB] </sites/default/files/secretarial-directive-availability-booster-

doses-covid-19-vaccines.pdf> to receive a booster dose of the Pfizer COVID-19 vaccine.

November

November 3, 2021

HHS Secretary issued a directive to expand eligibility for children five years and older [PDF, 93 KB] </sites/default/files/secretarial-directive-availability-covid-19-vaccines-children-ages-5-11.pdf> to receive an age-appropriate dose of the Pfizer COVID-19 vaccine.

November 8, 2021

A joint letter [PDF, 277 KB] </sites/default/files/becerra-cardona-letter-on-covid-19-vaccination-for-children.pdf> from HHS Secretary Becerra and Education Secretary Cardona is issued about how schools can support COVID-19 vaccination for children.

November 21, 2021

HHS Secretary issued a directive to expand eligibility for all adults ages 18 and older [PDF, 113 KB] </sites/default/files/secretarial-directive-availability-booster-doses-covid-19-vaccines.pdf> to receive a booster dose of COVID-19 vaccines.

October

October 20, 2021

FDA amended the emergency use authorizations (EUAs) to allow for a single booster dose the Moderna COVID-19 vaccine and Janssen (Johnson and Johnson) COVID-19 vaccine <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines>. FDA also authorized the use of heterologous (or "mix-and-match") booster dose of an available vaccine in eligible individuals following completion of primary vaccination with a different COVID-19 vaccine.

October 22, 2021

HHS Secretary issued a directive on Moderna and Janssen (Johnson and Johnson) vaccine boosters [PDF, 156 KB] </sites/default/files/secretarial-directive-

eligibility-receive-particular-covid-19-vaccine-boosters.pdf>*

October 29, 2021

FDA authorized the emergency use (EUA) for the Pfizer-BioNTech COVID-19 Vaccine for the prevention of COVID-19 to include children 5 through 11 years of age <https://www.fda.gov/news-events/press-announcements/fda-authorizes-pfizer-biontech-covid-19-vaccine-emergency-use-children-5-through-11-years-age>.

September

September 22, 2021

FDA amended the emergency use authorization (EUA) to allow a single booster dose of the Pfizer-BioNTech COVID-19 vaccine <https://www.fda.gov/news-events/press-announcements/fda-authorizes-booster-dose-pfizer-biontech-covid-19-vaccine-certain-populations> to be administered at least six months after completion of the vaccine's primary series in certain populations.

September 25, 2021

HHS Secretary issued a directive to allow a booster dose of the Pfizer COVID-19 vaccine to certain populations [PDF, 143 KB] </sites/default/files/secretarial-directive-eligibility-covid-19-vaccine-boosters.pdf>.

August

August 23, 2021

FDA approved the first COVID-19 vaccine, <https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine> Comirnaty (COVID-19 Vaccine, mRNA), which was previously known as Pfizer-BioNTech COVID-19 Vaccine, for the prevention of COVID-19 disease in individuals 16 years of age and older.

May

May 10, 2021

FDA amended the emergency use authorization for the Pfizer-BioNTech COVID-19 vaccine to include adolescents 12 through 15 years of age <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine>.

April

April 19, 2021

The White House announced that all people age 16 and older are eligible for the COVID-19 vaccine <https://www.whitehouse.gov/briefing-room/press-briefings/2021/04/19/press-briefing-by-white-house-covid-19-response-team-and-public-health-officials-30/>.

March

March 2, 2021

Acting HHS Secretary directed that teachers, school staff, and child care workers are eligible for COVID-19 vaccinations [PDF, 155 KB] </sites/default/files/secretarial-directive-prioritization-covid-19-vaccines.pdf>*.

March 17, 2021

Acting HHS Secretary issued a directive to expand COVID-19 vaccine eligibility to all Americans [PDF, 159 KB] </sites/default/files/secretarial-directive-eligibility-for-covid-19-vaccines.pdf>* by May 1, 2021.

February

February 27, 2021

FDA issued the third EUA for use of the Janssen COVID-19 vaccine <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine> in persons aged 18 years and older for the prevention of COVID-19.

December

> ***December 11, 2020***
> FDA issued the first emergency use authorization (EUA) for use of the Pfizer-BioNTech COVID-19 vaccine <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine> in persons aged 16 years and older for the prevention of COVID-19.
>
> ***December 14, 2020***
> The first deliveries of the COVID-19 vaccines began.
>
> ***December 18, 2020***
> FDA issued the second EUA for use of the Moderna COVID-19 vaccine <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine> in persons aged 18 years and older for the prevention of COVID-19.

Equitable Access to COVID-19 Vaccines

During the COVID-19 pandemic, each state, tribe, and territory received allocations of vaccines and developed its own plan for distributing vaccines to people in their jurisdiction.

Vaccinations in the United States began on December 14, 2020.

To ensure the equitable distribution of COVID-19 vaccines, the federal government stood up programs to reach high-risk communities directly and quickly.

- The Federal Retail Pharmacy Program sent doses to 21 pharmacy partners with over 40,000 activated stores, 40% of which are located in high-risk zip codes.
- The Health Center COVID-19 Vaccine Program allocated doses directly to community-based health centers who signed up to receive and administer COVID-19 vaccines. The program was open to more than 1,400 health centers nationwide. Over 91% of these health center patients were individuals or families living at or below 200% of the Federal Poverty Guidelines.

- The Rural Health Clinic COVID-19 Vaccine Distribution (RHCVD) Program <https://www.hrsa.gov/coronavirus/rural-health-clinics/distribution> distributed doses directly to Rural Health Clinics in medically-underserved rural communities.
- Tribal health programs and Urban Indian Organizations (UIOs) decided to receive vaccines either through the Indian Health Service (IHS) or through the State. To better understand the needs of American Indian and Alaska Native, HHS initiated tribal consultation in September 2020 to seek input from tribal leaders on COVID-19 vaccination planning for Indian Country.

Vaccine Data

The CDC's COVID Data Tracker <https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total> shows the total number of COVID-19 vaccinations administered in the United States.

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JAMA Health Forum™

JAMA Forum

Cutting the NIH—The $8 Trillion Health Care Catastrophe

David M. Cutler, PhD; Edward Glaeser, PhD

Author affiliations and article information are listed at the end of this article.

Scientists researching new cancer cures are neither culture warriors nor campus protesters. But so far, the biggest financial blows against academia have been borne by biomedical research. The Trump administration has selectively canceled grants, fired intramural researchers, and plans to cut billions that are paid by the National Institutes of Health (NIH) for indirect costs. The administration has proposed to Congress a 43% cut to next year's NIH budget, equivalent to $20 billion per year. The government has threatened to stop funding virtually all biomedical research if certain universities do not accept demands for changes in curriculum, admissions, hiring, and other policies—none of which are related to lifesaving science. As a result, hiring freezes are common at medical centers, and clinical trials are or might be put on hold.

Health Impacts

What could be the impact of these cuts? Although the extent of the proposed cuts is unprecedented, several recent studies allow us to forecast their likely impact. We focus our calculations here on one aspect of the potential consequences—the implications of the proposed cuts for drug discovery.

Federal funding for biomedical research is central to health care innovation.[1] More than 99% of all new drugs approved from 2010 through 2019 had some antecedent research funded by the NIH.[2] Data from Azouley et al[3] that examines the impact of NIH research funding on drug patents, using changes in grant allocations that come from idiosyncrasies in grant funding rules, is particularly useful here. Assuming that some efficiencies are possible, and thus that a 40% cut in NIH spending will translate into a smaller change in effective distributions, we can use the data from Azouley et al[3] to estimate the consequences of a 33% effective cut in biomedical research funding.

Azouley et al[3] estimate that a 33% reduction in NIH funding would be associated with a 15.3% reduction in patents associated with new drugs. We assume, like them, that this will lead to 15.3% fewer new therapies.[3] Although we do not quantify this here, cuts already made and proposed future staffing cuts at the US Food and Drug Administration may further slow the pace of drug approvals.

New therapies lengthen lives.[4,5] Buxbaum et al[6] estimate that new medical therapies generated 48% of the 3.3-year increase in life expectancy in the US between 1990 and 2015. If biomedical research remains as important in the future as in the past, a 15.3% reduction in new therapies would lead to a reduction in life expectancy of 0.24 years per person over the next 25 years. In a population of more than 340 million, this reflects 82 million fewer years of life. Economists use various methods to estimate the value of life and typically find that years of life are valued at roughly between $100 000 and $200 000 per year.[6] Even using the lower value in calculations, the lost health from the NIH cuts translates into more than $8.2 trillion ($100 000 × 82 million years).

These losses would be weighed against the gains that emerge from reduced public spending. Over 25 years, the proposed annual savings of $20 billion amounts to $500 billion in budgetary reductions. This pales in comparison to the $8.2 trillion in lost health, which is 16 times greater than the proposed cost savings. Put another way, punishing campuses by cutting health research funding would destroy the equivalent of one-quarter of annual gross domestic product in the US.

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Biomedical Research as a Growth Area

There are several other ways in which the proposed reductions in biomedical funding can harm health, including centrally their impact on the economy. Estimates suggest that every dollar of NIH spending leads to $2.56 of economic activity,[7] which is in line with a well-cited study that finds that adding an extra job generates 1.6 extra local jobs, and an extra skilled job generates even more employment.[8] Therefore, a $20 billion reduction in biomedical research will reduce economic output throughout the US by $51 billion. Biomedical research is spread widely geographically, and so too would the pain. For example, reducing NIH spending by 40% across the board would result in annual economic losses of $2.45 billion for the economy of Texas, $2.12 billion for the economy of Pennsylvania, and $851 million for the economy of Missouri.

The effects of these losses could compound over time because government research translates into productivity increases in private companies.[9] One estimate suggests that the 33% reduction in NIH spending could lead to a $48 billion reduction in the stock market value of pharmaceutical companies, which would have its own ripple effects on the economy.[3] We do not cover here the implications of proposed budgetary reductions on health through disinvestment in the public health infrastructure, or social safety nets, all of which will affect health, particularly of those who are already vulnerable.

Prospects for Policy Changes

In his first term, President Trump wisely showed little inclination to target biomedical research. Operation Warp Speed was a scientific triumph, delivering the vaccines that quelled the COVID-19 pandemic. In Trump's second term, by contrast, biomedical research has become a cudgel for reforms that are unrelated to the health of the US. Our calculations suggest that the proposed budgetary cuts to the NIH will create a social cost that is 16 times greater than the savings that the administration is attempting to achieve. For the sake of health and the economy, we can only hope that the Trump administration will recognize that funding science is good economic as well as health policy.

ARTICLE INFORMATION

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Feature | Article | June 13, 2025

Cuts to HIV Vaccine Research Come Amid Challenges to Other Vaccines, Treatment

Author(s): Julia Bonavitacola

Fact checked by: Maggie L. Shaw

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Key Takeaways

- Termination of HIV vaccine studies affects key research institutions, aligning with previous cuts to HIV-related programs under the Trump administration.
- The administration plans to focus on existing HIV elimination strategies, redirecting funds from the CDC to the proposed Administration for a Healthy America.

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The Trump administration has ended a program seeking a vaccine for HIV, the first in a series of decisions that is leaving vaccine research and expertise behind.

In a move that continues the Trump administration's opposition to HIV research and prevention, it was announced they would be terminating HIV vaccine studies primarily affecting the Duke Human Vaccine Institute, the Scripps Research Institute, Moderna's clinical trials through the HIV Vaccines Trial Network.[1] These decisions come at a time when HIV treatment and prevention efforts and vaccine research have come under fire from the administration.



Programs looking for an HIV vaccine were discontinued at the end of May,

Treatment and prevention of HIV has been a sticking point for the Trump administration, coming under fire soon after the inauguration. The administration has made several cuts to the

President's Emergency Plan for AIDS Relief,[2] rid the CDC of the Division of HIV Prevention,[3] and cut money for several studies related to HIV in March.[4] These actions have put HIV research, prevention, and treatment in a dangerous position, with the potential for these cuts to leave many without improved methods of addressing HIV.

continuing a trend of cutting back on HIV and vaccine research. | Image credit: weyo - stock.adobe.com

The announcement of the plans to cut the HIV vaccine program is another blow to HIV research nationwide. The cuts total $258 million dedicated to a program that did research into a potential vaccine,[5] with advisement to the NIH to not approve any future studies on an HIV vaccine.[1] The Trump administration is also seeking to change budgetary rules so that upfront costs of HIV vaccines would be accounted for in 1 year as opposed to multiple years, making it harder for these studies to be approved.

Vaccines, in general, have been a subject of dispute in the Trump administration, with Robert F. Kennedy, Jr, removing all members of the Advisory Committee on Immunization Practices on June 9,[6] continuing a trend of vaccine skepticism from the HHS secretary. Between these decisions, it is unclear how vaccines and vaccine development will evolve in the future and how these decisions will affect HIV vaccine research overall.

The Trump administration claims it will be focusing their efforts on currently available approaches to eliminating HIV, and that all critical programs related to HIV/AIDS will continue under the Administration for a Healthy America (AHA), which is the agency proposed by Kennedy as part of his overall health plan in America.[1] The HHS budget proposal released on June 10 indicates that the budget for AHA will be partially derived from redirected CDC funds, with the CDC taking a $5 billion cut.[7] This includes consolidating HIV/AIDS prevention and research that would cut $794 million for prevention and $1 billion to HIV/AIDS overall vs the 2024 fiscal year.

This move also comes as experts in HIV await the approval of lenacapavir, which has been shown to be near 100% effective in preventing HIV in the PURPOSE 2 trial (NCT04925752).[8] It is unknown how the twice-yearly injection will be introduced to vulnerable populations in the US given the cuts to the vaccine and prevention programs should the FDA give the green light to the treatment on the planned decision date of June 19.

The decisions made by the Trump administration regarding funding for HIV vaccines and prevention threaten the ability to end the HIV epidemic going forward. Even as new research is being done to find new means of preventing HIV, a cure for the virus still is the goal to ending the epidemic. This decision could be a big step back in not only domestic solutions but global solutions for a cure to HIV, as well as reducing the incidence of the virus throughout the globe.

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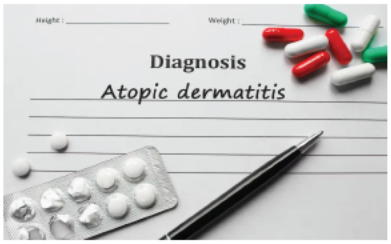
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Maggie L. Shaw

This study reveals that dupilumab is associated with a modestly increased risk of developing psoriasis, highlighting the importance of monitoring skin reactions during therapy.



December 23rd 2024

Five Years Later: Ongoing COVID-19 Challenges, Next Steps

Brooke McCormick

On this episode of Managed Care Cast, we speak with Jenny Han, MD, of Emory School of Medicine and Grady Hospital, about COVID-19, long COVID, and strategies for prevention and care.



June 16th 2025

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Pearl Steinzor

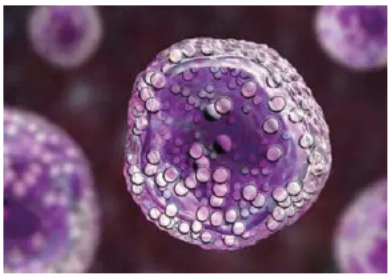
Target trial emulation study finds no added effectiveness or persistence with combination therapy for plaque psoriasis.



December 17th 2024

Diving Into Patient Preferences for Blood Cancer Treatments With Dr Sikander Ailawadhi

Three abstracts presented at the 2024 American Society of Hematology annual meeting focused on patient preferences and treatment choices in blood cancers.



June 14th 2025

A Look at Those With Durable Responses to Epcoritamab in LBCL

Mary Caffrey

A post-hoc analysis of EPCORE-NHL-1 was presented at ASCO.



June 14th 2025

EHA Plenary Abstracts Zoom in From Investigational Drugs to Molecular Signatures

Christina Mattina

Abstracts presented during the plenary session of the 2025 European Hematology Association (EHA) Congress spanned from novel drug regimens for myeloma and lymphoma to investigation of leukemias on the molecular and genetic levels.

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Cutting HIV Prevention Funding at CDC: What Would it Mean?



Lindsey Dawson

Mar 19 2025

On March 18th, reports began to emerge that the Trump administration is exploring cuts to the Centers for Disease Control and Prevention (CDC), including in the HIV prevention budget. CDC is the primary source of federal funding for HIV prevention in the U.S. and was the very first government agency funded to address the emerging HIV epidemic in the early 1980s. While CDC is the cornerstone of domestic HIV prevention efforts, representing 91% of all federal funding for HIV prevention, prevention funding represents a small share (3% in FY 2022) of what the federal government spends on HIV and a minuscule share of the federal budget overall. The FY24 appropriation for HIV prevention at the CDC totaled about $1 billion.

Most CDC HIV prevention funding is provided to state and local jurisdictions, allowing them to conduct health surveillance

activities and appropriately target communities. Additionally, grants to state and local health departments and national and community-based organizations (CBOs) fund HIV testing, prevention interventions, and linkage to care, which improves individual and public health outcomes. For example, in 2022 nearly 2 million HIV tests were conducted by 60 CDC-funded state and local health departments and 119 CBOs, resulting in about 8,000 people being newly diagnosed with HIV. State and local governments could theoretically make up for federal cuts in HIV prevention, but they may also be facing their own budget constraints and other significant cuts in federal funding, including in Medicaid. Under this scenario, states are likely to make different decisions based on their budgets and policy priorities, which could make access to HIV prevention resources more uneven across the country.

Eliminating this funding could jeopardize recent successes in addressing the nation's HIV epidemic, including those related to the Ending the HIV Epidemic (EHE) Initiative, which the first Trump administration created, and among other activities, bolstered HIV prevention efforts at the CDC by providing additional funding to a subset of targeted "EHE" jurisdictions. There has been a 12% decline in HIV incidence (new infections) nationally from 2018 to 2022 and a 21% decline in EHE jurisdictions between 2017 and 2022. CDC states that "increases in preexposure prophylaxis prescriptions, viral suppression, and HIV testing likely contributed to the decline," activities that the agency has a core role in supporting.

While some reports suggest that some or all of CDC's HIV prevention funding could be moved to another part of HHS, such as the Health Resources and Services Administration (HRSA), there is no formal proposal at this point so the future of any HIV prevention funding is uncertain. Additionally, HRSA's historical role has primarily been in the delivery of medical care. While it is

involved in HIV prevention through the delivery of PrEP at community health centers, it is not a prevention agency, and its HIV expertise lies primarily within the Ryan White HIV/AIDS Program, which is a federal safety net program for HIV care and, by statute, is prohibited from providing most HIV prevention services.

Diminished prevention efforts would likely lead to an increase in HIV incidence, with negative implications for individual well-being, public health, and health costs. CDC estimates that approximately 9,000 HIV infections were averted between 2017 and 2022, saving an estimated $5 billion in lifetime medical costs.

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Democracy Dies in Darkness

Deep cuts to HIV research could halt decades of progress, scientists say

The Trump administration has shut down government offices devoted to HIV and ended hundreds of millions of dollars in research aimed at preventing infections in high-risk groups.

April 4, 2025



By Fenit Nirappil

The Trump administration this week decimated HIV prevention programs across government health agencies after terminating hundreds of millions of dollars in grants for the next phase of the battle against the deadly virus.

Together, the cuts threaten to halt progress in the use of a revolutionary HIV medication that made it possible to finally stymie one of the world's most serious infectious diseases, according to researchers, medical providers and HIV advocacy groups.

The fight against HIV gained significant momentum more than a decade ago with the approval of preventive medication known as pre-exposure prophylaxis (PrEP), which is taken routinely and provides almost complete protection against infection from the virus.

But nearly two-thirds of the 1.2 million people at the greatest risk of contracting HIV infections are not on PrEP, health officials say.

Researchers have shifted their focus to identifying ways to achieve widespread use of PrEP among people most likely to encounter the virus, primarily Black and Latino men who have sex with men. That is crucial to stopping wider transmission of HIV.

But in recent weeks, the National Institutes of Health has pulled funding from many of those studies.

"Tremendous progress has been made in the last three decades, but the crux of the matter is we weren't finished. We weren't reaching everyone we need to reach," said Colleen Kelley, an infectious-diseases physician and chair of the HIV Medicine Association, an advocacy group of medical professionals. "It's like the rug is being ripped out under us."

Officials at NIH and its parent agency, the Department of Health and Human Services, did not answer questions about the grant cuts.

In his 2019 State of the Union address, President Donald Trump vowed to "defeat AIDS in America and beyond" after launching a campaign to end transmission by 2030.



Podcast episode

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How shakeups in U.S. foreign aid have upended the global fight against HIV/AIDS and the lives of people like Mary in Kenya.

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But in recent days, Trump's new administration eliminated numerous parts of federal health agencies devoted to that goal, according to multiple current and former employees and policy advocates briefed on the cuts.

It shuttered the HHS Office of Infectious Diseases & HIV Policy that coordinated the federal response. The Centers for Disease Control and Prevention lost staff in its HIV prevention division who conducted studies and surveillance, ran health campaigns and supported local prevention programs. The CDC's top HIV official was notified he would be among nine senior leaders reassigned to the Indian Health Service.

"We're being cut off at our legs, and they want to make America healthy again?" said Carl Schmid, executive director of the advocacy group HIV + Hepatitis Policy Institute.

Critical HIV programs would continue in a new Administration for a Healthy America office in HHS, the agency said in a statement provided by spokeswoman Emily G. Hilliard.

Such consolidation would be counterproductive, said Adrian Shanker, the deputy assistant secretary for health policy in the Biden administration.

"It's not possible to do all that work to end the HIV epidemic with so many fewer people and without the institutional knowledge of all the leadership of these key offices," said Shanker, who now consults for LGBTQ+ and HIV organizations.

The health agency overhaul follows weeks of cancellations of PrEP studies, including: A clinical trial to determine whether Black and Hispanic gay men are more likely to keep using the medication with the support of a patient navigator; an eye-tracking study to identify PrEP messaging that people notice and read; and research that would have measured the real-world effectiveness of periodic injections of the drugs vs. daily pills.

The recent cuts extend globally and to other areas of HIV research. Studies in South Africa, the Philippines and Canada were among those that lost funding. A 25-year-old group of clinical trials established to easily recruit adolescents for HIV studies was ordered to shut down, as were surveys to pinpoint the factors that place cisgender women most at risk for acquiring sexually transmitted infections and HIV, including whether they are homeless or experienced domestic violence.

In all, NIH terminated at least $759 million in grants involving HIV research, according to an unofficial tally kept by academics tracking the cuts. The agency awarded about $2.3 billion in HIV research grants last fiscal year. Federal officials did not respond to requests to offer their own accounting

“It’s a slaughter,” said Jim Pickett, a longtime HIV activist and a consultant to the youth trial network “They are taking money and investments and setting it on fire.”

Antiretroviral drugs turned HIV from a death sentence to a manageable chronic condition in the late 1990s and 2000s. Now, with HIV infections also preventable, an elusive end to the epidemic in the United States is closer than ever.

The grant terminations unleashed chaos as researchers scrambled to figure out how to cobble together other funding to keep their studies going. Many are planning to appeal the decisions and are hoping courts will step in or private foundations and corporations will replace the lost funding. But government funding has long been the backbone of HIV/AIDS research.

The termination letters often criticize the studies as unscientific because they relate to diversity, equity and inclusion or gender identity.

But scientists say it’s impossible to fight HIV without acknowledging people in the demographic groups that disproportionately contract the virus and are less likely than cisgender White men to use PrEP: Black and Hispanic gay men, transgender women and Black women. Men who have sex with men acquire more than two-thirds of new HIV infections. Nearly half of them are Black and Hispanic.

Public health officials prioritize spending prevention dollars for those most at risk, a strategy they say also reduces the threat to the general population.

“When we talk about maximizing resources and impact, you want to focus on the populations that are affected most,” said Philip Chan, an associate professor of medicine at Brown University who lost funding for the study on Black and Hispanic gay men’s use of PrEP. “This is based on data and science. This is not promoting DEI.”

The cuts to agencies and research have been especially upsetting to HIV activists who praised Trump during his first term, when he released a plan to end the HIV epidemic by 2030. Health officials implementing that plan emphasized the need to direct resources and research to areas and demographic groups most affected by HIV.

Since 2020, a government website has stated that "HHS agencies will support states and local communities to implement strategies to increase access to and use of PrEP — especially among African American and Latino gay and bisexual men, African American women, and other populations disproportionately affected by HIV."

Researchers said Trump is punishing them for supporting the mission he initiated during his first term.

"We have already invested all of this money to begin these studies which were grounded in evidence and peer-reviewed as scientifically superior," said Rebecca Schnall, a research professor at the Columbia University School of Nursing. She lost grants for studies on the effectiveness of HIV prevention strategies, including in communities identified as priorities under Trump's plan to end HIV.

"Essentially, we will have no return on investment," she said.

The crackdown on HIV research marks a reversal for veteran researchers and activists who fought to get the government to take the epidemic seriously in the 1980s and 1990s.

"This generation came up saving people's lives," said Jesus Ramirez-Valles, a professor of medicine at the University of California at San Francisco, who lost funding for research on prevention and treatment groups that serve gay and bisexual Latino men. "And that's what's being lost."

It was coming of age at the height of the AIDS epidemic that inspired Jeffrey Wickersham's passion for research. The first openly gay man Wickersham knew was a co-worker at a Texas theater in high school. He died of AIDS-related complications in 1996, Wickersham's freshman year of college. When Wickersham, now 48, came out to his parents that year, his mother said she did not want him to die of AIDS.

By the time he completed his postdoctoral training at Yale in 2012, AIDS deaths had plunged and the Food and Drug Administration had approved PrEP. As an associate professor of medicine at Yale, Wickersham focuses on research to improve both prevention and treatment.

NIH terminated funding for five projects Wickersham worked on. They include research to improve medical care for transgender women living with HIV and to develop an app that helps reduce the risk of HIV infection among people who use stimulant drugs such as methamphetamine.

"It's like seeing all the success of your child's growth and development, only to see all of that stripped away," Wickersham said.

The Adolescent Trials Network for HIV Interventions, first formed in 2001 to support studies of teenagers and young adults who are notoriously difficult to recruit for scientific research, received a stop-work order that shut down research at 14 sites where seven studies were being conducted.

The termination set off a scramble as researchers try to figure out how to comply with the federal directive without violating professional ethics. For example, some adolescents and young adults already are receiving counseling through one study of behavioral interventions to lower the HIV risk of young males who use stimulant drugs.

“It’s a huge ethical issue — how do we intervene when we’ve been told to stop work? What if somebody is suicidal?” said Sybil Hosek, a research medical professor at the University of Illinois Chicago and co-principal investigator of the network. “Ethically, we are going to do it anyway, but we have been told to stop.”

They are hoping the cancellation will be revoked once the federal government understands the damage.

Lena H. Sun and Caitlin Gilbert contributed to this report.

What readers are saying

The comments express significant concern and anger over recent cuts to HIV research funding, highlighting the potential setbacks in treatment and prevention efforts. Many commenters emphasize the critical role of research in developing life-saving treatments and express fear that... Show more

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POLITICS

Dr. Casey Means, Trump's pick for Surgeon General, faces criticism across the spectrum

MAY 11, 2025 · 8:39 AM ET

HEARD ON WEEKEND EDITION SUNDAY

By Ayesha Rascoe, Will Stone

3-Minute Listen PLAYLIST TRANSCRIPT

Dr. Casey Means, a health care entrepreneur and social media influencer, is Trump's pick for surgeon general. But she's facing pushback for her unconventional resume.

Sponsor Message

AYESHA RASCOE, HOST:

President Trump has a new pick for U.S. Surgeon General. He's tapped wellness influencer Dr. Casey Means. That's in place of his original choice, former Fox News contributor doctor Janette Nesheiwat. NPR's Will Stone is here with the details. Hi, Will.

WILL STONE, BYLINE: Hey there.

RASCOE: Why did Trump drop his first pick for surgeon general?

STONE: So no official statement from Trump or the White House on that, but it seems there may have been a few issues at play here. So first, Nesheiwat had come under scrutiny recently for misrepresenting her medical credentials, including where she went to medical school. This was revealed by an independent reporter, Anthony Clark, and has been matched by other outlets, though NPR has not independently confirmed the reporting. At the same time, Nesheiwat was also facing some strong opposition from those on the right and in Secretary Robert F. Kennedy Jr.'s Make America Healthy Again, or MAHA, movement. One reason was her support for COVID policies like masking and vaccines. So whatever the rationale, Trump took to social media this week and announced he tapped Dr. Casey Means instead, saying she has, quote, "impeccable MAHA credentials."

RASCOE: Well, tell us more about Casey Means. Who is she?

STONE: Yeah, she's a wellness influencer, author and entrepreneur. She has a company that sells glucose monitoring devices to consumers. Her background is in medicine. She went to Stanford medical school and went on to surgical residency, but she dropped out pretty far along in the program. Her book is kind of a self-help diet type of book. It really catapulted her into the online wellness space. She's been on big podcasts. She appeared at a highly publicized congressional round table on nutrition last year that featured Secretary Kennedy and other big names in the MAHA world. But her resume is definitely a problem for many in medicine and public health. She did have a practice in Oregon but, again, never completed her residency, and she doesn't have an active medical license right now. I called up Dr. Richard Carmona to get his take on this. Carmona was the surgeon general under George W. Bush.

RICHARD CARMONA: Every previous surgeon general, when you look, they've got the license. They've got the residency. They have had at least some leadership ability that's scalable. And we don't see any of that here. I think that our nation deserves better.

RASCOE: How are her supporters responding to this?

STONE: Well, Secretary Kennedy is doubling down on his support. He's claiming Dr. Means will be the greatest surgeon general in American history. It's also worth noting her brother, Calley Means, is a prominent advisor to Kennedy. A lot of her messaging aligns with the secretary. She rails against the health care industry, big food, and big pharma, talks a lot about nutrition and lifestyle. Here's what Kennedy said on Fox News just the other day.

(SOUNDBITE OF ARCHIVED RECORDING)

ROBERT F KENNEDY JR: Casey Means, we felt, was the best person to really bring the vision of MAHA to the American public. She has this unique capacity to articulate it.

STONE: Now, Casey Means has made statements casting doubt on the safety of certain vaccines and the vaccine schedule. She's also endorsed things like raw milk, similar to Kennedy. All of this is concerning to experts in public health. But some in the Kennedy coalition are not happy with the pick. For example, Kennedy's former running mate, Nicole Shanahan has criticized the choice heavily, as have others, and some of the pushback has to do with her vaccine stance, that she has not come out strongly enough against vaccines, especially the COVID shots. So this choice is revealing, I'd say, some fractures in the MAHA coalition, and that plus concerns about her lack of experience could derail her nomination. We'll see.

RASCOE: That's NPR's Will Stone. Thank you so much for talking with us.

STONE: Thank you.

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https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f

EXCLUSIVE U.S.

UnitedHealth Group Is Under Criminal Investigation for Possible Medicare Fraud

Company's stock has declined over financial performance and sudden replacement of CEO

By Christopher Weaver Follow *and Anna Wilde Mathews* Follow

Updated May 15, 2025 10:08 am ET



The probe of UnitedHealth adds to a list of government inquiries the company is facing. PHOTO: STEPHEN MATUREN/GETTY IMAGES

Key Points

What's This?

- The DOJ is investigating UnitedHealth Group for possible criminal Medicare fraud related to its Medicare Advantage business.
- The investigation adds to other government inquiries into UnitedHealth, including potential antitrust violations.
- UnitedHealth faces pressure from investigations, a stock price decline and a recent CEO change.

The Justice Department is investigating UnitedHealth Group for possible criminal Medicare fraud, people familiar with the matter said.

The healthcare-fraud unit of the Justice Department's criminal division is overseeing the investigation, the people said, and it has been an active probe since at least last summer.

While the exact nature of the potential criminal allegations against UnitedHealth is unclear, the people said the federal investigation is focusing on the company's Medicare Advantage business practices.

UnitedHealth said in a statement it hadn't been notified by the Justice Department of the criminal investigation. The statement said the company stands "by the integrity of our Medicare Advantage program."

A DOJ spokesman declined to comment.

The criminal probe adds to a list of government inquiries into the company, including investigations of potential antitrust violations and a civil investigation of its Medicare billing practices, including at its doctors offices, that The Wall Street Journal first reported in February.

UnitedHealth is seeking to recover from a meltdown of its stock over its financial performance and the sudden replacement this week of its chief executive officer, Andrew Witty, with its chairman and former CEO, Stephen Hemsley. UnitedHealth's stock has declined by more than 50% over the past month. Thursday, it fell 16% and was poised for its lowest closing price since 2020.

Last year, the company faced a hack of a technology unit that disrupted payments to many U.S. health providers for months, and the killing of its top insurance-arm executive.

All of this comes as the Trump administration and Congress look to cut federal health spending, a key source of UnitedHealth's success. In March, U.S. senators grilled Mehmet Oz, now the Medicare and Medicaid agency head, during his confirmation hearing on the findings of a Wall Street Journal investigation of practices of Medicare Advantage insurers such as UnitedHealth. Oz pledged a crackdown.

The criminal investigation could pose an additional challenge to UnitedHealth in the midst of a deep deficit of trust among shareholders, regulators and customers.

The Justice Department's criminal healthcare-fraud unit focuses on crimes such as kickbacks that trigger higher Medicare or Medicaid payments.

The fraud unit has offices in more than a dozen cities, but is managed from DOJ's headquarters in Washington, D.C. Prosecutors are working on the criminal investigation of UnitedHealth from the fraud unit's office in New York, the people familiar with the investigation said.

Andrew Witty, then CEO of UnitedHealth, testified in May 2024 before a Senate committee looking into hacking. PHOTO: KENT NISHIMURA/GETTY IMAGES

For years, the unit focused on busting doctors, laboratories and other service providers who overbill government health programs and insurers.

But the unit has turned its focus to insurers in the Medicare Advantage system, where they now oversee taxpayer-funded benefits for more than half the seniors and disabled people in the broader Medicare program, people familiar with the matter said.

Medicare Advantage insurers are paid extra for covering sicker patients, creating an incentive to document diagnoses for patients they cover. In some cases, the Journal's reporting has shown, questionable diagnoses by UnitedHealth added billions to taxpayers' costs.

The company disputed the Journal's findings, saying that its analysis was "inaccurate and biased," and that Medicare Advantage "provides better health outcomes and more affordable healthcare for millions of seniors" than traditional Medicare.

UnitedHealth's latest annual securities filing says the company "has been involved or is currently involved in various governmental investigations, audits and reviews," and flags involved agencies including the Justice Department. It doesn't specifically mention the criminal, civil and antitrust probes on which the Journal has reported.

UnitedHealth dismissed the Journal report in February revealing the civil Medicare fraud investigation into the company as "misinformation" and said that it wasn't aware of a "new" probe.

A March 11 email, revealed in a lawsuit by a UnitedHealth investor, shows a company lawyer acknowledging that "the government has asked us some questions regarding Optum's coding practices," referring to the Medicare billing practices of UnitedHealth's healthcare services arm, which includes its doctor groups.

The email, cautioning a former UnitedHealth employee on the possibility of being contacted by the government, described the investigation as "in the early stages."

A UnitedHealth spokesman said last week that the company stood by its February statement and declined to comment on the email.

The DOJ has struggled to make its case in fraud claims against UnitedHealth in the past. In March, a court-appointed special master recommended that a judge effectively dismiss a whistleblower case against UnitedHealth after concluding the government hadn't presented evidence that patient diagnoses submitted for payment were inaccurate. The judge in the case hasn't yet ruled on the recommendation.

That civil case, brought by a former UnitedHealth employee turned whistleblower in 2011 and joined by the government in 2017, concerned claims that UnitedHealth submitted $2 billion worth of diagnoses recorded by doctors that its own reviewers determined weren't supported by patients' medical charts.

The DOJ asked the judge to reject the special master's recommendation. UnitedHealth said the finding showed "there was no evidence to support the DOJ's claims we were overpaid or that we did anything wrong."

President Trump and Mehmet Oz, the Medicare and Medicaid agency head, this week. PHOTO: ANDREW HARNIK/GETTY IMAGES

Write to Christopher Weaver at Christopher.Weaver@wsj.com and Anna Wilde Mathews at Anna.Mathews@wsj.com

Appeared in the May 15, 2025, print edition as 'Health Insurer Faces Criminal Probe'.

Videos

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

AMERICAN PUBLIC HEALTH ASSOCIATION; IBIS REPRODUCTIVE HEALTH; INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL IMPLEMENT WORKERS (UAW); BRITTANY CHARLTON; KATIE EDWARDS; PETER LURIE; and NICOLE MAPHIS,

Plaintiffs,

v.

NATIONAL INSTITUTES OF HEALTH; JAY BHATTACHARYA, *in his official capacity as Director of the National Institutes of Health*; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services*,

Defendants.

Case No. 1:25-cv-10787-WGY

[PROPOSED] RULE 54(b) PARTIAL FINAL JUDGMENT

For all the reasons stated on the record on June 16, 2025, Plaintiffs American Public Health Association ("APHA"), Ibis Reproductive Health, International Union, United Automobile, Aerospace, and Agricultural Implement Workers ("UAW"), Brittany Charlton, Katie Edwards, Peter Lurie, and Nicole Maphis (collectively, "Plaintiffs") are entitled to judgment on their claim that the challenged "Directives" (specified below in paragraphs 1(a)-(j)) and "Resulting Grant

Terminations"[1] are arbitrary and capricious in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A). Pursuant to Federal Rule of Civil Procedure 54(b), and for all the reasons stated on the record, the Court finds that there is no just reason to delay entry of judgment on that claim.

It is hereby **ORDERED, ADJUDGED, AND DECREED** that:

1. The following Directives from the National Institute of Health ("NIH") and U.S. Department of Health & Human Services ("HHS"), taken as a whole, are **DECLARED** to be final agency action, arbitrary and capricious, and unlawful, in violation of 5 U.S.C. § 706(2)(A):

    a. The February 10, 2025 directive issued by the Acting Secretary of HHS entitled "Secretarial Directive on DEI-Related Funding." AR0004-05.[2]

    b. The February 12, 2025 memorandum entitled "NIH Review of Agency Priorities Based on the New Administration's Goals." AR0009.

    c. The February 13, 2025 memorandum entitled "Supplemental Guidance to Memo Entitled NIH Review of Agency Priorities Based on the New Administration's Goals." AR0016.

    d. The February 21, 2025 "Directive on NIH Priorities" entitled "Restoring Scientific Integrity and Protecting the Public Investment in NIH Awards." AR2930-31.

    e. The March 4, 2025 memorandum issued by NIH, entitled "Staff Guidance – Award Assessments for Alignment with Agency Priorities – March 2025." AR2136-42.

    f. The March 13, 2025 directive issued by Michelle Bulls, entitled "Award Revision Guidance and List of Terminated Grants via letter on 3/12." AR1957-68.

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[1] The term "Resulting Grant Terminations" refers to any terminations of any grants (including subawards and supplements) of Plaintiffs or members of Plaintiff associations APHA and UAW by the National Institutes of Health (including any of NIH's constituent institutes and centers), on the basis of one or more of the Challenged Directives, the Challenged Directives as a whole, or any of the reasoning therein, but specifically limited to, those specific grant terminations, including non-competitive renewals, that Plaintiffs identified in the spreadsheets submitted to the Court and served upon defendants on May 27, 2025 and June 13, 2025, which spreadsheets are Attached hereto as Exhibits A and Exhibit B, respectively.

[2] References herein to the administrative record produced by Defendants on June 2, 2025 match the page numbers in the record (*e.g.*, "AR0004" corresponds to "NIH_GRANTS_000004").

g. The March 20, 2025 memorandum issued by Sean R. Keveney, the Acting General Counsel at HHS, entitled "Termination of COVID-19 Grants." AR2591.

h. The March 25, 2025 memorandum issued by NIH, entitled "NIH Grants Management Staff Guidance – Award Assessments for Alignment with Agency Priorities – March 2025." AR3218.

i. The May 7, 2025 memorandum issued by Michelle Bulls, entitled "NIH Grants Management Staff Guidance – Award Assessments for Alignment with Agency Priorities – DRAFT." AR3547-77.

j. The May 15, 2025 memorandum issued by Michelle Bulls, entitled "NIH Grants Management Staff Guidance – Award Assessments for Alignment with Agency Priorities – DRAFT." AR3516-46.

k. The undated memoranda titled "NIH Grants Management Staff Guidance – Award Assessments for Alignment with Agency Priorities – Draft." AR3231-3350.

2. Pursuant to 5 U.S.C. § 706(2), the Directives set forth in Paragraphs 1(a)-(j) of this Judgment are hereby **OF NO EFFECT, VOID, ILLEGAL, SET ASIDE AND VACATED.**

3. The Resulting Grant Terminations pursuant to the Directives are **DECLARED** to be unlawful, arbitrary and capricious final agency actions under 5 U.S.C. § 706(2)(A).

4. Pursuant to 5 U.S.C. § 706(2), the Resulting Grant Terminations are hereby **OF NO EFFECT, VOID, ILLEGAL, SET ASIDE AND VACATED.**

5. Judgment shall enter in favor of Plaintiffs and against Defendants on Count I.A and I.C of the Complaint.

6. The Court retains jurisdiction to enforce this Judgment.

The Clerk is directed to enter judgment in conformity with the foregoing forthwith.

June 23, 2025

William G. Young
HON. WILLIAM G. YOUNG
Judge of the United States

CERTIFICATE OF SERVICE

I hereby certify that on June 23, 2025, a true and correct copy of the above document was filed via the Court's CM/ECF system and that a copy will be sent automatically to all counsel of record.

June 23, 2025

/s/ Suzanne Schlossberg
Suzanne Schlossberg

EXHIBIT A

***American Public Health Association, et al. v. National Institutes of Health, et al.*, No. 1:25-cv-10787-WGY**
Plaintiffs' List of Grants Impacted by the Directives (May 27, 2025)

This demonstrative is provided by Plaintiffs' counsel, pursuant to the Court's order on May 22, 2025, and to aid the Court in its understanding of the manner in which the Directives have been implemented as to Plaintiffs in *APHA, et al v. NIH, et al*. It contains information that Plaintiffs' counsel have been able to obtain and compile to date as to grant and program terminations. Inclusion of a grant or program on this list indicates that Plaintiffs' counsel have a good faith basis to believe that the *entire* grant or program and/or a supplement, parent, subpart, program or other award related to the grant or program has been terminated. Plaintiffs' counsel are continuing to analyze information regarding the grants that have been impacted by the Directives and will plan to provide supplemental lists as verification occurs. Plaintiffs reserve all rights to provide additional information regarding the impacts of the Directives on Plaintiffs and maintain that the resolution of Plaintiffs' claims—both as to liability and as to remedy—does not require the identification or individualized review of all impacted grants.

The Directives and terminations are unlawful in each of the following ways ("REASONS FOR EVERY GRANT"):

(1) They are in excess of statutory authority and contrary to statute (42 U.S.C. §§ 282(b)(4)–(6), 282(m)(1), 284(b)(1)(A), 284(b)(3)), in violation of 5 U.S.C. §§ 706(2)(A), 706(2)(C).

(2) They are contrary to regulation (45 C.F.R. § 75.372), in violation of 5 U.S.C. § 706(2)(A).

(3) They are arbitrary and capricious, in violation of 5 U.S.C. § 706(2)(A).

(4) They violate the separation-of-powers principle and the Due Process Clause of the U.S. Constitution, and they accordingly violate 5 U.S.C. § 706(2)(B).

Project Number	Grant Title	Reason Termination is Illegal
1R61HD117134-01	Supportive and restrictive factors and mental health in LGBT adolescent and young adult populations	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01DA054236	Project SMART: Social media Anti-vaping Messages to Reduce ENDS Use Among Sexual and Gender Minority Teens	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01HD115551	Understanding multilevel predictors affecting family formation among sexual and gender minority couples	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD015256-05	Sexual orientation-related disparities in obstetrical and perinatal health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD015256-05S1	Sexual orientation-related disparities in obstetrical and perinatal health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01HD109320-02	Advancing novel survey tools to increase participation and improve sexual and reproductive health data quality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01HD109320-02S1	Advancing novel survey tools to increase participation and improve sexual and reproductive health data quality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD016384-03	An Innovative, Prospective Model to Understand Risk and Protective Factors for Sexual Assault Experiences and Outcomes Among Sexual Minority Men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R21MD018509-02	Development and Pilot Evaluation of an Online Mentoring Program to Prevent Adversities Among Trans and Other Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AA031213-02	The Impact of Minority Stress on Alcohol-Related Sexual Assault among Sexual Minority College Students: An Intersectional, Mixed-Methodological Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD017573-03	Sexual Assault Recovery Among Sexual Minority Women: A Longitudinal, Multi-Level Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R15AA030898-01A1	Reconstruction of an SGM-specific sexual violence peer support program (SSS+)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R34AA030662-01A1	An Online Family-based Program to Prevent Alcohol Use and Dating and Sexual Violence among Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R21MH136855-01	Over-the-Counter PrEP: Acceptability, Feasibility, and Potential Impact of Access without a Prescription (OFFSCRIPT)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R33TW011665-06	Development and Testing of a Mobile Application to Enhance HIV Prevention Cascade in Malaysian MSM	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3U24MD017250-04S1	Research Coordinating Center to Reduce Disparities in Multiple Chronic Diseases (RCC RD-MCD)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
5U24MD017250-04	Research Coordinating Center to Reduce Disparities in Multiple Chronic Diseases (RCC RD-MCD)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5T32MH019139-35	Behavioral Sciences Research in HIV Infection	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o* (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
3U01MD019398-03S1	Increasing financial and health equity among low income black youth and young adults - DEIA Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3U01MD019398-03S2	Increasing financial and health equity among low income black youth and young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3U01MD019398-03S3	Increasing financial and health equity among low income black youth and young adults - Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5U01MD019398	Increasing financial and health equity among low income black youth and young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01MD020284-01	Measures of structural stigmatization and discrimination for HIV research with Latine sexual and gender minorities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01AA029076-04S1	Improving Measurement of Alcohol Use and Other Disparities by Sex, Sexual Orientation, and Gender Identity through Community Engagement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AA029076-04	Project Recognize: Improving Measurement of Alcohol Use and Other Disparities by Sex, Sexual Orientation, and Gender Identity through Community Engagement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AA030017	A Randomized Controlled Trial of a Game-Based Intervention to Reduce Alcohol Use among Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R21AA031548-01A1	Daily Impact of Sexual Minority Stress on Alcohol-Related Intimate Partner Violence among Bisexual+ Young Adults: A Couples' Daily Diary Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01AA031637-01A1	The Role of Local Structural Stigma in Alcohol Related Inequities among SGM Young Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1T32DA057926-01A1	Building an Interprofessional and diverse workforce in substance use and pain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o* (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1R01DA059240-01A1	Characterizing Intersectional Geospatial Stigma and Affirmation Landscapes and Their Influence on Black and Latino Bisexual Men At Risk for Substance Abuse and HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01DA059480-01A1	Elucidating minority stress influences on tobacco use at the intersection of sexual orientation and rurality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01DA060066-01	Combination of THC and CBD as a Novel Treatment for Co-Occurring Opioid Addiction and Chronic Pain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).

Project Number	Grant Title	Reason Termination is Illegal
1R01DA061661-01	Optimizing a Just-in-Time Adaptive Intervention to Increase Uptake of Chemsex Harm Reduction Services in MSM: A Micro-randomized Trial	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R21DA062591	Optimizing long-acting injectable PrEP strategies for sexual minority men who use methamphetamine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01AG063771-05S1	Effects of Social Networks and Policy Context on Health among Older Sexual and Gender Minorities in the US South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AG063771-05	Effects of Social Networks and Policy Context on Health among Older Sexual and Gender Minorities in the US South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
K12GM068524	San Diego IRACDA Scholars Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
3R01AG077934-03S1	Structural Racism and Discrimination in Sexual and Gender Minority Health Inequities - Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AG077934-03	Structural Racism and Discrimination in Older Men's Health Inequities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5UM2HD111102-03	Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) Scientific Leadership Center	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R34MH126894	Making Universal, Free-of-Charge Antiretroviral Therapy Work for Sexual and Gender Minority Youth in Brazil	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH128049-04	Tcher, Take Charge: Increasing PrEP Awareness, Uptake, and Adherence Through Health Care Empowerment and Addressing Social Determinants of Health Among Racially Diverse Trans Women in the Deep South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R34MH129208-03	3T-Prevent: Piloting a multi-level, combination intervention strategy to expand HIV and bacterial STI prevention	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R24NS132283-01S1	PURPOSE: Positively Uniting Researchers of Pain to Opine, Synthesize, and Engage	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R24NS132283-01	PURPOSE: Positively Uniting Researchers of Pain to Opine, Synthesize, and Engage	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1RF1MH132360-01	Brief digital intervention to increase COVID-19 vaccination among individuals with anxiety or depression	See REASONS FOR EVERY GRANT.
5R01MH133821-02	The Socioecology of Sexual Minority Stigma: Data Harmonization to Address Confounding Bias and Investigate Cross-Level Mental Health Effects	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01MH138335-01	Bisexual adolescents' and young adults' risk for depression and suicidal ideation: Developmental trajectories, risk and protective factors, and underlying mechanisms	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination Is Illegal
5K23DK139454-02	Structural Racism as a "Third hit" on kidney outcomes of Black individuals with APOL1 risk alleles	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o* (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5T32GM141862-04	iBioSTeP: NIH G-RISE program at UC Merced	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1R01GM155395-01	Promoting Inclusive Excellence	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o* (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1K99GM155594-01	Characterization of the metastatic TIME by subcellular spatial profiling	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1U19AI171110-01	QCRG Pandemic Response Program	See REASONS FOR EVERY GRANT.
5R01AI172092-03	Enhanced COhort methods for HIV Research and Epidemiology (ENCORE) among transgender women in the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AI174862-03	Cabotegravir PrEP: Actionable Robust Evidence for Translation into Practice (CABARET)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31AI181431-01A1	Prevention of Chlamydia trachomatis infections: Evaluation of vaccination and post-exposure prophylactic antibiotic use as population-level strategies	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
R01CA265945	Testing effective methods to recruit sexual and gender minority cancer patients for cancer studies	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99NS129753-02	Cell type-specific mechanisms of history-dependent perceptual biases in sensory cortex	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
F31GM151838-02	Understanding the role of coiled-coil domains in regulating liquid-liquid phase separation of protein assemblies in cell division	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99AG086530-01	Alzheimer's Disease and Related Dementia Neuropathologies and Exposures to Traffic Pollution Mixtures	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
R25MH129290	Short Trainings on Methods for Recruiting, Sampling, and Counting Hard-to-Reach Populations: The H2R Training Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
DP2AI164315	One Ballroom: Understanding Intersectional Stigma to Optimize the HIV Prevention Continuum among Vulnerable Populations in the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31DA060046-01	Dopamine Projections to the Amygdala in Goal-Directed and Habit Learning	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
US4DA060049-02	Advancing Tobacco Regulatory Science to Reduce Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R24DA061190-01	PRIDE-CARES: Patient-Responsive Initiatives for Diverse Engagement – LGBTQ+ Community Action in Research to Eliminate Substance Use Disorder	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
1R01DA061345-01	Race & Place: The Impacts of Racial Inequity on Substance Use and HIV Outcomes in Los Angeles	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31DA061593-01	Community and big-data system approaches to identifying and understanding the health impact of xylazine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99DA062328-01	The role of valence encoding amygdala ensembles in avoidance behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
8K00DA062570-02	Investigating the role of microglia molecular rhythms in the nucleus accumbens in OUD	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
R01AG073440-03	Examining Health Comorbidities and Healthcare Utilization Disparities among Older Transgender and Cisgender Adults in the U.S.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01AG089099-01	Social Networks and Cognitive Health among Black and Latino sexual minority men in NJ	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01HD105655-04S1	Understanding and Supporting Reproductive Decisions Among Women with Developmental Disabilities that Affect Cognition	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5K12GM106996-09	IRACDA at UCLA	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5U01HD108738-03	Harnessing the power of text messaging to reduce HIV incidence in adolescent males across the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R21HD109536	Evaluating Teen-Parent Dynamics in Adolescent COVID-19 Vaccine Acceptance and Uptake	See REASONS FOR EVERY GRANT.
1R01HD110428-01A1	Modeling Adolescent Health Care Decision-Making for Vaccines: A Community- Based Participatory Approach	See REASONS FOR EVERY GRANT.
1R21HD110617-01A1	Development and Initial Trial of Brief Interventions to Help Parents of Stigmatized Youth Reduce Distress and Strengthen Attachment	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01MH115765	A couples-based approach to HIV prevention for transgender women and their male partners	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01HD115985-01	The California Abundant Birth Project Evaluation: Advancing Birth Equity through Guaranteed Income for Pregnant People	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R25HD116367	Restoring equity to measuring and preventing perinatal intimate partner violence (Remap-IPV)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3P30AI117943-10S1	Third Coast Center for AIDS Research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH118245-05	Biopsychosocial mechanisms underlying internalizing psychopathology in a prospective, population-based cohort of sexual minority young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination Is Illegal
R25MH119858	SHINE Strong: Building the pipeline of HIV behavioral scientists with expertise in trans population health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5R33MH120236-04	Suicide Prevention for Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH121194-04	Monitoring Microaggressions and Adversities to Generate Interventions for Change (MMAGIC) for Black Women Living with HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99NS126639/R00NS126639	Mitochondrial fidelity in mammalian neurons	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5R25MH126703-05	Pipeline to Graduate Education and Careers in Behavioral and Social Science Research for URM Undergraduates: Addressing HIV in Sexual and Gender Minority Communities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5T32MH126772-04	Culturally-focused HIV Advancements through the Next Generation for Equity (CHANGE) Training Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5R21MH128114-02	Strengthening the HIV care continuum for transgender women living with HIV in Malaysia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH128130-04	STI Response and Recommendations Under PrEP (STIRRUP)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01MH128729-03S2	Project STRIVE (STudents Rising above) - Offsetting the health and mental health costs of resilience	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
7R01MH129175-03	Strategies to Prevent HIV Acquisition Among Transgender MSM in the US	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R34MH129187	Brothers building brothers by breaking barriers (B6): A resilience-focused intervention for young Black gay and bisexual men living with HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R34MH129189-03	Data-driven, peer-led messaging using social media influencers to increase PrEP awareness and uptake among transgender women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01MH129285	A multi-level approach to improve HIV prevention and care for transgender women of color	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH130375-02	A longitudinal and experience sampling investigation of rejection sensitivity and its role in sexual minority adolescents' mental health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R34MH132405-01	MyPrEP Plus: Development and Pilot Testing of Novel Pre-Exposure Prophylaxis Support Tools for Transgender Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MH132415	Understanding the Regional Ecology of a Future HIV Vaccine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
5R01MH133543-02	Implementing sustainable evidence-based mental healthcare in low-resource community settings nationwide to advance mental health equity for sexual and gender minority individuals	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R61MH133710-01A1	Targeting Minority Stressors to Improve Eating Disorder Symptoms in Sexual Minority Individuals with Eating Disorders	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
4R00DK133804	Utilizing a human stem cell model of the esophagus to understand racial disparities during injury repair	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1K23MH134111-01	Using youth-engaged methods to develop and evaluate a measure for disordered eating behaviors in transgender and gender-diverse youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31MH134720-01A1	Understanding Patient Level Implementation Determinants Related to Long-acting Injectable HIV Pre-Exposure Prophylaxis among Young Men Who Have Sex with Men Living in Rural Areas	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5R01MH134721-02	A randomized clinical trial of client-centered care coordination to improve pre-exposure prophylaxis use for Black men who have sex with men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R21DK134815-01A1	Transforming motivational interviewing into a computable model for automated patient diabetic counseling.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R34MH134912-01A1	Youth Empowerment and Safety Intervention for Systems-Involved Sexual and Gender Minority Youth at Risk of Suicide	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99MH135061-02	Oxytocin receptor signaling modulates social attachment via hippocampal CA2/3 function	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
3R01DK135099-02S1	Diversity Supplement for: Impact of a Healthy Checkout Policy on Healthfulness of Grocery Environments and Sales	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
R36MH135619	Transcriptomic contributions to the development and evolution of the human cerebral cortex	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5F32MH135634-02	The psychological underpinnings of gender disparities in adolescent mental health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
R01MH135738	Know your status: A cluster randomized controlled trial comparing healer-initiated HIV counseling and testing to standard of care in rural South Africa	See REASONS FOR EVERY GRANT.
5F99NS135767-02	Neural basis of movement in health and disease	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99MH135993-01	Neural circuit dynamics of spatial reward memory	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).

Project Number	Grant Title	Reason Termination is Illegal
1R21DK136084-01A1	Mobile pop-up units for diabetes prevention among Hispanics in rural Indiana	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31MH136729-01A1	Determining the role of discrimination in clinical presentation and treatment response among sexual minority people with OCD: A machine learning approach	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5U01DK137259-02	Renal transplant Equity through Partnership And Structural Transformation (REPAST)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1U01DK137262	CommunityRx - Chronic Kidney Disease (CRx-CKD): An EMR-integrated community resources referral intervention to address structural racism and kidney health disparities in rural North Carolina	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5U01DK137269-02	Mitigating the Effects of Structural Racism on Chronic Kidney Disease Disparities among African Americans	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5U01DK137272-02	NAVIGATE Kidney: A Multi-Level Intervention to Reduce Kidney Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
K23MH137389-01	ALIVE: Development and feasibility of a psychosocial intervention for sexual and gender minority autistic adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o* (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1R01MH137695-01	Measuring and Mapping Trajectories of Risk and Resilience for Suicidal Thoughts and Behaviors in Sexual and Gender Minority Preteens	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R34MH137753-01	Developing and pilot testing an eHealth decision support tool for young trans women to improve informed decision making about PrEP	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01MH140023-01	Mental Health Effects of Marriage Policy: Evidence from Linked Administrative Data in New Zealand	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R00GM140269-04	Evolution of Cargo Transport	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99DK140511-01	Fcγ Receptor-Mediated Pharmacogenomics of Antibody Therapies in Type 1 Diabetes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5T34GM141986-04	Maximizing Access to Research Careers (MARC) at University of Hawaii at Manoa	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM146016/4R00GM146016-03	Regulation of zinc-dependent lysosome morphological restructuring, zinc trafficking and low zinc homeostasis in C. elegans and human model systems	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
K99GM146243-01	The genetic control of neuronal number and behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM147825-02	Understanding and rewiring cellular behavior with synthetic biology approaches	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).

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5K99GM148819-02	Elucidating the epigenetic regulation of extracellular matrix and virus-induced fibroblast activation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5R01HL149778-05	Cardiovascular Health of Sexual and Gender Minorities in the Hispanic Community Health Study/Study of Latinos (SGM HCHS/SOL)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
K99GM151467-02	Nuclear and chromatin aberrations during non-apoptotic cell death in C. elegans and mammals	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
K99GM151473	Characterizing the role of tumor suppressor phase separation and chromatin organization in maintaining genomic integrity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM152834-02/4R00GM152834-03	Regulation of oxidative stress signaling by tyrosine phosphorylation of antioxidant enzymes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM152835-02	Testing the functional consequences of rapid centromeric DNA and protein evolution	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99GM154059-01A1	RNA and genome regionalization in giant single cells: implications for cellular patterning	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
K99GM154061	Investigating UPF3 paralog function in Nonsense-Mediated mRNA Decay and Genetic Compensation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
3R01AI155739-04S1	Diversity Supplement - Environmental surveillance of albendazole resistance markers in human infective helminths using dual amplicon metabarcoding	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99GM157463-01	Building Dendrite Architecture via Microtubule Nucleation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
K99GM157504	Understanding eukaryotic proteasome assembly regulation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99GM159354-01A1	Metabolic regulation of pancreatic metaplasia and neoplasia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5R01HL160326-05	Stigma and the non-communicable disease syndemic in aging HIV positive and HIV negative MSM	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3P01AI165075-01S1	Broad neutralization of pandemic threat co	See REASONS FOR EVERY GRANT.
R01AI169239	Uptake, safety and effectiveness of COVID-19 Vaccines during Pregnancy	See REASONS FOR EVERY GRANT.
5K99HL169908-02	Examining the Role of Structural Factors in Racial and Ethnic Disparities in Cardiovascular Disease	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5K99AI173544-02	Improving phage-based medicine with immunoengineering	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99HL173668-01	Resistance Exercise in the Prevention and Treatment of Heart Failure with Preserved Ejection Fraction (HFpEF)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).

Project Number	Grant Title	Reason Termination is Illegal
1K99AI182451-01	Molecular understanding of maternal humoral responses to pregnancy	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
R01CA237670	Project RESIST: Increasing Resistance to Tobacco Marketing Among Young Adult Sexual Minority Women Using the Inoculation Message Approaches	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1U54CA267730-01	Fostering Institutional Resources for Science Transformation: The FLORIDA-FIRST Health-science Brigade	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5U54CA267776-04	NIH FIRST Cohort Cluster Hiring Initiative at Icahn School of Medicine at Mount Sinai	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o* (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1UC2CA293786	ComPASS Health Equity Research Hub at Yale	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
U54MD007598	Accelerating Excellence in Translational Science (AXIS)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o(* b)(2), 285t-1(a)(b), and/or 288(a)(4).
5T37MD008636-10	Transdisciplinary Health Disparities Research Training for Native Hawaiians and Pacific Students	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5D43TW012274-03	Integrated Networks of Scholars in Global Health Research Training (INSIGHT)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1R01HG013145-01	Trans/Forming Genomics: Guidance for Research Involving Transgender and Gender Diverse People	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD013495-05	Health disparities, stress pathways, and stress-related comorbidities among MSM living with HIV	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD016864-03	K-VAC: Kentucky Vaccinating Appalachian Communities	See REASONS FOR EVERY GRANT.
R01MD016880-03	Increasing COVID-19 vaccine uptake among Latinos through a targeted clinical and community-behavioral intervention	See REASONS FOR EVERY GRANT.
4R00MD016964-03	Comprehensive computational analysis of genetic and regulatory differences between individuals with African and European ancestries across four brain regions	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o(* b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
P50MD017349	Chicago Chronic Condition Equity Network	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD017364-03	REDES: a peer network and mobile health (mHealth) enhanced CHW model to maximize COVID-19 vaccination among low income Latinos	See REASONS FOR EVERY GRANT.
1K99MD018451-01A1	Advancing Indigenous Cancer Health Equity through a Community-Centered Framework	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o(* b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
R01MD018459	Elucidating the high and heterogeneous risk of gestational diabetes among Asian Americans: an integrative approach of metabolomics, lifestyles, and social determinants	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination Is Illegal
R01MD018523	A Multilevel, Multiphase Optimization Strategy for PrEP: Patients and Providers in Primary Care	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD018679-02	Understanding the Role of Structural Oppression for Suicide Risk among Black Sexual and Gender Minority Adolescents and Young Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99MD019060	A Digital Health Intervention to Increase Condom Use Among Adolescent Sexual Minority Males	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1K99MD019292-01	A Multilevel Social Capital Approach to Address Cervical Cancer Screening and Follow Up Delays among Latinas in Safety-Net Settings	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
R21MD019345-01A1	Ecological momentary assessment of daily minority stressors and cannabis and tobacco co-use among sexual minority adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1P50MD019475-01	The Institute for Health Equity Research Catalyst Center	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1R21MD019829-01	The Roles of Parental Mental Health and Help-Seeking: Utilizing a Family Systems Approach to Upstream Suicide Prevention for Sexual Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31MD019996-01	Advancing Perinatal Health Equity through a Community-engaged Model of Healthcare Services	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1F31MD020261-01	Understanding the Macrosocial Drivers of Cardiovascular Health in the Rural South	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5R01NR020309-04	Harnessing the power of technology to develop a population-based HIV prevention program for trans girls	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99DC020570-02/4R00DC020570-03	Identifying neural circuits that support effortful listening	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o*(b)(2), 285t-1(a)(b), and/or 288(a)(4).
5R01NR020846-02	#TranscendentHealth - Adapting an LGB+ inclusive teen pregnancy prevention program for transgender boys	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1U24NR021014-02	Advancing Health Equity Through Innovative Community Capacity Building, Data Science & Delivering Community-Centered Structural Interventions & Outcomes: Drexel's ComPASS Coordinating Center (C3)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
OT2OD025276	PRIDEnet for the All of Us Research Program	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AA029044-04	Intersectional Approaches to Population-Level Health Research: Role of HIV Risk and Mental Health in Alcohol Use Disparities among Diverse Sexual Minority Youth	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
5R01AA029088-03	A unified protocol to address sexual minority women's minority stress, mental health and hazardous drinking	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
4R00AA030601-03	Stigma, Romantic Relationships, and Alcohol Use Among Transgender and Nonbinary Young Adults	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5F31AA030722-02	Examining differential effects of state equality-promoting policies on harmful alcohol use among sexual and gender minority adults in the U.S.: an econometrics approach for causal inference	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
1R15AA030898-01A1	Reconstruction of a SGM-specific sexual violence peer support program (SSS+)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1F31AA031420-01A1	Examining Proximal Associations between Minority Stress, PTSD Symptoms, and Alcohol Use among Bi+ College Students with Trauma Histories	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5R01ES034303-03	Research Employing Environmental Systems and Occupational Health Policy Analyses to Interrupt the Impact of Structural Racism on Agricultural Workers and Their Respiratory Health (RESPIRAR)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
OT2OD035659-01	Macro-level Health Considerations of Community and Criminal Justice System Relationships in North Texas	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
1K99EB036553-01	AN ADAPTIVE FRAMEWORK TO SYNTHESIZE AND RECONFIGURE BACTERIAL VIRUSES (PHAGES) TO COUNTER ANTIBIOTIC RESISTANCE	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283*o*(b)(2), 285t-1(a)(b), and/or 288(a)(4).
5U01DA036939-10	Multilevel Influences on HIV and Substance Use in a YMSM cohort	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3P2CHD041023-24S1	"Minnesota Population Center" (Note: this is a Diversity Supplement of the Parent Grant)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
3P30AI050409-26S1	Center for AIDS Research at Emory University	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01DA052016	Substance use and DNA methylation at the intersection of sex and gender	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R03DA052651	Improving Sexual Minority Health: Differences in Substance Use, Substance Use Treatment, and Associated Chronic Diseases among Rural versus Urban Populations	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01DA055673-03S1	Supplement entitled, "Exploring the accessibility, acceptability, and utilization of a community-based harm reduction vending machine among persons with limited opportunity structures."	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283*o*(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
R01DA056235	Structural Influences on Methamphetamine Use among Black Gay and Bisexual Men in Atlanta	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

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5R01DA056287-02	Comparative- and cost-effectiveness research determining the optimal intervention for advancing transgender women living with HIV to full viral suppression	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01DA056888-03	Optimizing PrEP Implementation and Cost-effectiveness among Sexual and Gender Minority Individuals with a Substance Use Disorder	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01DA058642-02	Testing a multistage model of risk factors for cannabis use utilizing a measurement burst design among sexual minority women, sexual minority gender diverse individuals, and heterosexual women	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01MD012793-05	Advancing novel methods to measure and analyze multiple types of discrimination for population health research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3R01MD015165-04S1	Multilevel Physical Activity Intervention for Low Income Public Housing Residents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5T32MH020004	Research Training in Late-Life NeuroPsychia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1R01NR020583-01	Ending the HIV Epidemic with Equity: An All-facility Intervention to Reduce Structural Racism and Discrimination and Its Impact on Patient and Healthcare Staff Wellbeing	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01NR021098	Evaluating the Implementation and De-Implementation of Pandemic Era SNAP Expansion Policies on Diet and Health: A Mixed Methods Project	See REASONS FOR EVERY GRANT.
1F31NR021239-01	Personal Healthcare Networks of Transgender and Gender-Diverse Adults After Gender-Affirming Surgery	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R00AA028049	A mixed-methods approach to understanding stress and hazardous drinking among same-sex female couples	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
T32DA031099-13	Substance Abuse Epidemiology Training Program (SAETP) at Columbia University	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K01DE033040-01A1	Developmental mechanisms in the formation and function of sensory-motor circuits responsible for suckling and mastication.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
U01OD033248	TransHealthGUIDE: Transforming Health for Gender-Diverse Youth Using Interventions to Drive Equity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3OT2OD035592	Proyecto Juntos	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5UM1AI068619-19	Integrating HIV Prevention, Gender-Affirmative Medical Care, and Peer Health Navigation for Transgender Women in the Americas: A Vanguard Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
3R01AG075734	Training the Long-Term Services and Supports Dementia Care Workforce in Provision of Care to Sexual and Gender Minority Residents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5UM2HD111076-03	Operations and Collaborations Center - Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) Operations and Collaborations Center (UM2 Clinical Trial Optional)	See REASONS FOR EVERY GRANT.
1K23HD112599-01A1	Caregiver decision making for seasonal respiratory vaccines for children	See REASONS FOR EVERY GRANT.
1R21HD116080-01	Confidentiality in use of health insurance coverage for reproductive health services	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
R01MH130007	Understanding the Interplay between Parent and Child Contributions in Parent-Child Anxiety Transmission	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5K99MH133994-02	Computational and neurodevelopmental mechanisms of memory-guided decision-making	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1R36MH135609-01	An intersectional approach to transgender and/or nonbinary college student mental health: The role of gender identity, race/ethnicity, socioeconomic status, and campus policy	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5K99NS135649-02	Computational Methods for Precise Holographic Control and Mapping of Neural Circuits	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM144750-02	Dynamic mechanisms of transcriptional coactivator function in Notch signaling	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99GM148723-02	Stress tolerant annual killifish: a new model for the cellular stress response	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1R15GM152943-01	"Mathematical Modeling and Scientific Computing for Infectious Disease Research."	See REASONS FOR EVERY GRANT.
5K99GM153720-02	Dissecting the synaptic and circuit mechanisms underlying olfactory-driven social behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99GM154060-01	TULP3 integrates essential ciliary functions	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
1K99GM157508-01	Unraveling the role of molecular capacitors that obscure cryptic genetic variation in Astyanax mexicanus during the evolution of eye loss	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5K99HL166700-02	Investigating relationships between naturalistic light exposure and sleep	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5P01AI168148-02	Leptospiral-Phagocyte Dynamics in Leptospirosis	See REASONS FOR EVERY GRANT.
1U19AI171401-01	Metropolitan AntiViral Drug Accelerator	See REASONS FOR EVERY GRANT.
R01CA251478	Local Flavor Policies to enhance equity in tobacco	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.

Project Number	Grant Title	Reason Termination is Illegal
R34CA283483-02	Multi-level school-based intervention to improve HPV vaccine uptake and completion in South Africa	See REASONS FOR EVERY GRANT.
5K99MD018629-02	Racism-related stress and birth outcomes among Latinas: New tools for maximizing conceptual and methodological validity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
5K01AG056669-05	The Epidemiology of Alzheimer's Disease and Related Dementias in Sexual and Gender Minority Older Adults: Identifying Risk and Protective Factors	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R24AG066599-03	Building Community and Research Engagement among Sexual and Gender Minority Older Adults at Risk for Alzheimer's Disease and Related Dementias	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01AG083177-02	Enhancing Measurement and Characterization of Roles and Experiences of Sexual and Gender Minority Caregivers of Persons living with Alzheimer's Disease and Related Dementias	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
2T32GM135742-06	UCSC IMSD	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
5R01MD018250-03	Assessing Cervical Cancer Healthcare Inequities in Diverse Populations: The ACHIEVE Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5R01CA274564-03	Impact of Allostatic Load and Neighborhood Contextual Factors on Breast Cancer in the Women's Health Initiative	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

EXHIBIT B

American Public Health Association, et al. v. National Institutes of Health, et al.
No. 1:25-cv-10787-WGY
Plaintiffs' Supplemental List of Grants Impacted by the Directives (June 13, 2025)

This demonstrative is provided by Plaintiffs' counsel, as a supplement to the original demonstrative provided on May 27, 2025 pursuant to the Court's order on May 22, 2025, to aid the Court in its understanding of the manner in which the Directives have been implemented as to Plaintiffs in *APHA, et al v. NIH, et al*. It contains information that Plaintiffs' counsel have been able to obtain and compile to date as to grant and program terminations. The terminations that were included in Plaintiffs' May 27, 2025 submission are contained in rows 1–234. Rows 235–367 contain the supplemental submissions. Inclusion of a grant or program on this list indicates that Plaintiffs' counsel have a good faith basis to believe that the entire grant or program and/or a supplement, parent, subpart, program or other award related to the grant or program has been terminated.

This list likely does not represent the complete universe of terminated grants and grant programs impacting Plaintiffs. Plaintiffs reserve all rights to provide additional information regarding the impacts of the Directives on Plaintiffs and maintain that the resolution of Plaintiffs' claims—both as to liability and as to remedy—does not require the identification or individualized review of all impacted grants.

The Directives and terminations are unlawful in each of the following ways ("REASONS FOR EVERY GRANT"):

(1) They are in excess of statutory authority and contrary to statute (42 U.S.C. §§ 282(b)(4)–(6), 282(m)(1), 284(b)(1)(A), 284(b)(3)), in violation of 5 U.S.C. §§ 706(2)(A), 706(2)(C).

(2) They are contrary to regulation (45 C.F.R. § 75.372), in violation of 5 U.S.C. § 706(2)(A).

(3) They are arbitrary and capricious, in violation of 5 U.S.C. § 706(2)(A).

(4) They violate the separation-of-powers principle and the Due Process Clause of the U.S. Constitution, and they accordingly violate 5 U.S.C. § 706(2)(B).

Row Number	Project Number	Grant Title	Reason Termination is Illegal
1	1R61HD117134-01	Supportive and restrictive factors and mental health in LGBT adolescent and young adult populations	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
2	R01DA054236	Project SMART: Social media Anti-vaping Messages to Reduce ENDS Use Among Sexual and Gender Minority Teens	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
3	R01HD115551	Understanding multilevel predictors affecting family formation among sexual and gender minority couples	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
4	5R01MD015256-05	Sexual orientation-related disparities in obstetrical and perinatal health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
5	5R01MD015256-05S1	Sexual orientation-related disparities in obstetrical and perinatal health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
6	5R01HD109320-02	Advancing novel survey tools to increase participation and improve sexual and reproductive health data quality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
7	3R01HD109320-02S1	Advancing novel survey tools to increase participation and improve sexual and reproductive health data quality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
8	5R01MD016384-03	An Innovative, Prospective Model to Understand Risk and Protective Factors for Sexual Assault Experiences and Outcomes Among Sexual Minority Men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
9	5R21MD018509-02	Development and Pilot Evaluation of an Online Mentoring Program to Prevent Adversities Among Trans and Other Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
10	5R01AA031213-02	The Impact of Minority Stress on Alcohol-Related Sexual Assault among Sexual Minority College Students: An Intersectional, Mixed-Methodological Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
11	5R01MD017573-03	Sexual Assault Recovery Among Sexual Minority Women: A Longitudinal, Multi-Level Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
12	1R15AA030898-01A1	Reconstruction of an SGM-specific sexual violence peer support program (SSS+)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
13	1R34AA030662-01A1	An Online Family-based Program to Prevent Alcohol Use and Dating and Sexual Violence among Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
14	1R21MH136855-01	Over-the-Counter PrEP: Acceptability, Feasibility, and Potential Impact of Access without a Prescription (OFFSCRIPT)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
15	5R33TW011665-06	Development and Testing of a Mobile Application to Enhance HIV Prevention Cascade in Malaysian MSM	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
16	3U24MD017250-04S1	Research Coordinating Center to Reduce Disparities in Multiple Chronic Diseases (RCC RD-MCD)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
17	5U24MD017250-04	Research Coordinating Center to Reduce Disparities in Multiple Chronic Diseases (RCC RD-MCD)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
18	5T32MH019139-35	Behavioral Sciences Research in HIV Infection	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
19	3U01MD019398-03S1	Increasing financial and health equity among low income black youth and young adults - DEIA Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
20	3U01MD019398-03S2	Increasing financial and health equity among low income black youth and young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
21	3U01MD019398-03S3	Increasing financial and health equity among low income black youth and young adults - Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
22	5U01MD019398	Increasing financial and health equity among low income black youth and young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

23	1R01MD020284-01	Measures of structural stigmatization and discrimination for HIV research with Latine sexual and gender minorities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
24	3R01AA029076-04S1	Improving Measurement of Alcohol Use and Other Disparities by Sex, Sexual Orientation, and Gender Identity through Community Engagement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
25	5R01AA029076-04	Project Recognize: Improving Measurement of Alcohol Use and Other Disparities by Sex, Sexual Orientation, and Gender Identity through Community Engagement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
26	5R01AA030017	A Randomized Controlled Trial of a Game-Based Intervention to Reduce Alcohol Use among Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
27	1R21AA031548-01A1	Daily Impact of Sexual Minority Stress on Alcohol-Related Intimate Partner Violence among Bisexual+ Young Adults: A Couples' Daily Diary Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
28	1R01AA031637-01A1	The Role of Local Structural Stigma in Alcohol Related Inequities among SGM Young Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
29	1T32DA057926-01A1	Building an interprofessional and diverse workforce in substance use and pain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
30	1R01DA059240-01A1	Characterizing Intersectional Geospatial Stigma and Affirmation Landscapes and Their Influence on Black and Latino Bisexual Men At Risk for Substance Abuse and HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
31	R01DA059480-01A1	Elucidating minority stress influences on tobacco use at the intersection of sexual orientation and rurality	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
32	1R01DA060066-01	Combination of THC and CBD as a Novel Treatment for Co-Occurring Opioid Addiction and Chronic Pain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
33	1R01DA061661-01	Optimizing a Just-in-Time Adaptive Intervention to Increase Uptake of Chemsex Harm Reduction Services in MSM: A Micro-randomized Trial	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
34	R21DA062591	Optimizing long-acting injectable PrEP strategies for sexual minority men who use methamphetamine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
35	3R01AG063771-05S1	Effects of Social Networks and Policy Context on Health among Older Sexual and Gender Minorities in the US South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
36	5R01AG063771-05	Effects of Social Networks and Policy Context on Health among Older Sexual and Gender Minorities in the US South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
37	K12GM068524	San Diego IRACDA Scholars Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
38	3R01AG077934-03S1	Structural Racism and Discrimination in Sexual and Gender Minority Health Inequities - Supplement	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
39	5R01AG077934-03	Structural Racism and Discrimination in Older Men's Health Inequities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
40	5UM2HD111102-03	Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) Scientific Leadership Center	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
41	R34MH126894	Making Universal, Free-of-Charge Antiretroviral Therapy Work for Sexual and Gender Minority Youth in Brazil	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
42	5R01MH128049-04	Tcher, Take Charge: Increasing PrEP Awareness, Uptake, and Adherence Through Health Care Empowerment and Addressing Social Determinants of Health Among Racially Diverse Trans Women in the Deep South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
43	5R34MH129208-03	3T-Prevent: Piloting a multi-level, combination intervention strategy to expand HIV and bacterial STI prevention	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
44	3R24NS132283-01S1	PURPOSE: Positively Uniting Researchers of Pain to Opine, Synthesize, and Engage	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
45	1R24NS132283-01	PURPOSE: Positively Uniting Researchers of Pain to Opine, Synthesize, and Engage	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

46	1RF1MH132360-01	Brief digital intervention to increase COVID-19 vaccination among individuals with anxiety or depression	See REASONS FOR EVERY GRANT.
47	5R01MH133821-02	The Socioecology of Sexual Minority Stigma: Data Harmonization to Address Confounding Bias and Investigate Cross-Level Mental Health Effects	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
48	1R01MH138335-01	Bisexual adolescents' and young adults' risk for depression and suicidal ideation: Developmental trajectories, risk and protective factors, and underlying mechanisms	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
49	5K23DK139454-02	Structural Racism as a "Third hit" on kidney outcomes of Black individuals with APOL1 risk alletes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
50	5T32GM141862-04	IBioSTeP: NIH G-RISE program at UC Merced	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
51	1R01GM155395-01	Promoting Inclusive Excellence	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
52	1K99GM155594-01	Characterization of the metastatic TIME by subcellular spatial profiling	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
53	1U19AI171110-01	QCRG Pandemic Response Program	See REASONS FOR EVERY GRANT.
54	5R01AI172092-03	Enhanced COhort methods for HIV Research and Epidemiology (ENCORE) among transgender women in the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
55	5R01AI174862-03	Cabotegravir PrEP: Actionable Robust Evidence for Translation into Practice (CABARET)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
56	1F31AI181431-01A1	Prevention of Chlamydia trachomatis infections: Evaluation of vaccination and post-exposure prophylactic antibiotic use as population-level strategies	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
57	R01CA265945	Testing effective methods to recruit sexual and gender minority cancer patients for cancer studies	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
58	5K99NS129753-02	Cell type-specific mechanisms of history-dependent perceptual biases in sensory cortex	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
59	F31GM151838-02	Understanding the role of coiled-coil domains in regulating liquid-liquid phase separation of protein assemblies in cell division	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
60	1K99AG086530-01	Alzheimer's Disease and Related Dementia Neuropathologies and Exposures to Traffic Pollution Mixtures	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
61	R25MH129290	Short Trainings on Methods for Recruiting, Sampling, and Counting Hard-to-Reach Populations: The H2R Training Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
62	DP2AI164315	One Ballroom: Understanding Intersectional Stigma to Optimize the HIV Prevention Continuum among Vulnerable Populations in the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
63	1F31DA060046-01	Dopamine Projections to the Amygdala in Goal-Directed and Habit Learning	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
64	U54DA060049-02	Advancing Tobacco Regulatory Science to Reduce Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
65	1R24DA061190-01	PRIDE-CARES: Patient-Responsive Initiatives for Diverse Engagement – LGBTQ+ Community Action in Research to Eliminate Substance Use Disorder	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
66	1R01DA061345-01	Race & Place: The Impacts of Racial Inequity on Substance Use and HIV Outcomes in Los Angeles	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
67	1F31DA061593-01	Community and big-data system approaches to identifying and understanding the health impact of xylazine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
68	1K99DA062328-01	The role of valence encoding amygdala ensembles in avoidance behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).

69	8K00DA062570-02	Investigating the role of microglia molecular rhythms in the nucleus accumbens in OUD	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
70	R01AG073440-03	Examining Health Comorbidities and Healthcare Utilization Disparities among Older Transgender and Cisgender Adults in the U.S.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
71	1R01AG089099-01	Social Networks and Cognitive Health among Black and Latino sexual minority men in NJ	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
72	R01HD105655-04S1	Understanding and Supporting Reproductive Decisions Among Women with Developmental Disabilities that Affect Cognition	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
73	5K12GM106996-09	IRACDA at UCLA	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
74	5U01HD108738-03	Harnessing the power of text messaging to reduce HIV incidence in adolescent males across the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
75	R21HD109536	Evaluating Teen-Parent Dynamics in Adolescent COVID-19 Vaccine Acceptance and Uptake	See REASONS FOR EVERY GRANT.
76	1R01HD110428-01A1	Modeling Adolescent Health Care Decision-Making for Vaccines: A Community-Based Participatory Approach	See REASONS FOR EVERY GRANT.
77	1R21HD110617-01A1	Development and Initial Trial of Brief Interventions to Help Parents of Stigmatized Youth Reduce Distress and Strengthen Attachment	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
78	R01MH115765	A couples-based approach to HIV prevention for transgender women and their male partners	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
79	1R01HD115985-01	The California Abundant Birth Project Evaluation: Advancing Birth Equity through Guaranteed Income for Pregnant People	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
80	R25HD116367	Restoring equity to measuring and preventing perinatal intimate partner violence (Remap-IPV)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
81	3P30AI117943-10S1	Third Coast Center for AIDS Research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
82	5R01MH118245-05	Biopsychosocial mechanisms underlying internalizing psychopathology in a prospective, population-based cohort of sexual minority young adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
83	R25MH119858	SHINE Strong: Building the pipeline of HIV behavioral scientists with expertise in trans population health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
84	5R33MH120236-04	Suicide Prevention for Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
85	5R01MH121184-04	Monitoring Microaggressions and Adversities to Generate Interventions for Change (MMAGIC) for Black Women Living with HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
86	5K99NS126639/R00NS126639	Mitochondrial fidelity in mammalian neurons	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
87	5R25MH126703-05	Pipeline to Graduate Education and Careers in Behavioral and Social Science Research for URM Undergraduates: Addressing HIV in Sexual and Gender Minority Communities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
88	5T32MH126772-04	Culturally-focused HIV Advancements through the Next Generation for Equity (CHANGE) Training Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
89	5R21MH128114-02	Strengthening the HIV care continuum for transgender women living with HIV in Malaysia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
90	5R01MH128130-04	STI Response and Recommendations Under PrEP (STIRRUP)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
91	3R01MH128729-03S2	Project STRIVE (STudents Rising above) - Offsetting the health and mental health costs of resilience	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.

92	7R01MH129175-03	Strategies to Prevent HIV Acquisition Among Transgender MSM in the US	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
93	R34MH129187	Brothers building brothers by breaking barriers (B6): A resilience-focused intervention for young Black gay and bisexual men living with HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
94	5R34MH129189-03	Data-driven, peer-led messaging using social media influencers to increase PrEP awareness and uptake among transgender women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
95	R01MH129285	A multi-level approach to improve HIV prevention and care for transgender women of color	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
96	5R01MH130375-02	A longitudinal and experience sampling investigation of rejection sensitivity and its role in sexual minority adolescents' mental health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
97	R34MH132405-01	MyPrEP Plus: Development and Pilot Testing of Novel Pre-Exposure Prophylaxis Support Tools for Transgender Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
98	5R01MH132415	Understanding the Regional Ecology of a Future HIV Vaccine	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
99	5R01MH133543-02	Implementing sustainable evidence-based mental healthcare in low-resource community settings nationwide to advance mental health equity for sexual and gender minority individuals	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
100	1R61MH133710-01A1	Targeting Minority Stressors to Improve Eating Disorder Symptoms in Sexual Minority Individuals with Eating Disorders	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
101	4R00DK133804	Utilizing a human stem cell model of the esophagus to understand racial disparities during injury repair	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
102	1K23MH134111-01	Using youth-engaged methods to develop and evaluate a measure for disordered eating behaviors in transgender and gender-diverse youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
103	1F31MH134720-01A1	Understanding Patient Level Implementation Determinants Related to Long-acting Injectable HIV Pre-Exposure Prophylaxis among Young Men Who Have Sex with Men Living in Rural Areas	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
104	5R01MH134721-02	A randomized clinical trial of client-centered care coordination to improve pre-exposure prophylaxis use for Black men who have sex with men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
105	1R21DK134815-01A1	Transforming motivational interviewing into a computable model for automated patient diabetic counseling.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
106	1R34MH134912-01A1	Youth Empowerment and Safety Intervention for Systems-Involved Sexual and Gender Minority Youth at Risk of Suicide	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
107	5K99MH135061-02	Oxytocin receptor signaling modulates social attachment via hippocampal CA2/3 function	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
108	3R01DK135099-02S1	Diversity Supplement for: Impact of a Healthy Checkout Policy on Healthfulness of Grocery Environments and Sales	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
109	R36MH135619	Transcriptomic contributions to the development and evolution of the human cerebral cortex	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
110	5F32MH135634-02	The psychological underpinnings of gender disparities in adolescent mental health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
111	R01MH135738	Know your status: A cluster randomized controlled trial comparing healer-initiated HIV counseling and testing to standard of care in rural South Africa	See REASONS FOR EVERY GRANT.
112	5F99NS135767-02	Neural basis of movement in health and disease	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
113	1K99MH135993-01	Neural circuit dynamics of spatial reward memory	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
114	1R21DK136084-01A1	Mobile pop-up units for diabetes prevention among Hispanics in rural Indiana	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.

115	1F31MH136729-01A1	Determining the role of discrimination in clinical presentation and treatment response among sexual minority people with OCD: A machine learning approach	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
116	5U01DK137259-02	Renal transplant Equity through Partnership And Structural Transformation (REPAST)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
117	1U01DK137262	CommunityRx - Chronic Kidney Disease (CRx-CKD): An EMR-integrated community resources referral intervention to address structural racism and kidney health disparities in rural North Carolina	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
118	5U01DK137269-02	Mitigating the Effects of Structural Racism on Chronic Kidney Disease Disparities among African Americans	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
119	5U01DK137272-02	NAVIGATE Kidney: A Multi-Level Intervention to Reduce Kidney Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
120	K23MH137389-01	ALIVE: Development and feasibility of a psychosocial intervention for sexual and gender minority autistic adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
121	1R01MH137695-01	Measuring and Mapping Trajectories of Risk and Resilience for Suicidal Thoughts and Behaviors in Sexual and Gender Minority Preteens	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
122	1R34MH137753-01	Developing and pilot testing an eHealth decision support tool for young trans women to improve informed decision making about PrEP	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
123	1R01MH140023-01	Mental Health Effects of Marriage Policy: Evidence from Linked Administrative Data in New Zealand	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
124	5R00GM140269-04	Evolution of Cargo Transport	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
125	1K99DK140511-01	Fcγ Receptor-Mediated Pharmacogenomics of Antibody Therapies in Type 1 Diabetes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
126	5T34GM141986-04	Maximizing Access to Research Careers (MARC) at University of Hawaii at Manoa	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
127	5K99GM146016/4R00GM146016-03	Regulation of zinc-dependent lysosome morphological restructuring, zinc trafficking and low zinc homeostasis in C. elegans and human model systems	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
128	K99GM146243-01	The genetic control of neuronal number and behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
129	5K99GM147825-02	Understanding and rewiring cellular behavior with synthetic biology approaches	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
130	5K99GM148819-02	Elucidating the epigenetic regulation of extracellular matrix and virus-induced fibroblast activation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
131	5R01HL149778-05	Cardiovascular Health of Sexual and Gender Minorities in the Hispanic Community Health Study/Study of Latinos (SGM HCHS/SOL)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
132	K99GM151467-02	Nuclear and chromatin aberrations during non-apoptotic cell death in C. elegans and mammals	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
133	K99GM151473	Characterizing the role of tumor suppressor phase separation and chromatin organization in maintaining genomic integrity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
134	5K99GM152834-02/4R00GM152834-03	Regulation of oxidative stress signaling by tyrosine phosphorylation of antioxidant enzymes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
135	5K99GM152835-02	Testing the functional consequences of rapid centromeric DNA and protein evolution	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
136	1K99GM154059-01A1	RNA and genome regionalization in giant single cells: implications for cellular patterning	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
137	K99GM154061	Investigating UPF3 paralog function in Nonsense-Mediated mRNA Decay and Genetic Compensation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).

138	3R01AI155739-04S1	Diversity Supplement - Environmental surveillance of albendazole resistance markers in human infective helminths using dual amplicon metabarcoding	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
139	1K99GM157463-01	Building Dendrite Architecture via Microtubule Nucleation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
140	K99GM157504	Understanding eukaryotic proteasome assembly regulation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
141	1K99GM159354-01A1	Metabolic regulation of pancreatic metaplasia and neoplasia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
142	5R01HL160326-05	Stigma and the non-communicable disease syndemic in aging HIV positive and HIV negative MSM	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
143	3P01AI165075-01S1	Broad neutralization of pandemic threat coronaviruses	See REASONS FOR EVERY GRANT.
144	R01AI169239	Uptake, safety and effectiveness of COVID-19 Vaccines during Pregnancy	See REASONS FOR EVERY GRANT.
145	5K99HL169908-02	Examining the Role of Structural Factors in Racial and Ethnic Disparities in Cardiovascular Disease	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
146	5K99AI173544-02	Improving phage-based medicine with immunoengineering	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
147	1K99HL173668-01	Resistance Exercise in the Prevention and Treatment of Heart Failure with Preserved Ejection Fraction (HFpEF)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
148	1K99AI182451-01	Molecular understanding of maternal humoral responses to pregnancy	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
149	R01CA237670	Project RESIST: Increasing Resistance to Tobacco Marketing Among Young Adult Sexual Minority Women Using the Inoculation Message Approaches	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
150	1U54CA267730-01	Fostering Institutional Resources for Science Transformation: The FLORIDA-FIRST Health-science Brigade	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
151	5U54CA267776-04	NIH FIRST Cohort Cluster Hiring Initiative at Icahn School of Medicine at Mount Sinai	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
152	1UC2CA293786	ComPASS Health Equity Research Hub at Yale	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
153	U54MD007598	Accelerating Excellence in Translational Science (AXIS)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
154	5T37MD008636-10	Transdisciplinary Health Disparities Research Training for Native Hawaiians and Pacific Students	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
155	5D43TW012274-03	Integrated Networks of Scholars in Global Health Research Training (INSIGHT)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
156	1R01HG013145-01	Trans/Forming Genomics: Guidance for Research Involving Transgender and Gender Diverse People	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
157	5R01MD013495-05	Health disparities, stress pathways, and stress-related comorbidities among MSM living with HIV	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
158	5R01MD016864-03	K-VAC: Kentucky Vaccinating Appalachian Communities	See REASONS FOR EVERY GRANT.
159	R01MD016880-03	Increasing COVID-19 vaccine uptake among Latinos through a targeted clinical and community-behavioral intervention	See REASONS FOR EVERY GRANT.
160	4R00MD016964-03	Comprehensive computational analysis of genetic and regulatory differences between individuals with African and European ancestries across four brain regions	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.

161	P50MD017349	Chicago Chronic Condition Equity Network	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
162	5R01MD017364-03	REDES: a peer network and mobile health (mHealth) enhanced CHW model to maximize COVID-19 vaccination among low income Latinos	See REASONS FOR EVERY GRANT.
163	1K99MD018451-01A1	Advancing Indigenous Cancer Health Equity through a Community-Centered Framework	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
164	R01MD018459	Elucidating the high and heterogeneous risk of gestational diabetes among Asian Americans: an integrative approach of metabolomics, lifestyles, and social determinants	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
165	R01MD018523	A Multilevel, Multiphase Optimization Strategy for PrEP: Patients and Providers in Primary Care	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
166	5R01MD018679-02	Understanding the Role of Structural Oppression for Suicide Risk among Black Sexual and Gender Minority Adolescents and Young Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
167	5K99MD019060	A Digital Health Intervention to Increase Condom Use Among Adolescent Sexual Minority Males	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
168	1K99MD019292-01	A Multilevel Social Capital Approach to Address Cervical Cancer Screening and Follow Up Delays among Latinas in Safety-Net Settings	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
169	R21MD019345-01A1	Ecological momentary assessment of daily minority stressors and cannabis and tobacco co-use among sexual minority adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
170	1P50MD019475-01	The Institute for Health Equity Research Catalyst Center	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
171	1R21MD019829-01	The Roles of Parental Mental Health and Help-Seeking: Utilizing a Family Systems Approach to Upstream Suicide Prevention for Sexual Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
172	1F31MD019996-01	Advancing Perinatal Health Equity through a Community-engaged Model of Healthcare Services	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
173	1F31MD020261-01	Understanding the Macrosocial Drivers of Cardiovascular Health in the Rural South	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
174	5R01NR020309-04	Harnessing the power of technology to develop a population-based HIV prevention program for trans girls	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
175	5K99DC020570-02/4R00DC020570-03	Identifying neural circuits that support effortful listening	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o/b)(2), 285t-1(a)(b), and/or 288(a)(4).
176	5R01NR020846-02	#TranscendentHealth - Adapting an LGB+ inclusive teen pregnancy prevention program for transgender boys	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
177	1U24NR021014-02	Advancing Health Equity Through Innovative Community Capacity Building, Data Science & Delivering Community-Centered Structural Interventions & Outcomes: Drexel's ComPASS Coordinating Center (C3)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
178	OT2OD025276	PRIDEnet for the All of Us Research Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
179	5R01AA029044-04	Intersectional Approaches to Population-Level Health Research: Role of HIV Risk and Mental Health in Alcohol Use Disparities among Diverse Sexual Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
180	5R01AA029088-03	A unified protocol to address sexual minority women's minority stress, mental health and hazardous drinking	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
181	4R00AA030601-03	Stigma, Romantic Relationships, and Alcohol Use Among Transgender and Nonbinary Young Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
182	5F31AA030722-02	Examining differential effects of state equality-promoting policies on harmful alcohol use among sexual and gender minority adults in the U.S.: an econometrics approach for causal inference	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
183	1F31AA031420-01A1	Examining Proximal Associations between Minority Stress, PTSD Symptoms, and Alcohol Use among Bi+ College Students with Trauma Histories	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o/b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.

184	5R01ES034303-03	Research Employing Environmental Systems and Occupational Health Policy Analyses to Interrupt the Impact of Structural Racism on Agricultural Workers and Their Respiratory Health (RESPIRAR)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
185	OT2OD035659-01	Macro-level Health Considerations of Community and Criminal Justice System Relationships in North Texas	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
186	1K99EB036553-01	AN ADAPTIVE FRAMEWORK TO SYNTHESIZE AND RECONFIGURE BACTERIAL VIRUSES (PHAGES) TO COUNTER ANTIBIOTIC RESISTANCE	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
187	5U01DA036939-10	Multilevel Influences on HIV and Substance Use in a YMSM cohort	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
188	3P2CHD041023-24S1	"Minnesota Population Center" (Note: this is a Diversity Supplement of the Parent Grant)	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
189	3P30AI050409-26S1	Center for AIDS Research at Emory University	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
190	R01DA052016	Substance use and DNA methylation at the intersection of sex and gender	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
191	R03DA052651	Improving Sexual Minority Health: Differences in Substance Use, Substance Use Treatment, and Associated Chronic Diseases among Rural versus Urban Populations	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
192	3R01DA055673-03S1	Supplement entitled, "Exploring the accessibility, acceptability, and utilization of a community-based harm reduction vending machine among persons with limited opportunity structures."	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o(b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
193	R01DA056235	Structural Influences on Methamphetamine Use among Black Gay and Bisexual Men in Atlanta	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
194	5R01DA056287-02	Comparative- and cost-effectiveness research determining the optimal intervention for advancing transgender women living with HIV to full viral suppression	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
195	5R01DA056888-03	Optimizing PrEP Implementation and Cost-effectiveness among Sexual and Gender Minority Individuals with a Substance Use Disorder	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
196	5R01DA058642-02	Testing a multistage model of risk factors for cannabis use utilizing a measurement burst design among sexual minority women, sexual minority gender diverse individuals, and heterosexual women	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
197	5R01MD012793-05	Advancing novel methods to measure and analyze multiple types of discrimination for population health research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
198	3R01MD015165-04S1	Multilevel Physical Activity Intervention for Low Income Public Housing Residents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
199	5T32MH020004	Research Training in Late-Life NeuroPsychiatric Disorders	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
200	1R01NR020583-01	Ending the HIV Epidemic with Equity: An All-facility Intervention to Reduce Structural Racism and Discrimination and its Impact on Patient and Healthcare Staff Wellbeing	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
201	R01NR021098	Evaluating the Implementation and De-Implementation of Pandemic Era SNAP Expansion Policies on Diet and Health: A Mixed Methods Project	See REASONS FOR EVERY GRANT.
202	1F31NR021239-01	Personal Healthcare Networks of Transgender and Gender-Diverse Adults After Gender-Affirming Surgery	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
203	R00AA028049	A mixed-methods approach to understanding stress and hazardous drinking among same-sex female couples	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
204	T32DA031099-13	Substance Abuse Epidemiology Training Program (SAETP) at Columbia University	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
205	1K01DE033040-01A1	Developmental mechanisms in the formation and function of sensory-motor circuits responsible for suckling and mastication.	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
206	U01OD033248	TransHealthGUIDE: Transforming Health for Gender-Diverse Youth Using Interventions to Drive Equity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

207	3OT2OD035592	Proyecto Juntos	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
208	5UM1AI068619-19	Integrating HIV Prevention, Gender-Affirmative Medical Care, and Peer Health Navigation for Transgender Women in the Americas: A Vanguard Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
209	3R01AG075734	Training the Long-Term Services and Supports Dementia Care Workforce in Provision of Care to Sexual and Gender Minority Residents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
210	5UM2HD111076-03	Operations and Collaborations Center - Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN) Operations and Collaborations Center (UM2 Clinical Trial Optional)	See REASONS FOR EVERY GRANT.
211	1K23HD112599-01A1	Caregiver decision making for seasonal respiratory vaccines for children	See REASONS FOR EVERY GRANT.
212	1R21HD116080-01	Confidentiality in use of health insurance coverage for reproductive health services	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
213	R01MH130007	Understanding the Interplay between Parent and Child Contributions in Parent-Child Anxiety Transmission	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
214	5K99MH133994-02	Computational and neurodevelopmental mechanisms of memory-guided decision-making	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
215	1R36MH135609-01	An intersectional approach to transgender and/or nonbinary college student mental health: The role of gender identity, race/ethnicity, socioeconomic status, and campus policy	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
216	5K99NS135649-02	Computational Methods for Precise Holographic Control and Mapping of Neural Circuits	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
217	5K99GM144750-02	Dynamic mechanisms of transcriptional coactivator function in Notch signaling	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
218	5K99GM148723-02	Stress tolerant annual killifish: a new model for the cellular stress response	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
219	1R15GM152943-01	"Mathematical Modeling and Scientific Computing for Infectious Disease Research."	See REASONS FOR EVERY GRANT.
220	5K99GM153720-02	Dissecting the synaptic and circuit mechanisms underlying olfactory-driven social behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
221	1K99GM154060-01	TULP3 integrates essential ciliary functions	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
222	1K99GM157508-01	Unraveling the role of molecular capacitors that obscure cryptic genetic variation in Astyanax mexicanus during the evolution of eye loss	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
223	5K99HL166700-02	Investigating relationships between naturalistic light exposure and sleep	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
224	5P01AI168148-02	Leptospiral-Phagocyte Dynamics in Leptospirosis	See REASONS FOR EVERY GRANT.
225	1U19AI171401-01	Metropolitan AntiViral Drug Accelerator	See REASONS FOR EVERY GRANT.
226	R01CA251478	Local Flavor Policies to enhance equity in tobacco	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
227	R34CA283483-02	Multi-level school-based intervention to improve HPV vaccine uptake and completion in South Africa	See REASONS FOR EVERY GRANT.
228	5K99MD018629-02	Racism-related stress and birth outcomes among Latinas: New tools for maximizing conceptual and methodological validity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
229	5K01AG056669-05	The Epidemiology of Alzheimer's Disease and Related Dementias in Sexual and Gender Minority Older Adults: Identifying Risk and Protective Factors	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

230	5R24AG066599-03	Building Community and Research Engagement among Sexual and Gender Minority Older Adults at Risk for Alzheimer's Disease and Related Dementias	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
231	5R01AG083177-02	Enhancing Measurement and Characterization of Roles and Experiences of Sexual and Gender Minority Caregivers of Persons living with Alzheimer's Disease and Related Dementias	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
232	2T32GM135742-06	UCSC IMSD	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
233	5R01MD016250-03	Assessing Cervical Cancer Healthcare Inequities in Diverse Populations: The ACHIEVE Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
234	5R01CA274564-03	Impact of Allostatic Load and Neighborhood Contextual Factors on Breast Cancer in the Women's Health Initiative	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
235	T32GM141882	Genetic Approaches to Development and Disease	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
236	U01AI156875-04	Digital, Limited Interaction Efficacy Trial of LifeSkills Mobile to Reduce HIV Incidence in Young Transgender Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
237	5R01MH134051-02	A Strengths-Based, Intersectional Approach to Suicide Prevention Among Black Sexual and Gender Minority Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
238	1R01HL169503-01A1	Geographically-Explicit Ecological Momentary Assessment Protocol to Assess the Linkages Between Intersectional Discrimination and CVD Risk Among Sexual and Gender Minorities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
239	1OT2OD037655-01	Building a Diverse Network to Support and Build Pathways for Historically Underrepresented Students in Quantitative-Focused Research Areas Within the All of Us Research Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
240	1K99NS133031-01A1	A comparative approach to uncovering the cellular and circuit basis of the role of the corticospinal tract in motor skill	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
241	1K99EY034700-01	Processing of visual information by spatial memory circuits in the avian brain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
242	5R01MH131475-02	Intervention to Enhance PrEP Persistence Among African-American Men Who Have Sex with Men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
243	5R21MD019388	Integrated Network Analysis of RADx-UP Data to Increase COVID-19 Testing and Vaccination Among Persons Involved with Criminal Legal Systems (PCLS)	See REASONS FOR EVERY GRANT.
244	1RF1MH132348-01	Improving Mental Health Among the LGBTQ+ Community Impacted by the COVID-19 Pandemic	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
245	5T32MH013043-53	Research Training Program in Psychiatric Epidemiology	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
246	5T32AI148099-04	Training in Translational Immunology Research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
247	1K01DA057880-01A1	Stigma, drug use, and HIV vulnerability among Hispanic and Latino sexual minority men	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
248	K24DA057874	Mentoring the next generation of substance use, HIV, and epigenetic researchers in sexual and gender minority health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
249	5K00NS115338-05	Circuit reconstruction of functionally-identified neurons in deep brain regions: application to grid cells	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
250	R01MH138297-01	The SUSTAIN 2 study - SUStained HIV treatment for adherence after interruption in care	See REASONS FOR EVERY GRANT.
251	5R01MH130277-05	Transgender-Specific Differentiated HIV Care: An Implementation Science Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
252	5R01MD016755-05	Creating Access to Resources and Economic Support (CARES)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.

253	5R01MH133260-02	Integration of a collaborative care model for mental health services into HIV care for pregnant and postpartum women in Kenya (the Tunawiri Study)	See REASONS FOR EVERY GRANT.
254	4R00AI166094-03	Stress-induced transposon mobilization in the human fungal pathogen Cryptococcus	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
255	5R01NR021019-03	Enhancing Structural Competency in School-Based Health Centers to Address LGBTQ+ Adolescent Health Equity	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
256	T32DC000038	Training for Speech and Hearing Sciences	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
257	OT2OD035845-01	Humanitarian Health Care Network: Bringing the Most Vulnerable to Care	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
258	1R21AI183907-01A1	Applying a Behavioral Economic Approach on PrEP and Hormone Options among Transgender Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
259	5P30CA015704-49	Cancer Center Support Grant	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
260	R25LM014575	Advancing Gender and Health Justice Research and Education	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
261	OT2OD035877-01	Achieving Optimal Sexual and Reproductive Health (SRWH Project)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
262	4R00HL157611-03	Toward Accurate Cardiovascular Disease Prediction in Hispanic/Latinos: Modeling Risk and Resilience Factors	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
263	1OT2OD035935-01	Leveraging a community-driven approach to address the impact of social determinants of health on structural inequities among Miami-Dade County's intergenerational LGBTQ+ Community	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
264	5K00MH132569-06	Developing multimodal biomarkers of cognitive ability in a genetic model of neurodevelopment	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
265	5K01MD019325-02	Enlace Familiar: Combating Mental Health Stigma, Improving Mental Health Literacy, Supporting Mental Health Discussions at Home, and Access to care among Latinx Adolescents from Mixed Status Families	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
266	5F31EY035165-02	Linking endoplasmic reticulum calcium handling to neuronal function in vivo in the Drosophila visual system	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
267	5R01MH123282-05	NEXUS: A novel social network approach to study the effects of intersectional stigma on HIV prevention among Latino MSM	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
268	1K99MH135212-01A1	Mapping Neural Dynamics in Hormone-sensitive Networks	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
269	T32GM135751	IMSD at the University of Massachusetts Chan Medical School	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
270	1K99HG013676-01	Using the continuum of genetic causality to investigate trans regulatory mechanisms	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
271	K99EY036650	Delineating the neural computational network for object recognition	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
272	5K99DA059613	Decoding Neuropeptide S Modulation of OFC-mediated Reward Seeking	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
273	D43TW011324	Malaysian Implementation Science Training (MIST) Program in HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
274	5R01TW012674-02	Reducing Stigma in People Who Inject Drugs with HIV Using a Rapid Start Antiretroviral Therapy Intervention	See REASONS FOR EVERY GRANT.
275	K99MD018671	Delineating the Role of the Homocysteine-Folate-Thymidylate Synthase Axis and Uracil Accumulation in African American Prostate Tumors	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.

276	T32GM148391-02	IMSD at Emory University	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
277	5T34GM149511-02	MARC at Emory University	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
278	1R25AI175048-01A1	Infectious Diseases Summer Program Integrating Research at Emory (INSPIRE)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
279	5K12GM000680	IRACDA Fellowships in Research and Science Training (FIRST)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
280	1R01MH135498-01A1	Using digital photovoice to explore the relationships between social media content and suicidality among transgender adolescents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
281	1R34MH129782	CA-LINC: A Culturally Adapted Care Coordination Suicide Detection and Intervention Model for Black Youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
282	K99/R00DC021581	Neural circuitry and population dynamics for perception of social vocalizations in the auditory pathway	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
283	R01TW012392	Buddhism and HIV Stigma in Thailand: An Intervention Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
284	R01TW012392-03S1	Buddhism and HIV Stigma in Thailand: An Intervention Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
285	3R37MH119194-05S1	Neurodevelopmental Mechanisms Underlying Stress Vulnerability during Adolescence	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
286	1R01HD112464-01A1	Health and economic consequences of changing federal and state policies on reproductive health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
287	5R25GM142065-04	Project SCORE (Student-Centered Outcomes Research Experience)	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
288	1R01DK135838-01	The Role of Structural Racism on Disparities in Clinical Outcomes for Diabetes: A Mixed Methods Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
289	1R36MH134774-01A1	The Effects of Structural Inequities and Syndemics on Willingness to Participate in HIV Research among Black Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
290	5T34GM145511	U-RISE @ UC Merced	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
291	5U54HG013243-02	Administrative Core: Pacific Center for Genomic Research - Centers in Genomic Research	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
292	3U24MD016258-03S2/5U24MD016258-03	RADx-UP CDCC	See REASONS FOR EVERY GRANT.
293	3T34GM141986-03S1	One Health Research Training for Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
294	F31AG087648-01	Network drivers of regional vulnerability to early Alzheimer's disease pathology	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
295	1F31HD113328-01A1	Mapping the cellular impacts of Chd8 haploinsufficiency and characterizing microglial activity in Chd8 mutant mice	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
296	1K99AG088361-01	Patterns and Mechanisms Underlying Somatic Mutations Across Long-Lived Bats	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
297	5K99EY035758-02	Understanding how mitochondrial interaction with other organelles in the retinal pigment epithelium (RPE) affect its function in the outer retina	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
298	3R01GM141329-04S1	Investigating the metal-dependent function, allostery and inhibition of CRISPR-Cas9	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).

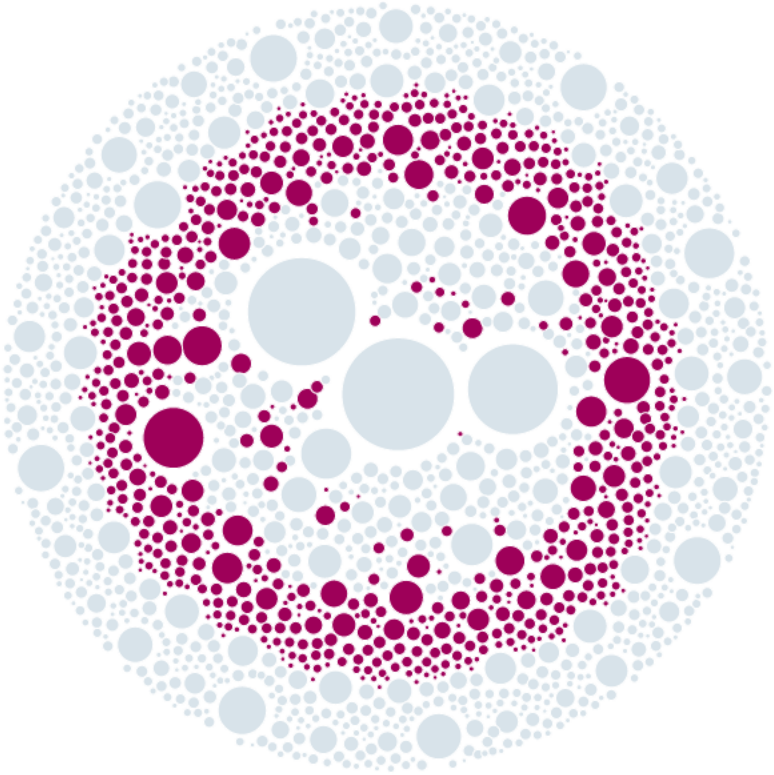
299	5F31MD018931-02	Hardship and Survival: The Impact of Migration-Related Trauma, Communal Coping, and Social Stressors on the Suicide and Mental Health Outcomes of Latina Immigrant Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
300	1F31DA059262-01A1	Exploration of the unique neurobehavioral profile of sequential opioid-stimulant polysubstance use disorders	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
301	F31NR021235-01	Examining Health Disparities in the use of Hematopoietic Cell Transplants for HIV- related Lymphoma	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
302	5T32DK007647	Graduate Training in Nutrition	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
303	1R36DA061635-01	Dissecting the role of loneliness on substance use- and HIV-related outcomes among sexual minority men in the United States and Canada	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
304	T32HD049339-16	GSH Training Grant	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
305	T34GM136450	U-RISE Training the Next Generation of Basic Biomedical Researchers a Holistic Approach	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
306	T32MH128395	Social Determinants of HIV	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
307	5F31HL168956-02	Mechanisms Underpinning Afterload-Induced Atrial Fibrillation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
308	R21MH135489-02	Leveraging Latinx Adolescents, Photovoice, and Longitudinal Data to Disentangle the Bidirectional Effects of Social Media and Mental Health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
309	T32GM145440	Medical Scientist Training Program	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
310	F99NS134207	Neurocomputational Mechanisms of Affective Semantic Memory Development	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
311	1F31HL178310-01	Investigating cellular adaptation to one-carbon metabolism perturbation	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
312	3R01GM072551-19S1	Synaptonemal complex assembly and function in meiosis	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
313	1F31DC022153-01	Leveraging human intracranial recordings to quantitatively characterize basal ganglia output during speech	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
314	1F31EY036742-01	Transcriptional and Developmental Basis of the Human X-linked Homeotic Hotspot	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
315	5T32MH096679-12	Research Training in Biobehavioral Disturbances of Eating Disorders	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
316	R01MD016417	Contextual Determinants of Sexual Minority Health in the United States	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
317	1R01CA276594-01	Randomized Controlled Trial of Dyadic Financial Incentive Treatment for Dual Smoker Couples: Evaluation of Efficacy, Mechanisms, and Cost Effectiveness	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
318	1F31CA281083-01A1	Understanding and Exploiting Apoptotic Dysregulation in Ovarian Cancer	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
319	K23MH137389-01	ALIVE: Development and feasibility of a psychosocial intervention for sexual and gender minority autistic adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
320	5R25GM142044-03	Frugal Science Academy: Training K-12 innovators and democratizing synthetic biology tools	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
321	K99ES035895	Spatiotemporal effects and associations between deforestation and alcohol and tobacco use in Indonesia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).

322	L60AA031839	A mixed-methods approach to understanding depression, suicide risks, and alcohol and other drug use among same-sex female couples	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
323	UH3AI169655-03	Multilevel strategies to understand and modify the role of structural and environmental context on HIV inequities for sexual and gender minorities of color	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
324	R01DA056264-03	Measuring the impact of structural racism and discrimination during adolescence on substance use, psychological distress	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
325	R01NR019512-03	Harnessing the power of peer navigation and mHealth to reduce health disparities in Appalachia	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
326	R37AG076057	How spouses influence each other's health in same- and different-sex marriages: A longitudinal and dyadic assessment from mid to later life	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
327	T32GM141862	G-RISE at UC Merced	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
328	5K99ES034819-02	Impact of Biomass Burning Aerosol and Humic-like Substances on Iron Homeostasis and Atherosclerosis	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
329	T32MH018870	Training in Schizophrenia and Psychotic Disorders: From Animal Models to Patients	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
330	1F31MD019985-01	Characterizing Economic Determinants of Violence and Safety Disparities Among Sexual and Gender Diverse Populations	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
331	5K99EY034700	Processing of visual information by spatial memory circuits in the avian brain	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
332	5R00CA260718-04	Testing the effect of anti-tobacco message framing on polytobacco use in lesbian, gay, bisexual, and transgender young adult adults	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
333	1R01CA284032	Evaluating Centralizing Interventions to Address Low Adherence to Lung Cancer Screening Follow-up in Decentralized Settings	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
334	5R25GM142087-04	Engineering Solutions for Better Health: Genetic Technology and Biomedical Engineering for Secondary Classrooms	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
335	1R25GM154387-01	The Biology of Climate Change: Impacts on Human Health and the Science of Solutions	See REASONS FOR EVERY GRANT.
336	T34GM149493	U-Rise at Cal State Fullerton	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
337	5K99NS129759-02	Investigating Descending Control of Walking	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
338	R21MH133755-01	The TAIL-PrEP Study: Acceptability and Feasibility of a Tailored Adherence Intervention for safe discontinuation of Long-acting PrEP	*See* REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
339	5U54CA132381-18	Partnership for the Advancement of Cancer Research: NMSU & Fred Hutch	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
340	5T32GM138075-04	Bridges to the Doctorate Research Training Program at California State University Long Beach	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
341	T32ES007142	Graduate Training in Biostatistics	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
342	4R00DA055508-03	A Gender-Affirming Stigma Intervention to Improve Substance Misuse and HIV Risk among Transgender Women	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
343	F99NS129176-02	Mechanistic description of tolerance/withdrawal from opioids in the paraventricular nucleus of the thalamus	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
344	1K99DC021727-01	Neuroplasticity and early cochlear implant use	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).

345	1F99NS139546-01	Neuro-Evolutionary Basis of Vertebrate Social Behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
346	5F31CA275157	The Role of the Fructose-1,6-Bisphoshatase 2 and c-Myc Interaction in Sarcoma Progression	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
347	R00DA056842	Native Spirit: Culturally-grounded substance use prevention for Indigenous adolescents	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
348	5R01MD018051-03	Modeling Resilience as a Multidimensional Protective Factor for Transgender Health Disparities: Measure Development and Longitudinal Evaluation of Resilience	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
349	5F31AA030907-02	Hitting Close to Home: A Multi-Method Investigation of Neighborhood Characteristics and Drinking Motives on Alcohol-Related Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
350	U01NR021576	Meet Me on the Pitch: Developing and testing a community-based sports and behavioral health intervention for newcomer youth	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
351	K99/R00K99MH127471	Distributed neural activity patterns underlying practice-based learning	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
352	5K99HD108801-02	Sex, Physiological State, and Genetic Background Dependent Molecular Characterization of CircuitsGoverning Parental Behavior	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
353	5R01AI179873-02	The basis of Influenza A virus strain-dependent reassortment potential	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(ii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
354	5T34GM149492-02	U-RISE at Cal Poly	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
355	3R01DK133453-02S1	Leveraging early-life microbes to prevent type 1 diabetes	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
356	5R01CA276500-02	Smoking and Cancer-Related Health Disparities among Sexual and Gender Minority Adults	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
357	3R01HL161049-03S1	Addressing System-level Barriers to COPD Guideline Concordant Care	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
358	1F31GM154412-01	The Role of Post-Translational Modifications in Bacterial Responses to Methylglyoxal	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
359	5R01HG011405-04	Elucidating the phenome-wide impact of sex and gender on disease	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
360	R01MD019763-01	A community driven modeling approach for identifying community & policy-level interventions to address the impact of structural racism and discrimination on adolescent substance use and mental health	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
361	5R01AA029989-04	Long-term and Daily Associations among Intersectional Minority Stress, Structural Oppression, and Alcohol Use and Misuse among Sexual Minority Adolescents of Color	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
362	5T32ES007322-23	Advanced training in environmental health and data science: molecules to populations	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o(b)(2), 285t-1(a)(b), and/or 288(a)(4).
363	1R01DC021839-01	Family language planning and language acquisition among deaf and hard of hearing children	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(h), 282(m)(2)(B)(iii), 283o (b)(2), 283p, 285t, 285t-1(a)(b), 288(a)(4), and/or 289a-2.
364	1P50MH129708-01A1	UW Practice-based Suicide Prevention Research Center	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(h), 283o (b)(2), 285t-1(a)(b), and/or 288(a)(4).
365	3R01DK135838-02	The Role of Structural Racism on Disparities in Clinical Outcomes for Diabetes: A Mixed Methods Study	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(ii), 283p, 285t, and/or 289a-2.
366	R25MH067127	Training for Scientists Conducting Research to Reduce HIV/AIDS Health Disparities	See REASONS FOR EVERY GRANT. In addition, the Directives and terminations are also in excess of statutory authority and contrary to statute—and also violate the separation-of-powers principle of the U.S. Constitution—because of, among other statutes: 42 U.S.C. §§ 282(b)(8)(D)(ii), 282(m)(2)(B)(iii), 283p, 285t, and/or 289a-2.
367	5R01MH133266-02	Integration of stepped care for Perinatal Mood and Anxiety Disorders among Women Living with HIV in Kenya	See REASONS FOR EVERY GRANT.

The Disappearing Funds for Chronic Diseases

These are the nearly 2,500 N.I.H. grants that have been ended or delayed.



Awards under $100,000 are not shown. Amounts shown are for the most recent fiscal year.

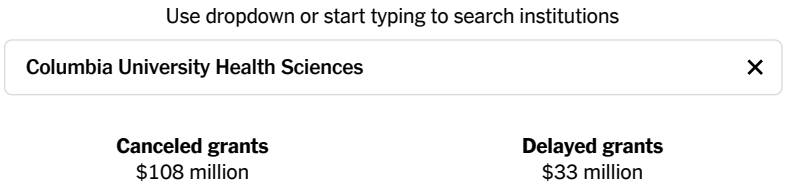
By Irena Hwang, Jon Huang, Emily Anthes, Blacki Migliozzi and Benjamin Mueller June 4, 2025

In his first months in office, President Trump has slashed funding for medical research, threatening a longstanding alliance between the federal government and universities that helped make the United States the world leader in medical science.

Some changes have been starkly visible, but the country's medical grant-making machinery has also radically transformed outside the public eye, a New York Times analysis found. To understand the cuts, The Times trawled through detailed grant data from the National Institutes of Health, interviewed dozens of affected researchers and spoke to agency insiders who said that their government jobs have become unrecognizable.

In all, the N.I.H., the world's premier public funder of medical research, has ended 1,389 awards and delayed sending funding to more than 1,000 additional projects, The Times found. From the day Mr. Trump was inaugurated through April, the agency awarded $1.6 billion less compared with the same period last year, a reduction of one-fifth. (N.I.H. records for May are not yet comparable.)

The impacts extend far beyond studies on politically disfavored topics and Ivy League universities like Columbia or Harvard. The disruptions are affecting research on Alzheimer's, cancer and substance use, to name just a few, and studies at public institutions across the country, including in red states that backed Mr. Trump.



Scale is larger than in previous graphic.

"I think people should know that research that they probably would support is being canceled," said Eden Tanner, a chemist at the University of Mississippi, who had been working with a colleague at Ohio State University to develop a novel approach for treating glioblastoma, an aggressive form of brain cancer. Their grant had been awarded through a program designed to diversify the biomedical workforce; in April, they were notified that it was being terminated.

"I would like to cure brain cancer," Dr. Tanner said. "I think that's not particularly controversial."

Mr. Trump's campaign against medical research has been carried out without congressional approval, and the legality is unclear. Lawsuits have challenged the slashing or delaying of funding.

Federal officials, who have accused the N.I.H. of wasteful spending, have attributed the cuts to changing scientific priorities.

The N.I.H. “regularly examines its research portfolio” to determine which projects are “the most meritorious,” Andrew Nixon, a spokesman for the U.S. Department of Health and Human Services, said in an email. “Regular reviews of ongoing activities will help us determine the most strategic balance of projects to support and the best way to manage them going forward, especially as we need to be responsive to the often-changing nature of biomedical scientific progress.”

Scientists fear that the sweeping cuts could do long-term damage to U.S. scientific research, which has long driven medical and financial progress for the nation. “The country is going to be mourning the loss of this enterprise for decades,” said Dr. Harold Varmus, a Nobel Prize-winning cancer biologist who served as the director of the N.I.H. during the Clinton administration and the director of the National Cancer Institute under President Barack Obama.

Publicly announced cancellations

The federal government has announced the termination of 1,389 awards, with more than $820 million in recent funding.

N.I.H. grants, awarded in a competitive process, are typically paid out in installments. A researcher with a $1 million four-year grant, for instance, will get about $250,000 a year. Scientists can use this money to buy equipment and supplies and to pay the salaries of the researchers who work in their labs, among other things.

From 2015 to 2024, there have been fewer than 20 terminations a year, on average, according to Jeremy M. Berg, former director of the National Institute of General Medical Sciences at the N.I.H. from 2003 to 2011. They were generally for extenuating circumstances, such as illness or research misconduct.

But since late February, the government has publicly announced the cancellation of 1,389 N.I.H. awards. The agency scoured grants for key words and phrases like “transgender,” “misinformation,” “vaccine hesitancy” and “equity,” ending those focused on certain topics or populations, according to a current N.I.H. program officer, who asked not to be identified for fear of retribution.

Studies focused on sexual and gender minority groups were among the first on the chopping block.

Feb. 27

Sexual and gender minorities; racial and ethnic groups

Diversity initiatives

Vaccines; pandemic threats

March 9

Columbia Univ. grants

March 13

Katherine Bogen, a doctoral student at the University of Nebraska-Lincoln, had been studying post-traumatic stress, alcohol use and intimate partner violence against bisexual women. The termination notice she received assailed studies “based primarily on artificial and nonscientific categories,” calling such research “antithetical to the scientific inquiry” and alleging that it was “often used to support unlawful discrimination on the basis of race and other protected characteristics, which harms the health of Americans.”

The language was “very insulting,” she said. “I get this letter that tells me, ‘Your research is not science. Not only is it ascientific, it’s a useless drain on resources, and, in fact, your research could be used to discriminate against ‘actual’ Americans or ‘regular’ Americans,’ or whatever they mean.”

The cuts spread to grants on health equity and racial and ethnic groups. Affected projects sought to improve access to mental health care for Latino, low-income and rural communities; to reduce maternal mortality among Black women; and to prevent gun violence in Asian American communities.

March 14

Sexual and gender minorities; racial and ethnic groups

March 19

Diversity initiatives

Vaccines; pandemic threats

March 29

Tsu-Yin Wu, a researcher at Eastern Michigan University who led the gun violence project, said that community leaders and study participants were “greatly disappointed” by the grant cancellation. “Some felt betrayed that their voices and engagement no longer matter.”

The agency cut grants for research on vaccine hesitancy, disinformation and misinformation, including a Northeastern University study on cancer misinformation on social media.

It also axed research on Covid-19, including studies that could have helped the nation respond to many infectious disease threats. Among them: a grant to Emory University and Georgia State University, where researchers had developed three potential drugs that showed promise against many RNA-based viruses, including coronaviruses, Ebola, avian influenza and measles, said George Painter, a pharmacologist at Emory who was co-leading the research.

In April, the agency terminated, in part or in whole, more than 350 grants meant to support students, early-career scientists or researchers from groups underrepresented in science. Among these terminations were F31 diversity grants, awarded to Ph.D. students who were members of certain racial or ethnic groups, disabled or from disadvantaged backgrounds.

March 31

Vaccines; pandemic threats

Sexual and gender minorities; racial and ethnic groups

April 9

Diversity initiatives and grants

April 14

April 29

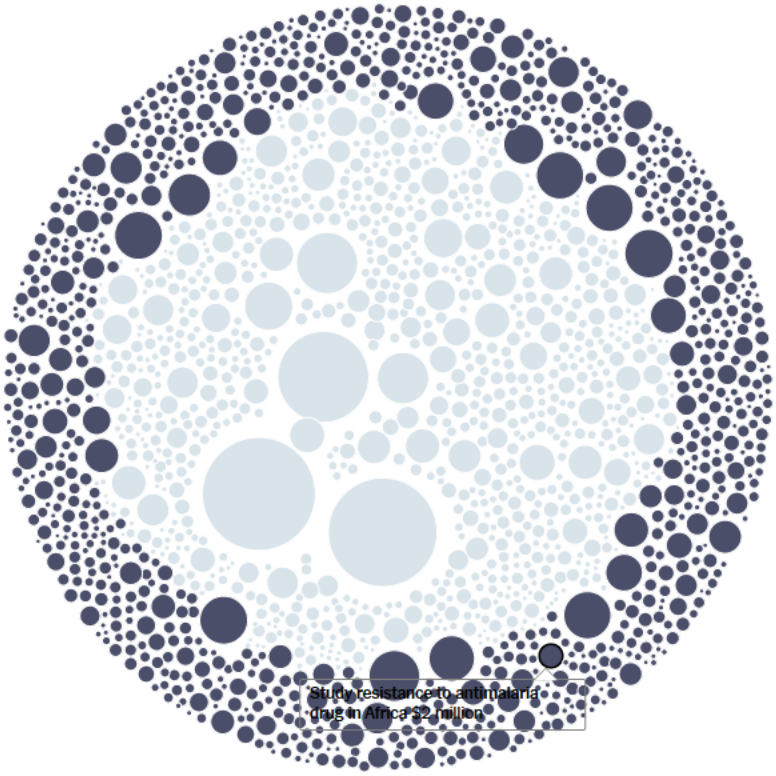
At the University of Pittsburgh, Luzmariel Medina-Sanchez, who was born and raised in Puerto Rico, and Sierra Wilson, a first-generation college student from Utah, both had their grants canceled. “It’s not even about the work I’m doing,” said Ms. Wilson, who studies how liver cells respond to drug overdoses. “It feels like it’s about me.”

Ms. Medina-Sanchez, who studies how a microbe can help treat celiac disease, said she may leave science altogether. “I feel racially targeted,” she said. “I feel like I’m not going to be a professional in the field of science in America, because obviously my name is Luzmariel.”

(Ms. Wilson and Ms. Medina-Sanchez stressed that they spoke only for themselves and not for the university.)

Delayed funding

In addition to **publicly announced cancellations**, these are the nearly 1,100 grants that have been **delayed**, with nearly $740 million in funding.



Awards under $100,000 are not shown.

Besides outright canceling projects, N.I.H. failed to distribute annual payments to more than 1,000 grants, The Times found.

The delays have stifled research on drug discovery, blood vessel health and injury response. In some cases, scientists have cut staff, paused hiring, trimmed back supplies or delayed experiments. Health officials have not explained which projects have been held up, why or for how long.

The Times compiled a list of the delayed grants by searching N.I.H. databases as of June 2 for ones that were funded in 2024 and expected to last beyond 2025, but have not gotten disbursements on schedule.

In the past, annual renewals were routine. Scientists submitted progress reports; the N.I.H. reviewed them and usually continued funding them, occasionally with a week or two of delays. But longer delays have become much more common since Mr. Trump took office.

Joshua Kritzer, a professor of chemistry at Tufts University, investigates the basic science behind potential drug candidates, laying the groundwork for future medications. Most of his lab work is supported by a five-year N.I.H. grant that received $1.4 million over the past two years. But since February, he had been waiting for the third year of expected funding to come in. He slashed purchases of essential supplies and contemplated laying off crucial researchers on his team.

On Tuesday, Kritzer finally received word that his funding had been released, several days after The Times asked federal officials about his and other delayed awards.

“Every week that’s delayed, it’s easily probably three to four weeks to get that research back to where it was,” said Dr. Kritzer, who noted that he was speaking for himself and not for his institution.

Mr. Nixon, the Department of Health spokesman, said that the agency would not discuss deliberations about specific awards but encouraged grant recipients to “speak with the designated N.I.H. officials on their award notice when questions arise.”

In some cases, delays have lasted so long that scientists wondered whether their grants were subject to a “shadow termination.”

The delays stem in part from additional screening for whether the grants align with Trump administration priorities, N.I.H. officials said. Other renewals have been delayed as overstretched N.I.H. staff members work through backlogs in funding. And political appointees are now vetting some projects, too, slowing the process further.

N.I.H. officials said they feared being fired if they processed a grant renewal that the administration disfavored.

In early May, Jon Lorsch, a longtime N.I.H. institute director who was recently promoted to acting deputy director of the agency’s external funding arm, emailed staff members denouncing the renewal of grants “that focused on topics that are not supported under N.I.H./H.H.S.'s priorities,” according to a copy of the email seen by The Times.

“The consequences of approving an award that should not have been approved could be very serious,” he wrote.

But Courtney Griffin, who leads a lab at the Oklahoma Medical Research Foundation and studies blood vessel development and disease, including complications due to diabetes, expressed confusion as to why her expected funding is not coming through. She and her colleagues were making contingency plans and looking for other sources of funding.

“It’s, ironically, a really inefficient use of people’s time to be in this guessing game,” she said, adding that the time could be better spent on biomedical research.

Months-long delays are also affecting new grants that were being vetted when the Trump administration cracked down on grant reviews.

A number of major Alzheimer's Disease Research Centers, some of which have operated for decades, have waited months for the Trump administration to decide whether to award them fresh five-year grants. The funding gaps have set back ongoing studies and

curtailed efforts to take images of patients' brains, though the N.I.H. has recently told some centers that they would soon receive funding.

“These centers have become a safety valve for people who can’t get a neurology appointment at a private center,” said Dr. Ann Cohen, a co-director of the University of Pittsburgh Alzheimer’s center. Now, she said, things have changed. “There are fewer clinic appointments, fewer opportunities for these individuals to get brain imaging.”

More cuts to come

The N.I.H. has also said that it will no longer fund projects in which U.S. researchers distribute some of their money to international partners, throwing the future of many global health projects into question and creating funding delays for ongoing research.

Beyond the disruption of individual projects, other proposed changes could undermine scientific research across the board, experts said. One would sharply curb funding for indirect research costs, such as building maintenance and administrative staff. And then there is Mr. Trump’s proposal to slash the N.I.H.’s total budget by about $18 billion, a cut of almost 40 percent.

A budget cut of that scale would be “truly draconian,” said Dr. Varmus, the former N.I.H. director, who said he hoped Congress would not approve such a sharp reduction. It could leave the agency without enough money to fund promising new work, drive some scientists overseas and prompt some up-and-coming researchers to leave science altogether, he said. “You can completely destroy the system in just a couple of years,” Dr. Varmus said.

Methodology

The Times’s analysis of cancellations is based on the list of terminated grant awards published by the Department of Health and Human Services as of May 30, 2025, and on records from RePORT, the National Institutes of Health’s registry of grants and projects, as of June 2, 2025.

Each circle in the graphics represents a grant award. The circles are sized by the total funding that N.I.H. authorized for each award. H.H.S.’s list of terminations includes a mix of main grant awards, supplements and amendments. The list also indicates a “total amount obligated,” but that figure generally is the total amount awarded to a grant over its lifetime, including any supplements and amendments, rather than the amount for the specific award terminated. The Times’s analysis above uses only the amount authorized for the specific award listed. In some cases, scientists had already spent much of the money they had been awarded before their grants were cancelled, but in others, they lost out on their entire awards. Award amounts and totals — including the year-to-year funding shortfall calculated by The Times — do not include N.I.H. grants administered by the U.S. Department of Veterans Affairs, because their funding amounts are not available in RePORT.

The Times examined cancellations of grants intended to train and support research by groups underrepresented in science. These include the R25 education program; the T32 and T34 training programs; F31 diversity grants; R01 research grants under funding opportunity

number PAR-22-241 and research supplements under funding opportunity number PA-23-189, both of which are specifically intended to promote diversity among grant recipients.

To identify grants with delayed funding, Times journalists used information about each grant's planned duration and prior awards, focusing on those that were eligible for continuation or noncompeting renewal. To account for reporting lags in the RePORTER database, The Times limited this analysis to a time period from Jan. 20 to April 30. The Times excluded grants that appear on H.H.S.'s public list of terminations and grants that have been marked in RePORTER as terminated. Based on interviews and an analysis of historical renewal data, The Times found such grants typically receive a notice of award at roughly the same time each year. Each circle representing a delayed grant is sized by the amount its main award received in fiscal year 2024. This list may include a small number of grants whose renewals are not yet recorded in N.I.H. databases, and others whose renewals are expected to be delayed, because of conversion of grant status for an investigator changing roles or institutions.

To classify each grant's area of research, The Times extracted the title, the public health relevance statement and the abstract from the N.I.H.'s RePORTER database and ExPORTER files. These fields were used as input for a series of automated prompts to a large language model.

The model generated a brief description of the grant's research objective. The model also determined if grants were related to research in areas like chronic diseases, vaccines, pandemic preparedness, misinformation, sexual and gender identity, health disparities and certain ethnic and racial groups, and diversity, equity and inclusion initiatives, and then assigned categories.

Times journalists read the projects' public health relevance statements and abstracts, and they checked the assigned categories for accuracy. They also checked hundreds of grant descriptions and edited them for accuracy and clarity. Only the project descriptions that have been edited by Times journalists are displayed in the article.

Sarah Cahalan contributed reporting.

Correction: June 5, 2025
An earlier version of this article included elevated grant totals for 11 affected institutions searchable in the search bar. The grant total for each institution included not only its own funding, but also a grant for another part of its school system, like a separate campus or medical center.

STAT PLUS
HEALTH

50 canceled measles clinics, and other local impact from HHS cuts

‘Mass layoffs is not how you make America healthier,’ city and county health officials say



A medical provider administers measles vaccine to a child at a health center in Lubbock, Texas, in February. RONALDO SCHEMIDT/AFP via Getty Images

By Elizabeth Cooney April 1, 2025

Cardiovascular Disease Reporter

Just last week, the leader of public health in Dallas had to cancel 50 vaccination clinics, including events specifically targeting schools with low immunization rates, all while the West Texas measles outbreak continues to flare.

Then on Tuesday came the layoffs of thousands of Health and Human Services employees. The "reduction in force" included many who staffed the agencies that supply information, expertise, and funding to local health departments that need data, dollars, and boots on the ground to do the work of preventing disease and responding to public health emergencies. The hits taken by the Centers for Disease Control and Prevention loom large in the cities, states, and counties that depend on the expertise and information that have been reliably supplied over the years.

After the termination of three CDC grants to Dallas on March 24, 11 full-time and 10 part-time staffers who worked in the epidemiology group to respond to outbreaks, including measles, lost their jobs, Philip Huang, a physician and director of Dallas Health and Human Services, said at a media briefing Tuesday arranged by a number of public health associations. The loss of those staffers forced the city to cancel the large number of vaccination clinics and other outreach events, he said.

Job cuts are only part of the picture.

"The technical expertise is really what we rely on on the ground," Huang said. "I know some of my colleagues out in West Texas have had a CDC team on the ground to respond to measles, but for every sort of issue that we deal with, we rely on that expertise."

In explaining his overhaul of HHS, Health Secretary Robert F. Kennedy said the cuts would streamline a bloated bureaucracy and prioritize chronic illness.

But the local public health figures at the briefing today expressed deep dismay over the federal cuts, saying they would translate into less disease prevention and a weakened emergency response.

"Today's reduction in force reorganization, mass layoffs, is not how you make America healthier," said Chrissie Juliano, executive director, Big Cities Health Coalition, echoing the Make America Healthy Again mission promoted by Kennedy. "It's not efficient. It

doesn't save money. It's not transparent, collaborative, or strategic. It is in some ways what appears to be fairly haphazard."

The loss of expertise at the federal level compounds challenges faced at the local level, said Lori Tremmel Freeman, chief executive officer of the National Association of County and City Health Officials. Many local health departments have seen money clawed back from the federal government, stopping their work abruptly.

She zeroed in on smoking, a leading risk factor for chronic disease and a leading cause of preventable death in the United States.

"RFK has initiated the Make America Healthy Again initiative, and he wants to reverse the chronic disease epidemic," she said. "We need to understand how we will do that by gutting both the FDA Center on Tobacco Products as well as eliminating the CDC Office of Smoking Health. How would we accomplish that important objective without those things in place?"

The impact will be felt deeply in smaller places, among the 3,300 public health departments in the country, the officials said. Losing even one multitasked staff member can cripple a rural department, where people already have more limited access to specialized care, to emergency services, to employment opportunities.

"When we remove any of the supports that we've put in place there, the people that suffer are the residents, the community members," said Sharon Gilmartin, executive director of Safe States Alliance. "In the midst of public health crises like the measles outbreak right now, why attack the very institutions solely focused on our health and well-being? What may look good on a budget spreadsheet will no doubt look different in our homes and communities."

Huang worries about how the latest science will be shared.

"I'm concerned about the quality of the science or some other political distortions of science that may then affect the information that's disseminated out throughout the country to clinicians and all of us," he said. "I mean, we've already seen some questionable things about measles. Vitamin A does not prevent measles and there should be no

confusion about something like that. And I do worry about that same sort of thing happening to other science that we depend on."

Asked what recourse public health may have, none of the speakers thought philanthropy or other sources could make up the shortfall in funding or knowledge dissemination.

"This truly is setting us back decades," Huang said. "You cannot just build this back again. It's taken so long to develop this expertise and the systems to do this and that support. And this is destroying that and it will set us back multiple decades."

Susan Polan, associate executive director of the American Public Health Association, appealed to lawmakers.

"Today we have to decide if we want a healthy and secure nation and what we're willing to do to fight to protect that," she said. "We know that what's happening right now is chaotic, it's cruel, and it undermines the stated goals that the plan is to make America healthy. I hope and demand that congressional leaders will rise up and do what they're supposed to do, which is address the fact that their appropriations are now being destroyed and undermined and without any seeming consequence."

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Have you been affected by cuts and restructuring at HHS?

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https://www.wsj.com/politics/policy/rfk-jr-maha-allies-benefit-3d1a963d

POLITICS | POLICY

How RFK Jr. Is Boosting 'Food Babe' and Other MAHA Acolytes

HHS secretary elevates lightly regulated wellness companies and allows advisers to keep investments, after vowing to end conflicts

By Kristina Peterson Follow *and Corrie Driebusch* Follow

May 9, 2025 5:00 am ET



Robert F. Kennedy Jr. in the Oval Office. PHOTO: ANDREW HARNIK/GETTY IMAGES

Key Points

What's This?

- RFK Jr., now HHS secretary, is being scrutinized for potential conflicts of interest.
- Companies run by RFK Jr.'s allies are benefiting from his rhetoric and policy changes.
- Ethics experts raise concerns about RFK Jr.'s appearances with MAHA allies and government backing.

WASHINGTON—Before taking office, Robert F. Kennedy Jr. vowed to avoid conflicts of interest in U.S. health policymaking, and said food companies and drugmakers exerted too much influence.

Now that he is President Trump's secretary of health and human services, some companies run by Kennedy's allies in the Make America Healthy Again movement are getting a boost from the government.

Kennedy has surrounded himself with MAHA activists and entrepreneurs touting alternative health approaches that stand to benefit from his rhetoric, changes in policy, and being publicly linked with the top public-health official.

When Kennedy announced at the Department of Health and Human Services headquarters last month that the agency would work with food companies to strip some artificial food dyes from the American diet, he was joined by Vani Hari, an activist known as the Food Babe who co-founded Truvani, a company that makes plant-based protein powders, snack bars and supplements. Target started selling some of her products in April.

Hari is "an extraordinary leader," Kennedy said after her remarks.

Also speaking was Dr. Mark Hyman, an author of nutrition books and the co-founder of a membership-based health program called Function Health. Hyman has been a "friend and partner on these issues for 20 years," Kennedy said, adding that his "The Blood Sugar Solution 10-Day Detox Diet" was "a very good book."



Vani Hari at HHS in April, when Kennedy said the department would work with companies to eliminate some food dyes. PHOTO: ANDREW HARNIK/GETTY IMAGES

On his website, Hyman sells a variety of supplements and nutrition books. Function Health closed a funding round in February that valued the company at $2.5 billion, up from $191 million in June 2024, according to data from PitchBook.

The kinds of appearances that RFK Jr. has been having with MAHA allies might not directly violate ethics rules that prohibit using public office to benefit private individuals or businesses, but they fall in a gray area that such rules were meant to deter, according to ethics experts.

Kennedy "made a point of the evils of government doing the bidding of business in food and nutrition and medical areas—this starts to look kind of like the same thing," said Noah Bookbinder, president of Citizens for Responsibility and Ethics in Washington, also known as CREW.

An HHS spokesman said, "It appears that the WSJ is taking issue with private citizens exercising First Amendment rights."

Kennedy has said he wants to end the way the pharmaceutical and food industries can shape government advice by funding research that goes into it. His supporters have said the shift is giving a seat at the table to a broader range of health approaches.

Hari and Hyman said they have been working on food and nutrition issues for years, and Hyman said he attended the event as a private citizen and a practicing doctor.

MAHA proponents at the April announcement on artificial food dyes.
ELIZABETH FRANTZ/REUTERS

"HHS has been a revolving door to the food and pharmaceutical industry and never given a voice to advocates and mothers like me until now," Hari said.

White House video

The mingling of the MAHA-aligned wellness industry and Kennedy's department business has given the wellness space the imprimatur of government backing, said Jessica Knurick, a registered dietitian who has disputed some MAHA claims.

In March, Kennedy and other cabinet officials filmed a video with so-called MAHA moms, including Hari, in which they stumbled while reading the scientific names of ingredients listed on packaged foods. One such word, "riboflavin," is vitamin B2, which helps the body break down carbohydrates and protein. The video was posted on the official White House X account.

The next month, Target started selling protein powders from Hari's company, Truvani. "I have been dreaming about this day for so long, and it's finally here," Hari said in an Instagram video that shows her discovering the powder in the store. It couldn't be determined when Target, which didn't respond to requests for comment, decided to stock the products.

After the announcement on food dyes with Kennedy, Hari appeared on CNN in an interview from the White House with Food and Drug Administration Commissioner Marty Makary.

Some outside executives are working with the administration temporarily as "special government employees," who aren't required to relinquish their outside salaries or investments. A top Kennedy aide, Calley Means, for example, is the co-founder of Truemed, a company whose affiliated doctors can affirm that wellness products are medically necessary so customers can buy them with health-savings accounts. Means declined to comment.

Truemed raised around $33 million in March and is now valued at $157 million, up from $49 million in January 2024, according to PitchBook.

Calley Means's sister, Dr. Casey Means, who is Trump's surgeon-general selection, is an investor in Hyman's Function Health, and co-founded Levels, a company offering glucose-monitoring devices and a health-tracking app.

Casey Means and journalist Megyn Kelly were on Capitol Hill for RFK Jr.'s January confirmation hearing. PHOTO: BEN CURTIS/AP

Another co-founder of Levels, Sam Corcos, has been working with the Department of Government Efficiency to overhaul the Internal Revenue Service. In March, Corcos appeared on Fox News in a joint interview with Treasury Secretary Scott Bessent. He was introduced both as the chief executive of Levels and as a Treasury Department adviser. Levels declined to comment.

'Good science'

Kennedy forged a movement by harnessing the efforts of those skeptical of the government's medical advice, and of big pharmaceutical and food companies. When Kennedy faced lawmakers earlier this year for his confirmation hearings, he told them: "We need good science and we need good leadership that is able to stand up to these big industries and not bend over for them."

Since taking office, he has appointed as his advisers people who have outside business interests, and has granted waivers regarding investments to other officials, according to financial disclosures and other documents.

Kennedy's senior counselor and principal deputy chief of staff, Stefanie Spear, who now oversees all communications for HHS, can continue operating her media consulting business, Stellar Inc., according to financial records. She is the chief executive and sole media consultant for the firm, the records show.

The husband of Kennedy's chief of staff, Heather Flick Melanson, has investments in $1.2 million in stock in Alphabet, Amazon.com and Microsoft; shares in the chip

maker Nvidia worth between $100,000 and $250,000; and a Napa Valley vineyard valued at more than $1 million, financial records show.

Kennedy granted Melanson a waiver regarding the investments but barred her from participating in specific matters involving some of the companies and alcoholic beverages.

HHS uses Amazon Web Services, including the hosting of 74 million Medicaid records, according to Amazon's website. How much alcohol adult men and women can safely consume is expected to be addressed in the federal dietary guidelines, slated to be updated this year.

Some ethics experts said a more effective option might have been for the Melansons to divest themselves. "How do you functionally enforce this, given how big the job is?" asked Tony Carrk, executive director of Accountable.US, a nonprofit focused on corporate influence.

The HHS spokesman said Kennedy, Melanson and Spear have abided by all ethics rules. "Any waiver that they received was limited in nature and carries with it mandatory recusals, which they have complied with," the spokesman said.

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Appeared in the May 10, 2025, print edition as 'RFK Jr. Is Boosting His Allies' Companies'.

Videos

ARTICLE JUN 18, 2025

How the Big, 'Beautiful' Bill Would Undermine Access to Life-Saving Substance-Use Disorder Treatment

[redacted]

Natasha Murphy

Strengthening Health, Health, Health Coverage and Access, +3 More

House Republicans' Medicaid cuts would lead to coverage losses for more than 1.6 million Medicaid enrollees with substance-use disorder, reducing their access to treatment.



The U.S. Capitol is seen in Washington, March 2019). (Getty/Drew Angerer)

The United States has struggled for decades to address the devastating toll of substance-use disorder (SUD), particularly with the opioid crisis that continues

to claim tens of thousands of lives annually. In recent years, health insurance coverage expansions and improved access to treatment have helped millions of Americans both begin and sustain recovery. Remarkably, in 2024, drug overdose deaths fell by nearly 27 percent thanks, in part, to better access to care.

The House Republican "One Big, Beautiful Bill" proposes sweeping Medicaid cuts that threaten to undermine this fragile progress by causing 7.8 million people on the program to lose their insurance. Accordingly, the bill would jeopardize access to services that both prevent substance use and provide treatment for many people with SUD. A new Center for American Progress analysis estimates that, if the bill were to become law, more than 1.6 million individuals with Medicaid-receiving SUD treatment would become uninsured—cutting off their access to lifesaving care. While these estimates reflect the House-passed bill, the Senate's more extreme Medicaid cuts could cause even greater coverage losses and disruptions to care.

Medicaid is a lifeline for people living with substance-use disorder

Medicaid is the largest payer of behavioral health services in the United States, including for SUD treatment. According to the latest available data, Medicaid covered nearly 60 percent of all national spending on SUD treatment in 2019—accounting for $17 billion out of the $30 billion spent across all payers. Medicaid covers a range of SUD treatments and services, including inpatient treatment; outpatient treatment, such as individual and group therapy; medication-assisted treatment; and some forms of naloxone, which can reverse opioid overdoses. Additionally, 36 states and the District of Columbia have approved Section 1115 Medicaid demonstration waivers that allow for expanded SUD treatment options and enable states to provide additional, wraparound services for individuals with SUD to achieve and sustain recovery. For example, one component of West Virginia's waiver authorizes Medicaid coverage for quick-response teams that provide follow-up support to individuals who have experienced an overdose or an SUD-related emergency, ensuring they get connected to care. New Mexico's waiver authorizes supportive housing services, including eviction prevention and move-in assistance for Medicaid enrollees with SUD.

The Affordable Care Act (ACA) improved SUD treatment access by making SUD services one of ten essential health benefits that nearly all insurers are required to cover. The ACA also allowed states to expand Medicaid eligibility to adults with incomes up to 138 percent of the federal-poverty level (FPL), providing millions of previously uninsured low-income adults with access to life-saving SUD treatment. One 2020 study found a 15.7 percentage point rise in the share of patients in SUD programs covered by Medicaid and a corresponding 13.7 point drop in the share of uninsured patients between 2013 and 2017 as a result of the ACA's Medicaid expansion. In 2021, 4.9 million Medicaid enrollees were treated for SUD, 43 percent of whom were adults with coverage under Medicaid expansion.

Uninterrupted access to treatment is essential for individuals with SUD. People who discontinue SUD treatment—especially opioid-use disorder (OUD) treatment—are more likely to overdose or experience adverse health events. Loss of insurance coverage can cause people to discontinue care or force people to rely on costly and otherwise avoidable inpatient-care and emergency-department services.

Medicaid is central addressing to the nation's opioid crisis response

Medicaid coverage is essential for sustaining and advancing the nation's progress in combating OUD and saving lives by preventing overdoses. In 2021, 1.8 million Medicaid enrollees ages 12 and older received treatment for OUD, including more than 420,000 adult enrollees with coverage through the ACA's Medicaid expansion. Expansion states with the highest share of Medicaid SUD enrollees treated for OUD in 2021 included: Rhode Island (61 percent), Maryland (60 percent), West Virginia (58 percent), Vermont (56 percent), and Maine (52 percent). Research shows that Medicaid expansion is associated with declines in opioid overdoses and heroin-related mortality.

Medication-assisted treatment for OUD—such as buprenorphine- and methadone-maintenance treatment—has been associated with decreased mortality. In addition, naltrexone is associated with improved treatment retention. However, cost can be a barrier for accessing these medications, making Medicaid indispensable for low-income individuals seeking recovery. Without Medicaid, these critical benefits would be out of reach for millions of low-income people navigating OUD.

House Republicans' Big, 'Beautiful' Bill could strip coverage from more than 1.6 million Medicaid enrollees in substance-use disorder treatment

The House-passed budget bill would enact several cuts to the Medicaid program that would result in coverage losses. The bulk of those coverage losses would come from the bill's proposed burdensome work-reporting requirements on adults enrolled in Medicaid through the ACA's expansion option. Specifically, the bill would require nonpregnant, nondisabled, noncaregiver adults ages 19 to 64 to document at least 80 hours of work per month or other qualifying activities (such as job training or volunteering) in order to maintain their Medicaid coverage. Individuals unable to meet the requirement would risk losing coverage. The Senate Finance Committee text goes even further, eliminating the exemption and requiring compliance from parents with children older than age 14.

Evidence from previous state-level implementations, including in Arkansas and New Hampshire, shows that work-reporting requirements do not increase employment but, instead, result in large-scale coverage losses among people eligible for Medicaid. The nonpartisan Congressional Budget Office estimates that the bill's work-reporting requirements would cause 4.8 million Medicaid enrollees to become uninsured.

Though the bill includes an exemption for individuals with SUD from work-reporting requirements, it remains unclear how states would implement or enforce that exemption. Past state implementation shows exemptions often fail to protect vulnerable populations from being tripped up by work requirements in practice. In 2018, Arkansas enrollees seeking work-requirement exemptions faced a complex, multistep process—and thousands lost coverage due to red tape.

Table 1 showcases CAP's estimates that more than 1.6 million Medicaid expansion enrollees receiving SUD treatment could become uninsured under the bill, leading to disruption or discontinuation of care.

TABLE 1

More than 1.6 million Medicaid enrollees with substance-use disorder could lose coverage and access to treatment under the House-passed Big, "Beautiful" Bill

Number of Medicaid expansion enrollees treated for a substance-use disorder and estimated number who could lose coverage due to work requirements, by expansion state

Click column heads to sort, or search within the table.

Search in table

State	Number of adult Medicaid expansion enrollees treated for a substance-use disorder, 2021	Estimated coverage losses due to proposed Medicaid work requirements
Alaska	10,788	$8,300
Arizona	93,324	$71,900
Arkansas	8,031	$6,200
California	219,586	$169,100
Colorado	68,818	$53,000
Connecticut	53,634	$41,300
Delaware	12,441	$9,600
District of Columbia	5,604	$4,300
Hawaii	10,526	$8,100
Idaho	-	-
Illinois	134,275	$103,400
Indiana	77,988	$60,100
Iowa	28,973	$22,300

Kentucky	102,314	$78,800
Louisiana	74,854	$57,600
Maine	14,789	$11,400
Maryland	61,384	$47,300
Massachusetts	59,857	$46,100
Michigan	105,550	$81,300
Minnesota	48,210	$37,100
Missouri	6,014	$4,600
Montana	18,254	$14,100
Nebraska	8,697	$6,700
Nevada	34,061	$26,200
New Hampshire	14,892	$11,500
New Jersey	63,240	$48,700
New Mexico	39,746	$30,600
New York	216,166	$166,400
North Carolina	-	-
North Dakota	5,361	$4,100
Ohio	174,684	$134,500
Oklahoma	14,286	$11,000
Oregon	76,773	$59,100
Pennsylvania	153,037	$117,800
Rhode Island	11,257	$8,700
South Dakota	-	-
Utah	19,824	$15,300

Vermont	12,224	$9,400
Virginia	-	-
Washington	165	$100
West Virginia	36,245	$27,900
Total	**2,095,872**	**$1,613,800**

▶ *Note*

Source: Source: Authors' analyis based on data from T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2021 (Washington: 2023); Michael Karpman, Jennifer M. Haley, and Genevieve M. Kenney, Expanding Federal Work Requirements for Medicaid Expansion Coverage to Age 64 Would Increase Coverage Losses, Urban Institute, April 30, 2025.

Table: Center for American Progress

CAP estimates that the states with the largest coverage losses among Medicaid enrollees being treated for SUD include California (nearly 170,000), New York (nearly 166,500), Ohio (134,500), and Pennsylvania (nearly 118,000). These coverage losses reflect the size of each state's Medicaid expansion population as well as each state's rate of SUD treatment take-up among people with Medicaid.

Conclusion

Medicaid is the financial backbone of our nation's behavioral health services infrastructure and provides critical access to care to individuals who need SUD treatment. The House-passed budget bill would cause significant Medicaid coverage losses, and in doing so, could erect new barriers to care for the more than 1.6 million Medicaid expansion enrollees receiving treatment for SUD.

Methodology

To calculate state-level impacts of how coverage losses would be felt by Medicaid enrollees with SUD due to the House-passed budget bill, CAP started with the Urban Institute's April 2025 projection that work requirements for expansion enrollees ages 19 to 64 would cause between 5.5 to 6.3 million people to lose coverage by 2026. Urban's estimate of 5.5 million people losing coverage assumed a 72 percent coverage-loss impact (applied equally to each state) among expansion enrollees ages 19 to 64 subject to work reporting requirements based on Arkansas' experience implementing this policy. Urban's 6.3 million estimate assumed an 82 percent coverage loss impact based on New Hampshire's experience attempting work reporting requirements. CAP applied

those percentages to federal data from 2021 (the most recent year available) on the number of Medicaid expansion enrollees who received SUD treatment that year (roughly 2 million people) by state. CAP then calculated the midpoint of those coverage losses in each state to estimate that more than 1.6 million Medicaid expansion enrollees receiving SUD treatment could become uninsured under the bill, leading to disruption or discontinuation of care.

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HEALTHWATCH

How Trump health agency cuts could impact Alzheimer's research and patients

By **Sara Moniuszko**
Edited By **Sarah Lynch Baldwin**, Paula Cohen
Updated on: April 7, 2025 / 9:31 AM EDT / CBS News



As the Trump administration makes major cuts to federal health agencies, including the National Institutes of Health, some Alzheimer's experts are worried about research for the brain-impairing disease being halted, which could impact treatment options and the lives of patients and their families.

o related programs have had staff placed on
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ell as increasing detection and diagnosis.

ericans everyday," the organization said in a statement,
zheimer's programs, were just unanimously reauthorized

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The association's president and CEO Joanne Pike said these public health programs are critical to those dealing with Alzheimer's and dementia across the country.

"Among other things, they ensure that people living with dementia, caregivers and health providers have the information, resources and support they need," Pike said. "The programs remain intact, but continuing on a path of reducing staff and resources could cause irreversible damage."

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According to the nonprofit Alzheimer's Impact Movement, federal funding for Alzheimer's research accounts for as much as $3.8 billion each year.

"Reduced research funding means we are delaying the development and refinement of treatments that could delay or prevent the onset of dementia symptoms, reducing quality of life and increasing suffering for both patients and families," Jason Krellman, a clinical neuropsychologist and assistant professor at Columbia University Irving Medical Center, told CBS News.

He says this is a crucial time for brain disease research, as drugs are being developed that show potential to treat the underlying causes of Alzheimer's rather than just slowing its symptoms.

"...rogress we are now starting to make toward cures for ... especially problematic because our population is aging ...efore become much more prevalent in the years to

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Cuts could threaten "the entire pipeline"

Lawrence Chernin, CEO and co-founder of Dabble Health, a company focused on cognitive health monitoring, worries funding cuts could leave potentially life-changing innovations behind. He and his team are developing an app that he hopes could give people a "cognitive score," similar to health apps that give sleep scores – but further testing is needed for scientific validatation.

Despite promising data from a pilot study, Chernin said traditional investors often consider tools like theirs "too early and too risky."

"Government funding through NIH and SBIR (Small Business Innovation Research) grants represents the only viable bridge from promising research to clinical validation," he told CBS News, adding that his company recently applied for an SBIR grant.

"Frankly, without this funding, our company may not survive," he said. "These NIH cuts don't just threaten our company; they threaten the entire pipeline of early-stage medical innovations that could transform Alzheimer's care."

SBIR helps fund the NIH's National Institute of Aging, which makes nearly $150 million in grants to small businesses each year. According to the institute, it is the largest source of early-stage funding for aging-related research and development, including interventions for Alzheimer's disease.

And while Chernin recognizes some people think there's a lot of waste in government spending, he says "overall it achieves so much," pointing to breakthroughs in cancer research, for example.

"Now, cancer isn't as terrible, actually, in terms of the scope of diseases like Alzheimer's is, because there are remedies for cancer," he said.

Improving health outcomes for all



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man and chief science officer at biotechnology company
cessfully completed a Phase 2 study, published last month
they've been developing.

"Clearly, we have a president who is changing things big-time in all domains of our lives. ... They want to cut funding and streamline the NIH, that's clear, but I'm not at all convinced that they are anti-health," he told CBS News. Hare said he thinks there will be more funding for areas consistent with the Make America Healthy Again initiative, Department of Health and Human Services Secretary Robert F. Kennedy Jr.'s platform focusing on chronic disease, food additives and other priorities.

So while there will be cuts to certain areas – COVID and DEI-related initiatives are already being hit, for example – Hare said he's not so worried about Alzheimer's research being slashed.

"I can't say that for sure. I'm not in the government. I just listened to the testimony that the new director of NIH gave to Congress in his confirmation hearings, and he specifically addressed Alzheimer's research, and he specifically said that there are avenues of research for Alzheimer's that are underfunded and deserve ongoing funding."

His company has previously received NIH funding for a non-Alzheimer's, pediatrics-related trial, while the Alzheimer's Association entirely funded the Phase 1 trial for Longeveron's Alzheimer's drug, Hare said. "If we didn't have that extraordinary funding from Alzheimer's Association and NIH, the company wouldn't have had been able to progress to where we are now." He said company remains "full steam ahead" on getting its product to those who "need it as quickly as possible."

While the long-term impacts of the cuts remain unclear, Charles J. Fuschillo, Jr, president and CEO of the Alzheimer's Foundation of America, said in a statement to CBS News that bipartisan cooperation is essential in the continued fight against Alzheimer's disease.

"We are grateful that federal policymakers in Congress and the White House worked together in a bipartisan manner over the last decade to deliver essential federal funding increases for Alzheimer's research, and appropriately treated Alzheimer's disease as a growing public health crisis, not a political issue," the statement read. "Building on that progress is vital to ensure we reach the finish line of finding a cure for Alzheimer's."

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(d) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2025.

SEC. 110206. ALLOWANCE OF BRONZE AND CATASTROPHIC PLANS IN CONNECTION WITH HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(2) is amended by adding at the end the following new subparagraph:

''(H) BRONZE AND CATASTROPHIC PLANS TREATED AS HIGH DEDUCTIBLE HEALTH PLANS.—The term 'high deductible health plan' shall include any plan—

''(i) available as individual coverage through an Exchange established under section 1311 or 1321 of the Patient Protection and Affordable Care Act, and

''(ii) described in subsection (d)(1)(A) or (e) of section 1302 of such Act.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to months beginning after December 31, 2025.

SEC. 110207. ON-SITE EMPLOYEE CLINICS.

(a) IN GENERAL.—Section 223(c)(1), as amended by the preceding provisions of this Act, is amended by adding at the end the following new subparagraph:

"(F) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

"(i) IN GENERAL.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in subclauses (I) and (II) of such subparagraph merely because the individual is eligible to receive, or receives, qualified items and services—

"(I) at a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual's spouse), or

"(II) at a healthcare facility operated primarily for the benefit of employees of the employer of the individual (or of the individual's spouse).

"(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—For purposes of this subparagraph, the term 'qualified items and services' means the following:

"(I) Physical examination.

"(II) Immunizations, including injections of antigens provided by employees.

"(III) Drugs or biologicals other than a prescribed drug (as such term is defined in section 213(d)(3)).

"(IV) Treatment for injuries occurring in the course of employment.

"(V) Preventive care for chronic conditions (as defined in clause (iv)).

"(VI) Drug testing.

"(VII) Hearing or vision screenings and related services.

"(iii) AGGREGATION.—For purposes of clause (i), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

"(iv) PREVENTIVE CARE FOR CHRONIC CONDITIONS.—For purposes of this subparagraph, the term 'preventive care for chronic conditions' means any item or service specified in the Appendix of Internal Revenue Service Notice 2019–45 which is prescribed to treat an individual diagnosed with the associated chronic condition specified in such Appendix for the purpose of preventing the exacerbation of such

chronic condition or the development of a secondary condition, including any amendment, addition, removal, or other modification made by the Secretary (pursuant to the authority granted to the Secretary under paragraph (2)(C)) to the items or services specified in such Appendix subsequent to the date of publication of such Notice.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months in taxable years beginning after December 31, 2025.

SEC. 110208. CERTAIN AMOUNTS PAID FOR PHYSICAL ACTIVITY, FITNESS, AND EXERCISE TREATED AS AMOUNTS PAID FOR MEDICAL CARE.

(a) IN GENERAL.—Section 223(d)(2)(A) is amended by adding at the end the following: ''For purposes of this subparagraph, amounts paid for qualified sports and fitness expenses shall be treated as paid for medical care.''.

(b) QUALIFIED SPORTS AND FITNESS EXPENSES.—Section 223(d)(2) is amended by adding at the end the following new subparagraph:

''(E) QUALIFIED SPORTS AND FITNESS EXPENSES.—For purposes of this paragraph—

''(i) IN GENERAL.—The term 'qualified sports and fitness expenses' means amounts paid exclusively for the sole purpose of participating in a physical activity including—

''(I) for membership at a fitness facility, or

''(II) for participation or instruction in physical exercise or physical activity.

''(ii) OVERALL DOLLAR LIMITATION.—

''(I) IN GENERAL.—The aggregate amount treated as qualified sports and fitness expenses with respect to any taxpayer for any taxable year shall not exceed $500 ($1,000 in the case of a joint return or a head of household (as defined in section 2(b))).

''(II) MONTHLY LIMIT.—The amount taken into account under subparagraph (A) as paid for participating in a physical activity during a month beginning during the taxable

year shall not exceed an amount equal to 1/12 of the amount in effect with respect to the taxpayer for the taxable year under subclause (I).

''(iii) FITNESS FACILITY.—For purposes of clause (i)(I), the term 'fitness facility' means a facility—

''(I) which provides instruction in a program of physical exercise, offers facilities for the preservation, maintenance, encouragement, or development of physical fitness, or serves as the site of such a program of a State or local government,

''(II) which is not a private club owned and operated by its members,

''(III) which does not offer golf, hunting, sailing, or riding facilities,

''(IV) the health or fitness component of which is not incidental to its overall function and purpose, and

''(V) which is fully compliant with the State of jurisdiction and Federal anti-discrimination laws.

"(iv) TREATMENT OF PERSONAL TRAINERS, EXERCISE VIDEOS, ETC.—The term 'qualified sports and fitness expenses' shall not include any amount paid for—

"(I) videos, books, or similar materials,

"(II) remote or virtual instruction in a physical exercise or physical activity, unless such instruction is live, or

"(III) one-on-one personal training.

"(v) PROGRAMS WHICH INCLUDE COMPONENTS OTHER THAN PHYSICAL EXERCISE AND PHYSICAL ACTIVITY.—Rules similar to the rules of section 213(d)(6) shall apply in the case of any program that includes physical exercise or physical activity and also other components. For purposes of the preceding sentence, travel and accommodations shall be treated as a separate component.

"(vi) MEMBERSHIP, PARTICIPATION, AND INSTRUCTION MUST BE CONTINUING.—An amount shall not be treated

as paid for the purpose of participating in a physical activity unless—

"(I) in the case of a membership at a fitness facility, such membership is for more than 1 day, and

"(II) in the case of participation or instruction in physical exercise or physical activity, the amount paid constitutes payment for more than 1 occasion of such participation or instruction.

"(vii) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2026, each dollar amount in clause (ii)(I) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2025' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 110209. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under

separate high deductible health plans, only one such coverage shall be taken into account),

''(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

''(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

''(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 110210. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAs.

(a) IN GENERAL.—Section 106(e)(2) is amended to read as follows:

''(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified HSA distribution' means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee contributed directly to a health savings account of such employee if—

''(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) if during the 4-year period preceding the date the employee so establishes coverage the employee was not covered under such a high deductible health plan, and

''(ii) such arrangement is described in section 223(c)(1)(B)(v) with respect to any portion of the plan year remaining after such distribution is made, if such employee remains enrolled in such arrangement.

''(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).''.

(b) PARTIAL REDUCTION OF LIMITATION ON DEDUCTIBLE HSA CONTRIBUTIONS.—Section 223(b)(4) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual

during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).''.

(c) CONVERSION TO HSA-COMPATIBLE ARRANGEMENT FOR REMAINDER OF PLAN YEAR.—Section 223(c)(1)(B), as amended by this preceding provisions of this Act, is amended by striking ''and'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting '', and'', and by adding at the end the following new clause:

''(v) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if

such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year.''.

(d) INCLUSION OF QUALIFIED HSA DISTRIBUTIONS ON W–2.—

(1) IN GENERAL.—Section 6051(a), as amended by the preceding provisions of this Act, is amended by striking ''and'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting '', and'', and by inserting after paragraph (20) the following new paragraph:

''(21) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.''.

(2) CONFORMING AMENDMENT.—Section 6051(a)(12) is amended by inserting ''(other than any qualified HSA distribution, as defined in section 106(e)(2))'' before the comma at the end.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2025.

SEC. 110211. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2), as amended by the preceding provisions of this Act, is amended by adding at the end the following new subparagraph:

''(F) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage beginning after December 31, 2025.

SEC. 110212. CONTRIBUTIONS PERMITTED IF SPOUSE HAS HEALTH FLEXIBLE SPENDING ARRANGEMENT.

(a) CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ARRANGEMENT.—Section 223(c)(1)(B), as amended by this preceding provisions of

this Act, is amended by striking ''and'' at the end of clause (iv), by striking the period at the end of clause (v) and inserting '', and'', and by adding at the end the following new clause:

''(vi) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2025.

SEC. 110213. INCREASE IN HEALTH SAVINGS ACCOUNT CONTRIBUTION LIMITATION FOR CERTAIN INDIVIDUALS.

(a) INCREASE.—

(1) IN GENERAL.—Section 223(b) is amended by adding at the end the following new paragraph:

"(9) INCREASE IN LIMITATION FOR CERTAIN TAXPAYERS.—

"(A) IN GENERAL.—The applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by $4,300 and $8,550, respectively.

"(B) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The amount of the increase under subparagraph (A) (determined without regard to this subparagraph) shall be reduced (but not below zero) by the amount which bears the same ratio to the amount of such increase (as so determined) as—

"(i) the excess (if any) of—

"(I) the taxpayer's adjusted gross income for such taxable year, over

"(II) $75,000 ($150,000 in the case of a joint return, if the eligible individual has family coverage), bears to

"(ii) $25,000 ($50,000 in the case of a joint return, if the eligible individual has family coverage).

For purposes of the preceding sentence, adjusted gross income shall be determined in the same manner as under section 219(g)(3)(A), except determined without regard to any deduction allowed under this section.''.

(2) ONLY TO APPLY TO EMPLOYEE CONTRIBUTIONS.—Section 106(d)(1) is amended by inserting ''and section 223(b)(9)'' after ''determined without regard to this subsection''.

(b) INFLATION ADJUSTMENT.—Section 223(g), as amended by the preceding provisions of this Act, is amended—

(1) by inserting '', (b)(9)(A), (b)(9)(B)(i)(II),'' before ''and (c)(2)(A)'' each place it appears,

(2) by striking ''clauses (ii) and (ii)'' in paragraph (1)(B)(i) and inserting ''clauses (ii), (iii), and (iv)'',

(3) by striking ''and'' at the end of paragraph (1)(B)(ii),

(4) by striking the period at the end of paragraph (1)(B)(iii) and inserting '', and'', and

(5) by inserting after paragraph (1)(B)(iii) the following new clause:

"(iv) in the case of the dollar amounts in subsections (b)(9)(A) and (b)(9)(B)(i)(II), 'calendar year 2025'.".

(c) EFFECTIVE DATE.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2025.

(2) SUBSECTION (b).—The amendments made by subsection (b) shall apply to taxable years beginning after December 31, 2026.

SEC. 110214. REGULATIONS.

The Secretary of the Treasury and the Secretary of Health and Human Services may each prescribe such rules and other guidance as may be necessary or appropriate to carry out the amendments made by this part.

Subtitle B—Make Rural America and Main Street Grow Again

PART 1—EXTENSION OF TAX CUTS AND JOBS ACT REFORMS FOR RURAL AMERICA AND MAIN STREET

SEC. 111001. EXTENSION OF SPECIAL DEPRECIATION ALLOWANCE FOR CERTAIN PROPERTY.

(a) IN GENERAL.—Section 168(k) is amended—

(1) in paragraph (2)—

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Implications of Medicaid Work and Reporting Requirements for Adults with Mental Health or Substance Use Disorders

Heather Saunders (https://www.kff.org/person/heather-saunders/),

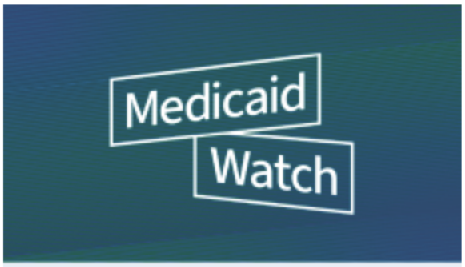
Amaya Diana (https://www.kff.org/person/amaya-diana/),

Elizabeth Hinton (https://www.kff.org/person/elizabeth-hinton/), and

Robin Rudowitz (https://www.kff.org/person/robin-rudowitz/)

Published: Jun 23, 2025

(https://www.kff.org/tag/medicaid-watch/)The House recently passed a budget reconciliation bill (https://www.congress.gov/119/meeting/house/118300/documents/BILLS-119119-3rh.pdf) that includes national Medicaid work requirements (https://www.kff.org/from-drew-altman/making-sense-of-medicaid-work-requirements/) for adults in the Affordable Care Act (ACA) expansion group, which the Congressional Budget Office (CBO) estimates (https://www.cbo.gov/publication/61461) would reduce federal Medicaid spending by $344 billion over ten years and increase the number of people without health insurance by 4.8 million (https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf). On June 16, the Senate Finance (https://www.finance.senate.gov/imo/media/doc/finance_committee_legislative_text_title_vii.pdf) committee released proposed reconciliation language with some substantive changes to the Medicaid work requirement provisions, but this language



This research is part of KFF's Medicaid Watch, featuring policy research, polling, and news about the Medicaid financing debate and related issues. View more.

application, renewal, and every six months thereafter, starting no later than December 31, 2026 or individuals could be denied or disenrolled from coverage. For additional details about this process, see KFF's explainer (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/).

Medicaid plays a large part in coverage and treatment of behavioral health conditions, covering nearly one-third (https://www.kff.org/mental-health/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-mental-illness/) of all adults with mental health disorders and one-fifth of all adults with substance use (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/)disorders; among Medicaid expansion enrollees specifically, 24% have a diagnosed behavioral health condition. Continuous Medicaid coverage supports ongoing (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833436) treatment for mental health and substance use disorders, and disruptions may negatively affect individuals' mental and physical health. Additionally, many adults with mild or moderate conditions already work (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/) or engage in qualifying activities but rely on Medicaid-covered medications and treatments to maintain steady employment. This brief describes key challenges that Medicaid work requirements may pose for adults with mental health or substance use disorders.

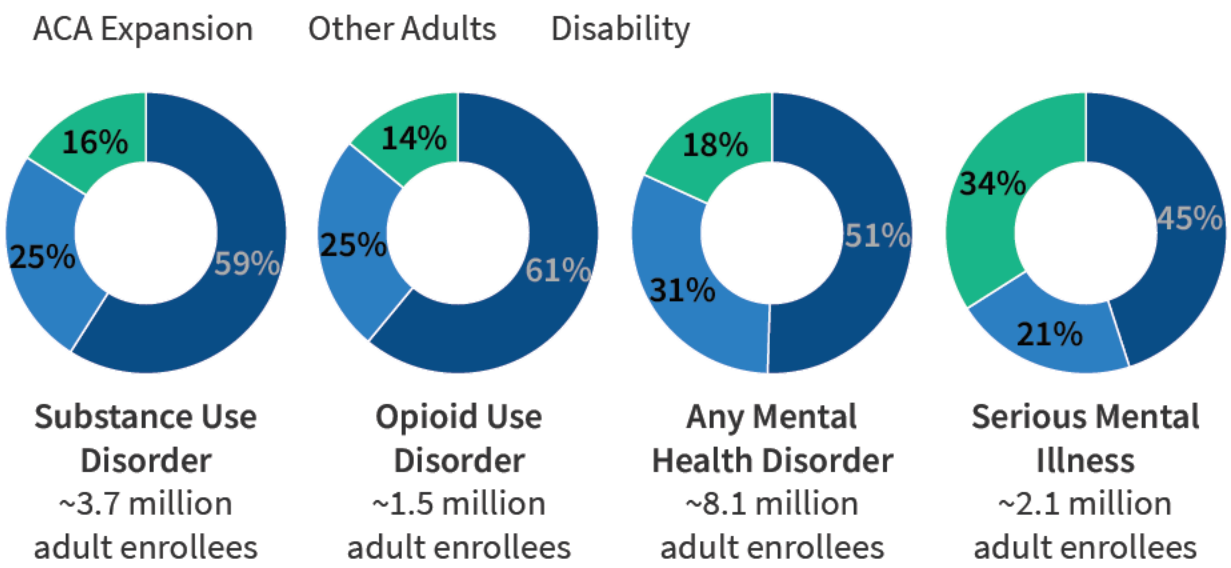
Medicaid expansion is the primary coverage pathway for people with mental health or substance use disorders. Among Medicaid-covered adults diagnosed with a substance use disorder (https://www.kff.org/mental-health/issue-brief/sud-treatment-in-medicaid-variation-by-service-type-demographics-states-and-spending/), 59% qualify through ACA expansion (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/), similar to those with opioid use disorders (https://www.kff.org/medicaid/issue-brief/implications-of-potential-federal-medicaid-reductions-for-addressing-the-opioid-epidemic/) (61%), any mental health disorder (51%), and serious mental illness (45%, defined here as schizophrenia, other psychotic disorders, and bipolar disorders). These shares are higher when limited to ACA Medicaid expansion states (Figure 1). Others qualify for Medicaid by receiving Supplemental Security Income (SSI) for a disability, as a low-income parent, or pregnant/postpartum individual. Although certain serious mental illness diagnoses may qualify for SSI (https://www.kff.org/medicare/issue-brief/the-connection-between-social-security-disability-benefits-and-health-coverage-through-medicaid-and-medicare/), the disability determination process is lengthy (https://www.ssa.gov/faqs/en/questions/KA-01801.html) and complex, and overall two-thirds (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-disabilities/#:~:text=Disability%20is%20defined%20as%20having,%2Dcare%2C%20or%20independent%20living.) of Medicaid enrollees with disabilities qualify through non-disability pathways, such as Medicaid expansion. Substance use disorders alone do not qualify individuals for SSI.

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Distribution of eligibility pathway for Medicaid-covered adults with diagnosed mental health disorder or substance use disorder in all states

All States | ACA Expansion States



Note: MS is excluded due to data quality issues; VA and ID due to unavailable expansion data; and MO due to mid-2021 Medicaid expansion. Denominators include both expansion and non-expansion states. Non-expansion states as of 2021 are AL, GA, FL, KS, NC, SC, SD, TN, TX, WI, and WY. Serious mental illness includes enrollees diagnosed with schizophrenia, other disorders involving psychosis, or bipolar disorder. Any mental illness includes mild, moderate, or severe diagnoses. Substance use disorders include any diagnosed type. Analysis limited to adults ages 19–64 who do not also have Medicare coverage. For methods, see KFF briefs.

Source: KFF Analysis of T-MSIS, 2021 • Get the data • Download PNG

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The House-passed bill (and language proposed by the Senate Finance Committee) specifies exemptions for individuals with substance use disorders or "disabling" mental disorders from Medicaid work requirements under the "medically frail" designation. Participation in a SUD treatment program is also listed as an exemption (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/) in the bill. However, the bill does not explicitly define which diagnoses constitute "disabling" mental disorders. Mental health disorders that substantially impair daily functioning—such as schizophrenia, other disorders involving psychosis, or bipolar disorder—might be among those considered "disabling" mental disorders under the medically frail designation (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-

Federal and state decisions about implementing work requirements may be particularly impactful for adults with mental health or substance use disorders. However, the extent of the impact may depend heavily on how these requirements are defined and operationalized, and many details currently remain unclear**.** Upcoming federal guidance may provide some clarification, but processes could still vary by state. For example, the House bill does not specify (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/) how states would be expected to identify individuals who are exempt or whether/when individuals may be required to self-report or provide documentation to confirm they meet exemption criteria. Potential challenges include:

- **The House bill does not specify states will be required to use available data to automatically verify exemptions, and even states using data may miss some individuals due to data limitations**. While states could cross-reference Medicaid enrollment records with other data sources, such as Medicaid claims, to identify (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/) exemption-qualifying conditions like substance use disorders or certain mental disorders, there is often a delay of weeks or months between a service being delivered and claims being fully processed. The length of this delay may also differ by state and Medicaid managed care organization, the primary way (https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/) most enrollees receive care. Claims further delayed due to disputes, denials, or bundling with other services can further obscure specific diagnoses. These data limitations could leave some exempt individuals unidentified, requiring them to initiate and navigate the state's exemption process. States with outdated or less integrated (https://www.kff.org/policy-watch/implementing-work-requirements-on-a-national-scale-what-we-know-from-state-waiver-experience/) data systems may face additional challenges, potentially increasing reliance on manual reporting—particularly difficult for individuals with mental health or substance use disorders. For example, when Arkansas (https://www.kff.org/policy-watch/implementing-work-requirements-on-a-national-scale-what-we-know-from-state-waiver-experience/) implemented Medicaid work requirements, data-matching identified about two thirds (https://www.kff.org/report-section/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas-key-findings-9243/) of enrollees, exempting them from reporting work hours or exemption status. Among those who had to actively report, about 70% (https://www.urban.org/sites/default/files/2025-03/Assessing-Potential-Coverage-Losses-among-Medicaid-Expansion-Adults-under-a-Federal-Medicaid-Work-Requirement.pdf#:~:text=Range%20based%20on%20enrollee%20reporting%20patterns%20for,the%20work%20reporting%20requirement.%20Estimates%20are%20rounded.) did not obtain an exemption or report compliance with the work requirements, ultimately resulting in over 18,000 people losing coverage. Arkansas is among a subset of states that already makes (https://www.kff.org/report-section/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018-issue-brief/) "medically frail" determinations because they opt to provide an "alternative benefit package" to ACA expansion adults,

led to some individuals with medical conditions or disabilities that prevented them from working to "fall through the cracks" when the state implemented its work policies in 2018.

Common behavioral health symptoms would make it more challenging for individuals with these conditions to self-report work or exemption status. Behavioral health symptoms can include challenges with concentration, planning, energy levels, anxiety, feelings of overwhelm, and difficulties managing stress, all of which may make it harder for enrollees to understand requirements, navigate complex submission processes, and troubleshoot issues that arise. Individuals experiencing severe or acute behavioral health (https://www.kff.org/mental-health/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-mental-illness/) symptoms (https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968#:~:text=Complications,disease%20and%20other%20medical%20conditions) may find it particularly difficult to provide documentation (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/), especially for those whose disorders are compounded by unstable employment, housing instability, or homelessness (https://pmc.ncbi.nlm.nih.gov/articles/PMC8423293/)—which is more common among those with serious mental health disorders or severe substance use disorders. Therefore, mental health and substance use disorders themselves could increase the risk of Medicaid coverage loss under proposed requirements. Provider burden may increase if provider documentation is required to obtain an exemption. Under New Hampshire's work requirement waiver, adults who self-attested to being medically frail were still required to obtain certification (https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf) from a medical professional of their medical frailty exemption, which was reportedly difficult for enrollees to navigate and complicated for providers.

Ray, age 23, was diagnosed with bipolar disorder two years ago. He experiences severe episodes of mania and depression. Although medication helps, it does not eliminate symptoms, and Ray doesn't always take his medications consistently. Maintaining steady employment is often challenging, and Ray is awaiting a determination hearing for his SSI application.

In the Medicaid expansion state where Ray lives, bipolar disorder qualifies as a "disabling" mental disorder, exempting him from Medicaid work requirements. However, the state is unable to automatically verify / data match the exemption, requiring Ray to submit documentation to confirm he is exempt from the requirements.

Last month, Ray received a Medicaid renewal notice reminding him to submit his exemption documentation by May 1st but difficulty filling his prescription led to a medication gap and resulted in a severe depressive episode. During these episodes, Ray struggles with energy, motivation, clarity of thought, and focus, making daily tasks —including submitting paperwork—overwhelming.

Ray did not submit the required documentation by the deadline and Medicaid followed up with a notice of noncompliance a week later, giving him 30 additional days to respond. However, Ray's mental health hadn't improved, and he did not follow up. Shortly after, he went to the emergency room due to persistent suicidal thoughts. At the ER, Ray discovered he had been disenrolled from Medicaid. The ER provided short-term stabilization care and a prescription for medication. He could not afford to fill the medications prescribed by ER doctors.

to regain coverage.

- **Mild and moderate mental health disorders may not qualify adults for exemptions from work requirements; however, symptoms could lead to employment gaps, making compliance with new requirements more difficult.** People with mild or moderate disorders can experience episodic symptoms (https://pmc.ncbi.nlm.nih.gov/articles/PMC7954721/#:~:text=Chronic%20diseases%20associated%20with%20episodic,safety%20obligations%20and%20productivity%20goals.), such as depressive episodes (https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007#:~:text=Loss%20of%20interest%20or%20pleasure,for%20food%20and%20weight%20gain) or severe anxiety, which can disrupt consistent employment. The House bill allows states to provide short-term hardship (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/) exceptions, such as during inpatient psychiatric stays; however, these exceptions are not federally required and must be requested by the enrollee. Additionally, variation in work requirement implementation could further affect compliance. For instance, states that require verification of work history over three consecutive preceding months may present greater compliance challenges compared to states with less stringent criteria.

John has a depressive disorder where he intermittently experiences severe episodes. When his depressive episodes occur, daily tasks become difficult. His medication generally helps manage his depression and maintain employment. His condition is not classified as "disabling," so he must meet Medicaid work requirements (at least 80 hours per month) to maintain coverage in the expansion state where he lives.

John's state verifies every six months that he worked at least 80 hours each month, and chooses to "look-back" the two preceding months when verifying compliance at application and renewal. In May, John experienced a depressive episode that left him unable to meet the 80 hours of work. Following adjustments to his mental health medications and with therapy, he returned to work later the same month, but still fell short of the required 80 hours for that month.

On July 1st, when John's Medicaid renewal and verification of work compliance were due, he was deemed noncompliant because he was unable to meet the 80 hours of work requirements in May. John received a noncompliance notice from the state, and 30 days later, lost Medicaid coverage and access to mental health care. Without coverage or alternative payment options, John is unable to access his medication and treatment services, resulting in a worsening of his mental health condition.

He can reapply for Medicaid after he meets the state's 80-hour monthly work requirements for two consecutive months.

- **Individuals with new or undiagnosed behavioral health disorders may struggle to qualify or maintain Medicaid coverage without sufficient work history or formal diagnoses.** Adults experiencing sudden symptoms, such as a first episode (https://www.webmd.com/schizophrenia/first-episode-psychosis) of psychosis, may face significant difficulties navigating (https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-medicaid-work-requirement-provisions-in-the-big-beautiful-bill/) exemption processes quickly, particularly at the onset of a disorder, which can be confusing and difficult in itself. Additionally, many

diagnosis remain subject to work and reporting requirements, potentially leading to coverage loss if symptoms disrupt employment. Even in states that use Medicaid claims data to identify exemptions, there is typically processing time between service dates and when the visit appears in claims data, which can delay states' identification of individuals with new diagnoses. In addition, applicants with recent employment gaps due to mental health or substance use symptoms may face additional barriers documenting compliance or exemption status at enrollment. For example, Georgia—the only state currently requiring work compliance at Medicaid application—experienced significantly lower enrollment (https://www.kff.org/policy-watch/implementing-work-requirements-on-a-national-scale-what-we-know-from-state-waiver-experience/) than anticipated due to these requirements, though it did not allow (https://www.urban.org/sites/default/files/2025-03/Assessing-Potential-Coverage-Losses-among-Medicaid-Expansion-Adults-under-a-Federal-Medicaid-Work-Requirement.pdf#:~:text=Range%20based%20on%20enrollee%20reporting%20patterns%20for,the%20work%20reporting%20requirement.%20Estimates%20are%20rounded.) any exemptions.

Being (https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/) in poor health is associated with an increased risk of job loss, while access to affordable health supports obtaining and maintaining (https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/) employment. Regular access to care, including mental health and substance use disorder treatment, can help stabilize behavioral health symptoms. However, disruptions or losses in coverage can interrupt treatment, exacerbating these conditions. For instance, stopping medication for opioid use disorder significantly increases mortality risk, with individuals facing a six-fold greater risk of death in the four (https://pubmed.ncbi.nlm.nih.gov/34076676/) weeks immediately following treatment discontinuation.

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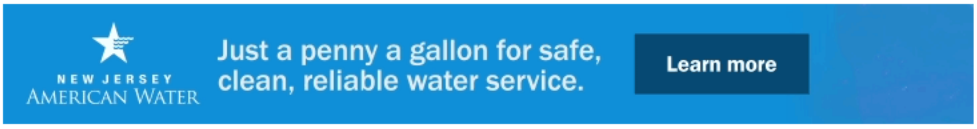
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Breaking News: CNN Report: U.S. Strikes Iran(https://www.insidernj.com/cnn-report-u-s-strikes-iran)



NEWS

ry Kennedy for Gutting Ground Zero Firefighters and 9/11

By In… …n News (https://www.insidernj.com/category/news)



Wednesday, **Senator Andy Kim (D-NJ)** (https://www.kim.senate.gov/) confronted Health and Human Services Secretary Robert F. Kennedy Jr. for gutting the World Trade Center Health Program which provides medical monitoring and treatment for 9/11 first responders and survivors of the deadly terrorist attacks. During his question line, Senator Kim upheld his promise to voice the anger of a fire captain in New Jersey who was diagnosed with cancer and spoke out at a recent town hall in Chatham against cuts to the program.

When Senator Kim pressed on why the cuts were made, **Secretary Kennedy said,** "We try to be as careful as we can about what we cut and what we didn't. We made a couple of mistakes."

Senator Kim responded, "I don't think you were trying to be as careful as you can. That's the problem that we've seen by rushing these decisions."

He went on to demand that Secretary Kennedy promise that the program's staffing would be returned to what it was before he became Secretary, but Secretary Kennedy refused to confirm it would be continued at full strength.

VIDEO OF FULL QUESTION LINE (https://youtu.be/Eloh9gd4UIw)

Senator Kim continued to amplify the fire captain's concerns, including by asking why the National Firefighter Cancer Registry was shut down and no longer allows firefighters to enroll. The registry was a federal initiative to study and reduce cancer among firefighters before being shut down when the Trump administration gutted the National Institute for Occupational Safety and Health.

Secretary Kennedy responded, "I don't know about that."

Secretary Kennedy agreed to work with the Senator to try and get the registry back up and running as soon as possible.

Senator Kim concluded his question line by calling for bipartisan agreement to support heroes at the World Trade Center, stating, "If we can't even agree on that, if that is not seen as a high enough priority then I am worried about everything else."

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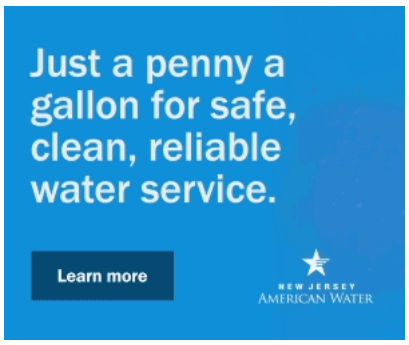
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Lea County resident tests positive for measles after death

March 6, 2025 - Measles - Alert

SANTA FE – The New Mexico Department of Health (NMDOH) confirms that a deceased resident of Lea County, who was unvaccinated, tested positive for measles.

The official cause of death is still under investigation by the New Mexico Office of the Medical Investigator. However, NMDOH Scientific Laboratory has confirmed the presence of the measles virus. The individual did not seek medical care before passing.

Measles is a highly contagious respiratory illness that can cause severe complications. One in five cases requires hospitalization, and approximately three in every 1,000 cases result in death.

The only prevention for the highly contagious respiratory illness is vaccination. With ongoing exposures in Lea County, NMDOH urges residents to get vaccinated to protect themselves and their families.

“We don’t want to see New Mexicans getting sick or dying from measles,” said **Dr. Chad Smelser**, NMDOH Deputy State Epidemiologist. “The measles-mumps-rubella (MMR) vaccine is the best protection against this serious disease.”

To support community protection, NMDOH has scheduled free measles vaccination clinics in Lea County on Tuesday, March 11:

- 9 a.m. — 3 p.m. at the Hobbs Public Health Office, 1923 N. Dal Paso.
- 9 a.m. — 3 p.m. at the Lovington Public Health Office, 302 N. 5th Street.

If you have symptoms, call before visiting. Staff will provide guidance based on symptom severity:

- Hobbs Office (575) 397-2463.
- Lovington Office (575) 396-2853.

Anyone with measles-related questions – such as about symptoms or vaccinations – is asked to call the NMDOH Helpline at 1-833-796-8773. The Helpline is staffed by nurses

able to provide guidance in English and in Spanish.

More information is available on the NMDOH website at http://measles.doh.nm.gov.

This new case brings the total number of cases in the measles outbreak to 10. All cases have been residents of Lea County. Cases have included six adults and four children under the age of 17. Seven of the cases were unvaccinated, while the remaining three have unknown vaccination histories.

Media Contact

We would be happy to provide additional information about this press release. Simply contact David Morgan at 575-528-5197 (Office) or 575-649-0754 (Mobile) with your questions.

Versión en Español

En un esfuerzo para hacer que nuestros comunicados de prensa sean más accesibles, también tenemos disponibles una versión en español. Por favor presione el enlace de abajo para acceder a la traducción.

Muerte Reportada por Sarampión en el Condado de Lea

PRESS RELEASE

LAC Opposes Senate's Proposed Reconciliation Package, Emphasizing Harms of Medicaid and SNAP Funding Cuts

June 17, 2025

The U.S. Senate Finance and Agriculture Committees released their reconciliation text that, like the House-passed reconciliation bill, would effectuate the largest cut to Medicaid in the program's history and make fundamental and drastic changes to the Supplemental Nutrition Assistance Program (SNAP) if enacted.

Even more so than the House-passed bill, these Senate proposals would terminate access to lifesaving health care and food assistance for low-income individuals and families to pay for tax cuts that overwhelmingly benefit the wealthiest Americans and corporations.

As the single largest payer for mental health (MH) and substance use disorder (SUD) care in the country, Medicaid has played a critical role in providing access to treatment and services for those with MH and SUD conditions. Cutting Medicaid will only make addressing the overdose crisis even more challenging.

The Senate Finance Committee proposal's cuts are deeper than the House-passed one, almost certainly resulting in even more people losing coverage than the Congressional Budget Office (CBO) estimated for the House bill. The CBO estimates 16 million people would lose health coverage if the House passed legislation becomes law, including 7.8 million people who currently get their health insurance through Medicaid. The loss of coverage — and lives — under this new draft is going to be devastating.

While the House-passed bill contained provisions targeted at states with large populations and more robust safety net programs, like New York and California, the Senate Finance Committee's proposal goes even further by targeting the 40 states and the District of Columbia that expanded Medicaid with even deeper Medicaid cuts.

The draconian cuts to the Medicaid program in the form of new work requirements in the House-passed bill was made even worse in the Senate proposal by expanding the requirement to parents of dependents over the age of 14 (as opposed to no age limit in the House bill). The history of Medicaid work requirements in states that have implemented them indicates that these requirements do not lead to more people working or increased economic mobility – rather, they lead to people losing coverage, making it more difficult for them to work. Far from simply addressing "fraud, waste, and abuse" as claimed, if either the House-passed bill or Senate proposal is enacted,

millions of eligible people will lose their Medicaid benefits due to the complexities of navigating bureaucratic red tape to prove hours worked or qualification for an exemption. These significant coverage losses are why the work requirement provision in the House-passed bill has a projected “savings” of $344 billion. That is the savings expected because people who have access to healthcare today will lose that coverage if either of these proposals become law.

While the proposed cuts to SNAP in the Senate Agriculture Committee’s text are not as far-reaching as the House-passed bill, the Senate proposal would still fundamentally alter the nature of SNAP by shifting costs to states that have historically been picked up by the federal government and putting significant pressure on already strained state budgets.

The Legal Action Center champions the rights of individuals with arrest and conviction records, substance use disorders, and HIV/AIDS — populations that will be disproportionately impacted by these harmful policies given the pervasive stigma and discrimination faced by many of these individuals that make securing and maintaining employment more challenging.

We are disappointed and disheartened that the Senate Finance Committee ignored the significant majority of the public who are opposed to and worried about the potential impacts of federal funding cuts to Medicaid. Rather than reject the House-passed reconciliation bill or propose a moderated version, the Senate Finance Committee decided to make it worse.

We urge the millions of people across this country who have been speaking up and making their voices heard to continue to do so and let the Senate know their proposal to cut Medicaid even further is unacceptable and just plain wrong. **This fight is not over — we can defeat this draconian legislation if we keep speaking up, sharing our stories, and fighting to protect Medicaid and SNAP.**

***

Media contact below:

Arianne Keegan, Director of Communications
Legal Action Center
communications@lac.org
(212) 243-1313

***

United States Senate

WASHINGTON, DC 20510

June 12, 2025

The Honorable Donald Trump
President of the United States of America
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20515

The Honorable Mike Johnson
Speaker of the House
US House of Representatives
Washington, DC 20515

Dear President Trump, Leader Thune, and Speaker Johnson,

In May, Republicans in the U.S. House of Representatives passed a reconciliation package that, if enacted, will impose the largest cuts to health care in United States history, slashing funding for Medicaid and the Affordable Care Act by more than $1 trillion and triggering more than $500 billion in Medicare cuts. Republicans' cuts to Medicaid and the Affordable Care Act will cause 16 million people in the U.S. to lose health insurance coverage. A majority of adults living in rural areas are concerned that these health care cuts will "negatively impact hospitals, nursing homes, and other health care providers in [their] community."[1] They are right to be worried, as these cuts will have devastating consequences for health outcomes and costs, jobs, and the economic success of rural communities. Today, we write to provide you with detailed information about rural hospitals that are uniquely at risk of financial distress and even closure, conversion, or service reductions because of the cuts in the House-passed reconciliation package. The information provided by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina (Sheps Center) illustrates what your party's reconciliation bill will mean for the health of Americans living in rural communities.

Enacting these drastic health care cuts that will kick millions of people off their health insurance coverage, rural hospitals will not get paid for the services they are required by law to provide to patients. In turn, rural hospitals will face deeper financial strain that could lead to negative health outcomes for the communities they serve. Already, rural hospitals are struggling: in 2023, there were 50 fewer rural hospitals than in 2017, and lack of health care access in rural America is contributing to worse health outcomes.[2] Faced with additional cuts to their revenue, many rural hospitals may be forced to stop providing certain services, including obstetric, mental

[1] Audrey Kearney, et al., *KFF Tracking Poll: The Public's View of Funding Reductions to Medicaid*, KFF (June 6, 2025), https://www kff.org/medicaid/poll-finding/kff-health-tracking-poll-the-publics-views-of-funding-reductions-to-medicaid/.

health, and emergency room care, may have to convert to clinics or standalone emergency centers, or close altogether. Rural hospitals are often the largest employers in rural communities, and when a rural hospital closes or scales back its services, communities are not only forced to grapple with losing access to health care, but also with job loss and the resulting financial insecurity.[3]

In order to understand in greater detail how rural communities could be impacted by health care cuts contained in the reconciliation package, we requested the attached data from the Sheps Center on the financial vulnerability of rural hospitals and potential impacts on their viability.[4] These hospitals have been identified as at-risk hospitals based on financial data, including: whether the hospital has been unprofitable for the last three years; whether the hospital is at risk of financial distress relative to peer hospitals; and whether the hospital serves a disproportionately high share of Medicaid patients. The findings demonstrate that hundreds of rural hospitals across the country would feel pain from the House-passed reconciliation bill. Altogether, 338 hospitals either experienced three consecutive years of negative total margins, serve the highest share of Medicaid patients or both.[5] 83 rural hospitals are at the highest relative risk of financial distress based on a model that uses hospital financial performance, organizational trains, and market characteristics to predict future financial distress.[6]

Republican health care cuts would be felt by rural hospitals across the country. In Louisiana, 32 rural hospitals—or a majority of rural hospitals in the state—are serving a high concentration of Medicaid patients. A total of 33 hospitals are at risk based on serving a high share of Medicaid patients, experiencing negative total margins, or both. In Alaska and Kentucky, 44 percent of the rural hospitals with available Medicaid payer mix data serve high concentrations of Medicaid patients. In West Virginia, nearly a quarter of rural hospitals are serving high concentrations of Medicaid patients, and 15 percent of rural hospitals are at the highest relative risk of financial distress, per the financial distress index. In Alabama, 8 rural hospitals—nearly 20 percent of rural hospitals with available data—are in the highest relative risk category of financial distress. In Tennessee, 9 rural hospitals—or 18 percent of rural hospitals in the state with available data—have experienced 3 years of negative total margins, and 9 rural hospitals are at highest relative risk of financial distress. In short, many of these rural

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[2] Zachary Levinson, et al., *Key Facts About Hospitals*, KFF (Feb. 19, 2025) https://www.kff.org/key-facts-about-hospitals/?entry=national-hospital-spending-national-spending-on-hospital-care; Jazmin Orozco Rodriguez, *Rural Americans are way more likely to die young. Why?* The Washington Post (Apr. 15, 2024), https://www.washingtonpost.com/politics/2024/04/15/rural-americans-are-way-more-likely-die-young-why/.

[3] Anil Rupasingha and Julia Cho, *Federal Assistance and Rural Hospital Closings: The Impact of the USDA Community Facilities Program*, US Dept. of Agriculture Economic Research Service (Jan. 2025), https://ers.usda.gov/sites/default/files/_laserfiche/publications/110766/ERR-344.pdf?v=54249; Carol A. Mills, et al., *The impact of rural general hospital closures on communities – A systematic review of the literature*, The Journal of Rural Health (Nov. 20, 2023), https://onlinelibrary.wiley.com/doi/10.1111/jrh.12810.

[4] See attached.

[5] Looking to each individual financial indicator: 133 rural hospitals experienced three consecutive years of negative total margins, 213 rural hospitals serve the highest share of Medicaid patients. There is some overlap.

[6] Tyler Malone, et al., *An Updated Model of Rural Hospital Financial Distress*, The J. of Rural Health (Oct. 3, 2024), https://onlinelibrary.wiley.com/doi/10.1111/jrh.12882 (Names of these hospitals have not been provided).

hospitals are facing financial instability today, even before any of the Republican health care cuts take effect. Rural hospitals will be disproportionately impacted by health care cuts.

Addressing the crisis in rural health care access is a national, bipartisan priority,[7] and it should be bipartisan to not worsen it. However, if your party passes these health care cuts into law, Americans in rural communities across the country risk losing health care services and jobs supported by their local hospitals. We urge you to read the attached report and reconsider your position. It is not too late to stop these cuts. Billionaire tax breaks are not worth the cost to American lives and livelihoods.

Sincerely,

Edward J. Markey
United States Senator

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

Jeffrey A. Merkley
United States Senator
Ranking Member, Committee on Budget

Charles E. Schumer
United States Senator

[7] Hearing: Rural Health Care: Supporting Lives and Improving Communities, US Senate Finance Committee (May 16, 2024), https://www.finance.senate.gov/hearings/rural-health-care-supporting-lives-and-improving-communities; Hearing: Improving Health Care Access in Rural Communities: Obstacles and Opportunities, US Senate Finance Subcommittee on Health Care (May 17, 2023), https://www.finance.senate.gov/hearings/improving-health-care-access-in-rural-communities-obstacles-and-opportunities; Hearing: A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities, US Senate Health, Education, Labor, and Pensions Subcommittee on Primary Health and Retirement Security (May 17, 2023), https://www.help.senate.gov/hearings/a-crisis-in-mental-health-and-substance-use-disorder-care-closing-gaps-in-access-by-bringing-care-and-prevention-to-communities.

OFFICE OF SENATOR EDWARD J. MARKEY

NUMBER OF AT-RISK RURAL HOSPITALS PER STATE

"Substantial cuts to Medicaid or Medicare payments could increase the number of unprofitable rural hospitals and elevate their risk of financial distress. In response, hospitals may be forced to reduce service lines, convert to a different type of health care facility, or close altogether." - Dr. Holmes, Malone, and Pink, Cecil G. Sheps Center for Health Services Research, University of North Carolina

The following is the number of hospitals that meet one or both of two financial criteria: (1) the hospital is in the top 10% Medicaid payer mix of rural hospitals across the country, (2) the hospital has experienced three consecutive years of negative total margin. This means these rural hospitals face greater risk of being forced to stop providing some services, converting, or closing.

STATE	NUMBER OF AT-RISK RURAL HOSPITALS
ALABAMA	5
ALASKA	5
ARIZONA	5
ARKANSAS	1
CALIFORNIA	28
COLORADO	6
CONNECTICUT	1
DELAWARE	1
FLORIDA	1
GEORGIA	4
HAWAII	6
IDAHO	3
ILLINOIS	9
INDIANA	12
IOWA	2
KANSAS	6
KENTUCKY	35
LOUISIANA	33
MAINE	2
MASSACHUSETTS	1
MICHIGAN	4
MINNESOTA	2
MISSISSIPPI	8
MISSOURI	4
MONTANA	8
NEBRASKA	2
NEVADA	2
NEW HAMPSHIRE	1
NEW MEXICO	15
NEW YORK	11
NORTH CAROLINA	5
NORTH DAKOTA	3
OHIO	11
OKLAHOMA	21
OREGON	4
PENNSYLVANIA	5
SOUTH CAROLINA	5
SOUTH DAKOTA	2
TENNESSEE	9
TEXAS	15
UTAH	3
VIRGINIA	6
WASHINGTON	14
WEST VIRGINIA	7
WISCONSIN	3
WYOMING	2
TOTAL	**338**

AT-RISK RURAL HOSPITALS LIST

The following is a list of at-risk rural hospitals identified based on two financial criteria: (1) the hospital is in the top 10% Medicaid payer mix of rural hospitals across the country, (2) the hospital has experienced three consecutive years of negative total margin. The Sheps Center evaluated hospitals based on Financial Distress Index data, but individualized data on that measure was not provided.

		HOSPITAL NAME	CITY	CONGRESSIONAL DISTRICT	STATE	TOP MEDICAID PROVIDER	THREE YEARS NEGATIVE MARGINS
ALASKA	5	PROVIDENCE VALDEZ MEDICAL CENTER	VALDEZ	AK-00	AK	X	0
		PROVIDENCE SEWARD MEDICAL & CARE CEN	SEWARD	AK-00	AK	X	0
		PROV. KODIAK ISLAND MEDICAL CENTER	KODIAK	AK-00	AK	X	0
		CORDOVA COMMUNITY MEDICAL CENTER	CORDOVA	AK-00	AK	X	0
		KETCHIKAN MEDICAL CENTER	KETCHIKAN	AK-00	AK	0	X
ALABAMA	5	COMMUNITY HOSPITAL INC.	TALLASSEE	AL-02	AL	0	X
		MARION REGIONAL MEDICAL CENTER	HAMILTON	AL-04	AL	0	X
		LAWRENCE MEDICAL CENTER	MOULTON	AL-04	AL	0	X
		BULLOCK COUNTY HOSPITAL	UNION SPRINGS	AL-02	AL	X	0
		HILL HOSPITAL OF SUMTER COUNTY	YORK	AL-07	AL	X	0
ARKANSAS	1	WADLEY MEDICAL CENTER AT HOPE	HOPE	AR-04	AR	0	X
ARIZONA	5	PAGE HOSPITAL	PAGE	AZ-02	AZ	X	0
		WINSLOW MEMORIAL HOSPITAL	WINSLOW	AZ-02	AZ	X	0
		COPPER QUEEN COMM. HOSP.	BISBEE	AZ-07	AZ	X	0
		CARONDELET HOLY CROSS HOSPITAL	NOGALES	AZ-07	AZ	X	0
		COBRE VALLEY REG. MEDICAL CENTER	GLOBE	AZ-02	AZ	X	0
CALIFORNIA	28	ADVENTIST HEALTH ST. HELENA	ST. HELENA	CA-04	CA	0	X
		MAD RIVER COMMUNITY HOSPITAL	ARCATA	CA-02	CA	X	0
		OROVILLE HOSPITAL	OROVILLE	CA-01	CA	X	0
		ST ELIZABETH COMMUNITY HOSPTIAL	RED BLUFF	CA-01	CA	X	0
		ADVENTIST HEALTH REEDLEY	REEDLEY	CA-21	CA	X	0
		HI - DESERT MEDICAL CENTER	JOSHUA TREE	CA-23	CA	X	0
		BARSTOW COMMUNITY HOSPITAL	BARSTOW	CA-23	CA	X	0
		ADVENTIST HEALTH UKIAH VALLEY	UKIAH	CA-02	CA	X	0
		PIONEERS MEM. HOSPITAL	BRAWLEY	CA-25	CA	X	0
		MEMORIAL HOSPITAL - LOS BANOS	LOS BANOS	CA-13	CA	X	0
		EASTERN PLUMAS HEALTH CARE	PORTOLA	CA-03	CA	X	0
		ADVENTIST HEALTH TEHACHAPI VALLEY	TEHACHAPI	CA-20	CA	X	0
		SOUTHERN INYO HOSPITAL	LONE PINE	CA-03	CA	X	0
		JOHN C. FREMONT HEALTHCARE DISTRICT	MARIPOSA	CA-05	CA	0	X
		MAYERS MEMORIAL HOSPITAL	FALL RIVER MILLS	CA-01	CA	X	0
		JEROLD PHELPS COMMUNITY HOSPITAL	GARBERVILLE	CA-02	CA	X	0
		BIGGS-GRIDLEY MEMORIAL HOSPITAL	GRIDLEY	CA-01	CA	X	0
		MOUNTAINS COMMUNITY HOSPITAL	LAKE ARROWHEAD	CA-23	CA	X	0
		KERN VALLEY HEALTHCARE DISTRICT	LAKE ISABELLA	CA-20	CA	X	0
		TRINITY HOSPITAL	WEAVERVILLE	CA-02	CA	X	0
		FAIRCHILD MEDICAL CENTER	YREKA	CA-01	CA	X	0
		ADVENTIST HEALTH CLEARLAKE	CLEARLAKE	CA-04	CA	X	0
		SUTTER LAKESIDE HOSPITAL	LAKEPORT	CA-04	CA	X	0
		MODOC MEDICAL CENTER	ALTURAS	CA-01	CA	X	0
		BEAR VALLEY COMMUNITY HOSPITAL	BIG BEAR	CA-23	CA	X	0
		MEE MEMORIAL HOSPITAL	KING CITY	CA-18	CA	X	0
		HAZEL HAWKINS MEM. HOSPITAL	HOLLISTER	CA-18	CA	X	0
		COALINGA REGIONAL MEDICAL CENTER	COALINGA	CA-13	CA	X	
COLORADO	6	DELTA COUNTY MEMORIAL HOSPITAL	DELTA	CO-03	CO	0	X

		CONEJOS COUNTY HOSPITAL	LA JARA	CO-03	CO	X	0
		GRAND RIVER HOSPITAL DISTRICT	RIFLE	CO-03	CO	X	0
		PROWERS MEDICAL CENTER	LAMAR	CO-04	CO	X	0
		SOUTHWEST MEMORIAL HOSPITAL	CORTEZ	CO-03	CO	X	0
		ARKANSAS VALLEY REGL MED CTR	LA JUNTA	CO-03	CO	X	0
CONNECTICUT	1	SHARON HOSPITAL	SHARON	CT-05	CT	0	X
DELAWARE	1	NANTICOKE MEMORIAL HOSPITAL	SEAFORD	DE-00	DE	0	X
FLORIDA	1	LAKESIDE MEDICAL CENTER	BELLE GLADE	FL-20	FL	X	0
GEORGIA	4	WASHINGTON CO REG MED CTR	SANDERSVILLE	GA-12	GA	0	X
		IRWIN COUNTY HOSPITAL	OCILLA	GA-08	GA	X	X
		FANNIN REGIONAL HOSPITAL	BLUE RIDGE	GA-09	GA	0	X
		FLINT RIVER COMMUNITY HOSPITAL	MONTEZUMA	GA-02	GA	X	0
HAWAII	6	KAU HOSPITAL	PAHALA	HI-02	HI	X	0
		KOHALA HOSPITAL	KAPAAU	HI-02	HI	X	0
		MOLOKAI GENERAL HOSPITAL	KAUNAKAKAI	HI-02	HI	X	0
		LANAI COMMUNITY HOSPITAL	LANAI	HI-02	HI	0	X
		SAMUEL MAHELONA MEMORIAL HOSPITAL	KAPAA KAUAI	HI-02	HI	X	0
		HALE HOOLA HAMAKUA	HONOKAA	HI-02	HI	X	0
IOWA	2	MERCYONE - NEWTON MEDICAL CENTER	NEWTON	IA-01	IA	0	X
		MANNING REGIONAL HEALTHCARE CENTER	MANNING	IA-04	IA	X	0
IDAHO	3	POWER COUNTY HOSPITAL DISTRICT	AMERICAN FALLS	ID-02	ID	X	0
		ST. LUKES JEROME LTD	JEROME	ID-02	ID	X	0
		CASSIA REGIONAL HOSPITAL	BURLEY	ID-02	ID	X	0
ILLINOIS	9	KATHERINE SHAW BETHEA HOSPITAL	DIXON	IL-16	IL	0	X
		OSF SACRED HEART MEDICAL CENTER	DANVILLE	IL-02	IL	0	X
		RICHLAND MEMORIAL HOSPITAL	OLNEY	IL-12	IL	0	X
		HARRISBURG MEDICAL CENTER INC.	HARRISBURG	IL-12	IL	X	0
		HOOPESTON COMMUNITY MEMORIAL HOSPITA	HOOPSETON	IL-02	IL	0	X
		FRANKLIN HOSPITAL	BENTON	IL-12	IL	X	0
		MASSAC MEMORIAL HOSPITAL	METROPOLIS	IL-12	IL	X	0
		HARDIN COUNTY GENERAL HOSPITAL	ROSICLARE	IL-12	IL	X	0
		CRAWFORD MEMORIAL HOSPITAL	ROBINSON	IL-12	IL	X	0
INDIANA	12	DAVIESS COMMUNITY HOSPITAL	WASHINGTON	IN-08	IN	0	X
		MEMORIAL HOSPITAL LOGANSPORT	LOGANSPORT	IN-04	IN	0	X
		COMMUNITY HOSPITAL OF BREMEN INC.	BREMEN	IN-02	IN	0	X
		ASCENSION ST. VINCENT RANDOLPH	WINCHESTER	IN-03	IN	X	0
		ASCENSION ST. VINCENT JENNINGS	NORTH VERNON	IN-09	IN	X	0
		ASCENSION ST. VINCENT CLAY	BRAZIL	IN-08	IN	X	0
		ASCENSION ST VINCENT SALEM	SALEM	IN-09	IN	X	0
		IU HEALTH JAY HOSPITAL	PORTLAND	IN-03	IN	0	X
		FRANCISCAN HEALTH RENSSELAER	RENSSELAER	IN-04	IN	0	X
		SULLIVAN COUNTY COMMUNITY HOSPITAL	SULLIVAN	IN-08	IN	X	0
		ADAMS MEMORIAL HOSPITAL	DECATUR	IN-03	IN	0	X
		HARRISON COUNTY HOSPITAL	CORYDON	IN-09	IN	0	X
KANSAS	6	CENTURA BOB WILSON MEMORIAL HOSPITAL	ULYSSES	KS-01	KS	0	X
		UKHS GREAT BEND CAMPUS	GREAT BEND	KS-01	KS	0	X
		KIOWA COUNTY MEMORIAL HOSPTIAL	GREENSBURG	KS-04	KS	0	X
		RUSH COUNTY MEMORIAL HOSPITAL	LACROSSE	KS-01	KS	0	X
		NORTON COUNTY HOSPITAL	NORTON	KS-01	KS	0	X
		GREAT PLAINS OF SMITH CO. INC	SMITH CENTER	KS-01	KS	0	X
KENTUCKY	35	WHITESBURG ARH	WHITESBURG	KY-05	KY	X	0

	HIGHLANDS REGIONAL MEDICAL CENTER	PRESTONSBURG	KY-05	KY	X	0
	UOFL HEALTH-SHELBYVILLE	SHELBYVILLE	KY-04	KY	0	X
	T.J. SAMSON COMMUNITY HOSPITAL	GLASGOW	KY-02	KY	X	0
	ST. CLAIRE MEDICAL CENTER	MOREHEAD	KY-05	KY	X	0
	MIDDLESBORO ARH	MIDDLESBORO	KY-05	KY	X	0
	SPRING VIEW HOSPITAL	LEBANON	KY-01	KY	X	0
	ADVENTHEALTH MANCHESTER	MANCHESTER	KY-05	KY	X	X
	BOURBON COMMUNITY HOSPITAL	PARIS	KY-06	KY	X	0
	HARLAN ARH	HARLAN	KY-05	KY	X	0
	DEACONESS HENDERSON HOSPITAL	HENDERSON	KY-01	KY	X	0
	SAINT JOSEPH MOUNT STERLING	MT. STERLING	KY-06	KY	X	X
	TUG VALLEY ARH	SOUTH WILLIAMSOI	KY-05	KY	X	0
	OWENSBORO HEALTH TWIN LAKES MEDICAL	LEITCHFIELD	KY-02	KY	X	0
	BAPTIST HEALTH CORBIN	CORBIN	KY-05	KY	X	0
	CLARK REGIONAL MEDICAL CENTER	WINCHESTER	KY-06	KY	X	0
	BAPTIST HEALTH MADISONVILLE	MADISONVILLE	KY-01	KY	0	X
	THE MEDICAL CENTER OF ALBANY	ALBANY	KY-01	KY	X	0
	THREE RIVERS MEDICAL CENTER	LOUISA	KY-05	KY	X	0
	KENTUCKY RIVER MEDICAL CENTER	JACKSON	KY-05	KY	X	0
	TJ HEALTH COLUMBIA	COLUMBIA	KY-01	KY	X	0
	PINEVILLE COMMUNITY HEALTH CENTER	PINEVILLE	KY-05	KY	0	X
	MARCUM & WALLACE MEMORIAL HOSPITAL	IRVINE	KY-06	KY	X	0
	OUR LADY OF THE WAY	MARTIN	KY-05	KY	X	0
	CASEY COUNTY HOSPITAL	LIBERTY	KY-01	KY	X	0
	CARROLL COUNTY MEMORIAL HOSP	CARROLLTON	KY-04	KY	X	0
	THE MEDICAL CENTER AT CAVERNA	HORSE CAVE	KY-02	KY	X	0
	FORT LOGAN HOSPITAL	STANFORD	KY-05	KY	X	0
	MARY BRECKINRIDGE HOSPITAL	HYDEN	KY-05	KY	X	0
	JANE TODD CRAWFORD HOSPITAL	GREENSBURG	KY-02	KY	X	0
	BARBOURVILLE ARH HOSPITAL	BARBOURVILLE	KY-05	KY	X	0
	SAINT JOSEPH BEREA	BEREA	KY-06	KY	X	0
	RUSSELL COUNTY HOSPITAL	RUSSELL SPRINGS	KY-01	KY	X	0
	MCDOWELL ARH	MCDOWELL	KY-05	KY	X	0
	FLEMING COUNTY HOSPITAL	FLEMINGSBURG	KY-06	KY	X	0
LOUISIANA	**33** OCHSNER ST. MARY	MORGAN CITY	LA-03	LA	X	0
	SAVOY MEDICAL MANAGEMENT GROUP INC.	MAMOU	LA-04	LA	X	0
	IBERIA MEDICAL CENTER	NEW IBERIA	LA-03	LA	X	0
	WEST CARROLL HEALTH SYSTEMS LLC	OAK GROVE	LA-05	LA	X	0
	NORTH LOUISIANA MEDICAL CENTER	RUSTON	LA-05	LA	X	0
	WINN PARISH MEDICAL CENTER	WINNFIELD	LA-05	LA	X	0
	AVOYELLES HOSPITAL	MARKSVILLE	LA-05	LA	X	0
	OAKDALE COMMUNITY HOSPITAL	OAKDALE	LA-04	LA	X	0
	MOREHOUSE GENERAL HOSPITAL	BASTROP	LA-05	LA	X	0
	DESOTO REGIONAL HEALTH SYSTEM	MANSFIELD	LA-04	LA	X	0
	ALLEN PARISH HOSPITAL	KINDER	LA-04	LA	X	0
	FRANKLIN MEDICAL CENTER	WINNSBORO	LA-05	LA	X	0
	MINDEN MEDICAL CENTER	MINDEN	LA-04	LA	X	0
	RICHLAND PARISH HOSPITAL SERVICE DIS	RAYVILLE	LA-05	LA	X	0
	BYRD REGIONAL HOSPITAL	LEESVILLE	LA-04	LA	X	0
	MERCY REGIONAL MEDICAL CENTER	VILLE PLATTE	LA-04	LA		X
	CITIZENS MEDICAL CENTER	COLUMBIA	LA-05	LA	X	0

		CALDWELL MEMORIAL HOSPITAL	COLUMBIA	LA-05	LA	X	0
		EAST CARROLL PARISH HOSPITAL	LAKE PROVIDENCE	LA-05	LA	X	0
		SABINE MEDICAL CENTER	MANY	LA-04	LA	X	0
		OUR LADY OF THE ANGELS HOSPITAL MC	BOGALUSA	LA-05	LA	X	0
		SOUTHEAST REGIONAL MEDICAL CENTER	KENTWOOD	LA-05	LA	X	
		ACADIAN MEDICAL CENTER	EUNICE	LA-04	LA	X	
		ST. HELENA PARISH HOSPITAL	GREENSBURG	LA-05	LA	X	0
		UNION GENERAL HOSPITAL INC.	FARMERVILLE	LA-04	LA	X	0
		WEST FELICIANA PARISH HOSPITAL	ST. FRANCISVILLE	LA-05	LA	X	0
		WEST ASCENSION PARISH HOSPITAL	DONALDSONVILLE	LA-02	LA	X	0
		HOOD MEMORIAL HOSPITAL	AMITE	LA-05	LA	X	0
		FRANKLIN FOUNDATION HOSPITAL	FRANKLIN	LA-03	LA	X	0
		CHRISTUS COUSHATTA HEALTH CARE CTR	COUSHATTA	LA-04	LA	X	0
		MADISON PARISH HOSPITAL	TALLULAH	LA-05	LA	X	0
		TRINITY MEDICAL	FERRIDAY	LA-05	LA	X	0
		LALLIE KEMP REGIONAL MEDICAL CENTER	INDENDENCE	LA-05	LA	X	X
MASSACHUSETTS	1	BAYSTATE FRANKLIN MEDICAL CENTER	GREENFIELD	MA-02	MA	0	X
MAINE	2	THE AROOSTOOK MEDICAL CENTER	PRESQUE ISLE	ME-02	ME	0	X
		MAINE COAST MEMORIAL HOSPITAL	ELLSWORTH	ME-02	ME	0	X
MICHIGAN	4	MCLAREN CENTRAL MICHIGAN	MT PLEASANT	MI-02	MI	0	X
		CARSON CITY HOSPITAL	CARSON CITY	MI-02	MI	0	X
		ASPIRUS ONTONAGON HOSPITAL	ONTONAGON	MI-01	MI	0	X
		ASCENSION BORGESS-LEE HOSPITAL	DOWAGIAC	MI-05	MI	X	0
MINNESOTA	2	RANGE REGIONAL HEALTH SERVICES	HIBBING	MN-08	MN	X	0
		MAYO CLINIC HEALTH SYSTEM-FAIRMONT	FAIRMONT	MN-01	MN	0	X
MISSOURI	4	BOTHWELL REGIONAL HEALTH CENTER	SEDALIA	MO-04	MO	0	X
		SCOTLAND COUNTY MEMORIAL HOSPITAL	MEMPHIS	MO-06	MO	0	X
		PARKLAND HLTH CTR - BONNE TERRE	BONNE TERRE	MO-08	MO	X	0
		LAFAYETTE REGIONAL HEALTH CENTER	LEXINGTON	MO-04	MO	0	X
MISSISSIPPI	8	ALLIANCE HEALTHCARE SYSTEM	HOLLY SPRINGS	MS-01	MS	0	X
		DELTA HEALTH-NORTHWEST REGIONAL	CLARKSDALE	MS-02	MS	X	
		BAPTIST MEM HOSPITAL BOONEVILLE	BOONEVILLE	MS-01	MS	0	X
		GREENWOOD LEFLORE HOSPITAL	GREENWOOD	MS-02	MS	0	X
		JEFF ANDERSON REGIONAL MEDICAL CENTE	MERIDIAN	MS-03	MS	0	X
		HIGHLAND COMMUNITY HOSPITAL	PICAYUNE	MS-04	MS	0	X
		PANOLA MEDICAL CENTER	BATESVILLE	MS-02	MS	X	X
		BAPTIST MEDICAL CENTER - YAZOO	YAZOO CITY	MS-02	MS	0	X
MONTANA	8	NORTHEAST MONTANA HEALTHCARE-POPLAR	POPLAR	MT-02	MT	X	0
		PRAIRIE COMMUNITY HOSPITAL	TERRY	MT-02	MT	X	0
		GARFIELD CO. HEALTH CENTER	JORDAN	MT-02	MT	X	0
		LOGAN HEALTH CUTBANK	CUTBANK	MT-01	MT	X	0
		BIG HORN HOSPITAL	HARDIN	MT-02	MT	X	0
		NORTHEAST MONTANA HEALTH SERVICES	WOLF POINT	MT-02	MT	X	0
		PROVIDENCE ST JOSEPH MEDICAL CTR	POLSON	MT-01	MT	0	X
		BIG SKY MEDICAL CENTER	BIG SKY	MT-01	MT	0	X
NORTH CAROLINA	5	UNC ROCKINGHAM HOSPITAL	EDEN	NC-06	NC	0	X
		PERSON MEMORIAL HOSPITAL INC	ROXOBORO	NC-04	NC	0	X
		CHATHAM HOSPITAL INC	SILER CITY	NC-09	NC	0	X
		MH ANGEL MEDICAL CENTER LLLP	FRANKLIN	NC-11	NC	0	X
		BLUE RIDGE REGIONAL HOSPITAL	SPRUCE PINE	NC-05	NC		X
NORTH DAKOTA	3	NELSON COUNTY HEALTH SYSTEM-HOSPITAL	MCVILLE	ND-00	ND	X	0

		PRESENTATION MEDICAL CENTER	ROLLA	ND-00	ND	X	0
		MERCY HOSPITAL	DEVILS LAKE	ND-00	ND	X	0
NEBRASKA	2	AVERA CREIGHTON HOSPITAL	CREIGHTON	NE-03	NE	0	X
		OGALLALA COMMUNITY HOSPITAL	OGALLALA	NE-03	NE	0	X
NEW HAMPSHIRE	1	CHESHIRE MEDICAL CENTER	KEENE	NH-02	NH	0	X
NEW MEXICO	15	ALTA VISTA REGIONAL HOSPITAL	LAS VEGAS	NM-03	NM	X	0
		EASTERN NEW MEXICO MEDICAL CENTER	ROSWELL	NM-03	NM	X	0
		ESPANOLA HOSPITAL	ESPANOLA	NM-03	NM	X	0
		PLAINS REGIONAL MEDICAL CTR - CLOVIS	CLOVIS	NM-03	NM	X	0
		REHOBOTH MCKINLEY CHRISTIAN HOSPITAL	GALLUP	NM-03	NM	X	0
		CARLSBAD MEDICAL CENTER	CARLSBAD	NM-02	NM	X	0
		COVENANT HEALTH HOBBS HOSPITAL	HOBBS	NM-03	NM	X	0
		ROOSEVELT GENERAL HOSPITAL	PORTALES	NM-03	NM	X	0
		LOVELACE REGIONAL HOSPITAL-ROSWELL	ROSWELL	NM-03	NM	X	0
		SOCORRO GENERAL HOSPITAL	SOCORRO	NM-02	NM	X	0
		DR. DAN C. TRIGG	TUCUMCARI	NM-03	NM	X	0
		LINCOLN COUNTY MEDICAL CENTER	RUIDOSO	NM-01	NM	X	0
		MINER OF COLFAX MEDICAL CENTER	RATON	NM-03	NM	X	0
		MIMBRES MEMORIAL HOSPITAL	DEMING	NM-02	NM	X	0
		HOLY CROSS HOSPITAL	TAOS	NM-03	NM	X	0
NEVADA	2	BATTLE MOUNTAIN GENERAL HOSPITAL	BATTLE MOUNTAIN	NV-02	NV	X	0
		HUMBOLDT GENERAL HOSPITAL	WINNEMUCCA	NV-02	NV	0	X
NEW YORK	11	WYOMING COUNTY COMMUNITY HOSPITAL	WARSAW	NY-24	NY	0	X
		NEWARK WAYNE COMMUNITY HOSPITAL	NEWARK	NY-24	NY	X	0
		GENEVA GENERAL HOSPITAL	GENEVA	NY-24	NY	0	X
		BON SECOURS COMMUNITY HOSPITAL	PORT JERVIS	NY-18	NY	X	0
		WESTFIELD MEMORIAL HOSPITAL	WESTFIELD	NY-23	NY	0	X
		CLAXTON HEPBURN MEDICAL CENTER	OGDENSBURG	NY-21	NY	0	X
		MASSENA MEMORIAL HOSPITAL	MASSENA	NY-21	NY	X	0
		GARNET HEALTH MEDICAL CENTER - CATSK	HARRIS	NY-19	NY	X	0
		CLIFTON-FINE HOSPITAL	STAR LAKE	NY-21	NY	X	0
		GOUVERNEUR HOSPITAL	GOUVERNEUR	NY-21	NY	X	0
		LEWIS COUNTY GENERAL HOSPITAL	LOWVILLE	NY-21	NY	0	X
OHIO	11	SOUTHERN OHIO MEDICAL CENTER	PORTSMOUTH	OH-02	OH	X	0
		WAYNE HOSPITAL COMPANY	GREENVILLE	OH-08	OH	X	0
		EAST LIVERPOOL CITY HOSPITAL	EAST LIVERPOOL	OH-06	OH	X	0
		COSHOCTON REGIONAL MEDICAL CENTER	COSHOCTON	OH-12	OH	X	0
		TWIN CITY HOSPITAL	DENNISON	OH-06	OH	0	X
		HARRISON COMMUNITY HOSPITAL	CADIZ	OH-06	OH	0	X
		BUCYRUS COMMUNITY HOSPITAL	BUCYRUS	OH-05	OH	X	0
		HOLZER MEDICAL CENTER JACKSON	JACKSON	OH-02	OH	X	0
		GALION COMMUNITY HOSPITAL	GALION	OH-05	OH	X	0
		ADAMS COUNTY REGIONAL MEDICAL CENTER	SEAMAN	OH-02	OH	X	0
		FAYETTE COUNTY MEMORIAL HOSP	WASHINGTON COU	OH-15	OH	X	0
OKLAHOMA	21	INTEGRIS MIAMI HOSPITAL	MIAMI	OK-02	OK	0	X
		BLACKWELL REGIONAL HOSPITAL	BLACKWELL	OK-03	OK	0	X
		MCALESTER REGIONAL HEALTH CENTER	MCALESTER	OK-02	OK	0	X
		HILLCREST HOSPITAL CUSHING	CUSHING	OK-03	OK	0	X
		CHOCTAW MEMORIAL HOSPITAL	HUGO	OK-02	OK	X	0
		SEQUOYAH COUNTY CITY OF SALLISAW HOS	SALLISAW	OK-02	OK	X	0
		INTEGRIS GROVE HOSPITAL	GROVE	OK-02	OK	0	X

	PERRY MEMORIAL HOSPITAL	PERRY	OK-03	OK	0	X
	WAGONER HOSPITAL AUTHORITY	WAGONER	OK-02	OK	X	0
	ADAIR COUNTY HEALTH CENTER	STILWELL	OK-02	OK	X	X
	HILLCREST HOSPITAL HENRYETTA	HENRYETTA	OK-02	OK	0	X
	LINDSAY MUNICIPAL HOSPITAL AUTHORITY	LINDSAY	OK-04	OK	X	0
	MERCY HOSPITAL WATONGA	WATONGA	OK-03	OK	X	0
	MERCY HOSPITAL TISHOMINGO	TISHOMINGO	OK-02	OK	X	0
	MERCY HEALTH/LOVE COUNTY	MARIETTA	OK-04	OK	0	X
	MERCY HOSPITAL HEALDTON INC.	HEALDTON	OK-04	OK	X	0
	CLEVELAND AREA HOSPITAL	CLEVELAND	OK-03	OK	X	0
	CARNEGIE TRI-COUNTY MUNICIPAL HOSPIT	CARNEGIE	OK-03	OK	0	X
	HASKELL REGIONAL HOSPITAL	STIGLER	OK-02	OK	X	
	HARMON MEMORIAL HOSPITAL	HOLLIS	OK-03	OK	0	X
	MEMORIAL HOSPITAL OF TEXAS COUNTY	GUYMON	OK-03	OK	0	X
OREGON 4	SILVERTON HOSPITAL	SILVERTON	OR-05	OR	X	X
	PROVIDENCE SEASIDE HOSPITAL	SEASIDE	OR-01	OR	0	X
	ST CHARLES MADRAS	MADRAS	OR-02	OR	X	0
	GOOD SHEPHERD MEDICAL CENTER	HERMISTON	OR-02	OR	X	0
PENNSYLVANIA 5	UPMC JAMESON	NEW CASTLE	PA-16	PA	0	X
	UPMC NORTHWEST HOSPITAL	SENECA	PA-15	PA	0	X
	UPMC KANE	KANE	PA-15	PA	0	X
	UPMC HORIZON HOSPITAL	GREENVILLE	PA-16	PA	0	X
	HIGHLANDS HOSPITAL	CONNELLSVILLE	PA-14	PA	X	0
SOUTH CAROLINA 5	OCONEE MEMORIAL HOSPITAL	SENECA	SC-03	SC	0	X
	MUSC HEALTH CHESTER MEDICAL CENTER	CHESTER	SC-05	SC	0	X
	MUSC HEALTH MARION MEDICAL CENTER	MULLINS	SC-07	SC	0	X
	THE REGIONAL MEDICAL CENTER	ORANGEBURG	SC-06	SC	0	X
	ABBEVILLE AREA MEDICAL CENTER	ABBEVILLE	SC-03	SC	0	X
SOUTH DAKOTA 2	SANFORD ABERDEEN MEDICAL CENTER	ABERDEEN	SD-00	SD	0	X
	BENNETT COUNTY HOSPITAL	MARTIN	SD-00	SD	X	0
TENNESSEE 9	UNICOI COUNTY HOSPITAL	ERWIN	TN-01	TN	0	X
	WAYNE MEDICAL CENTER	WAYNESBORO	TN-07	TN	0	X
	BAPTIST MEM HOSPITAL HUNTINGDON	HUNTINGDON	TN-08	TN	0	X
	WEST TN HEALTHCARE VOLUNTEER HOSPITA	MARTIN	TN-08	TN	0	X
	DYERSBURG REGIONAL MEDICAL CENTER	DYERSBURG	TN-08	TN	0	X
	ST THOMAS DEKALB HOSPITAL	SMITHVILLE	TN-06	TN	0	X
	SAINT THOMAS HIGHLAND HOSPITAL	SPARTA	TN-06	TN	0	X
	VANDERBILT WILSON COUNTY HOSPITAL	LEBANON	TN-05	TN	0	X
	SAINT THOMAS STONES RIVER HOSPITAL	WOODBURY	TN-06	TN	0	X
TEXAS 15	ANSON GENERAL HOSPITAL	ANSON	TX-19	TX		X
	ASCENSION SETON SMITHVILLE	SMITHVILLE	TX-10	TX	0	X
	VAL VERDE REGIONAL MEDICAL CENTER	DEL RIO	TX-23	TX	0	X
	FALLS COMMUNITY HOSPITAL AND CLINIC	MARLIN	TX-17	TX	0	X
	COVENANT HOSPITAL PLAINVIEW	PLAINVIEW	TX-19	TX	0	X
	SCENIC MOUNTAIN MEDICAL CENTER	BIG SPRING	TX-19	TX	0	X
	EL CAMPO MEMORIAL HOSPITAL	EL CAMPO	TX-22	TX	X	0
	COVENANT HOSPITAL LEVELLAND	LEVELLAND	TX-19	TX	0	X
	NORTH RUNNELS HOSPITAL DISTRICT	WINTERS	TX-11	TX	0	X
	PALACIOS COMMUNITY MEDICAL CENTER	PALACIOS	TX-22	TX	X	0
	HASKELL MEMORIAL HOSPITAL	HASKELL	TX-19	TX		X
	MITCHELL COUNTY HOSPITAL	COLORADO CITY	TX-19	TX	0	X

	TMC BONHAM HOSPITAL	BONHAM	TX-04	TX	0	X
	MID COAST MEDICAL CENTER-CENTRAL	LLANO	TX-11	TX	X	0
	BAYLOR SCOTT & WHITE - MARBLE FALLS	MARBLE FALLS	TX-31	TX	0	X
UTAH 3	FILLMORE COMMUNITY HOSPITAL	FILLMORE	UT-02	UT	0	X
	BLUE MOUNTAIN HOSPITAL	BLANDING	UT-03	UT	X	0
	BEAVER VALLEY HOSPITAL	BEAVER	UT-02	UT	0	X
VIRGINIA 6	SOUTHAMPTON MEMORIAL HOSPITAL	FRANKLIN	VA-02	VA	0	X
	SOUTHERN VIRGINIA REGIONAL MED. CTR.	EMPORIA	VA-04	VA	X	X
	COMMUNITY MEMORIAL HOSPITAL	SOUTH HILL	VA-05	VA	0	X
	CARILION TAZEWELL COMMUNITY HOSPITAL	TAZEWELL	VA-09	VA	0	X
	RAPPAHANNOCK GENERAL HOSPITAL	KILMARNOCK	VA-01	VA	0	X
	LEE COUNTY COMMUNITY HOSPITAL	PENNINGTON GAP	VA-09	VA	X	0
WASHINGTON 14	SAMARITAN HOSPITAL	MOSES LAKE	WA-04	WA	X	0
	TOPPENISH COMMUNITY HOSPITAL	TOPPENISH	WA-04	WA	X	0
	SUMMIT PACIFIC MEDICAL CENTER	ELMA	WA-06	WA	X	0
	ODESSA MEMORIAL HOSPITAL	ODESSA	WA-05	WA	X	0
	COULEE MEDICAL CENTER	GRAND COULEE	WA-04	WA	X	0
	PROVIDENCE ST JOSEPHS HOSPITAL	CHEWELAH	WA-05	WA	0	X
	PROSSER MEMORIAL HEALTH	PROSSER	WA-04	WA	X	0
	KLICKITAT VALLEY HEALTH	GOLDENDALE	WA-04	WA	X	0
	OTHELLO COMMUNITY HOSPITAL	OTHELLO	WA-04	WA	X	0
	THREE RIVERS HOSPITAL	BREWSTER	WA-04	WA	X	0
	FORKS COMMUNITY HOSPITAL	FORKS	WA-06	WA	X	0
	MID-VALLEY HOSPITAL	OMAK	WA-04	WA	X	0
	ASTRIA SUNNYSIDE HOSPITAL	SUNNYSIDE	WA-04	WA	X	0
	MASON GENERAL HOSPITAL	SHELTON	WA-06	WA	X	0
WISCONSIN 3	HOLY FAMILY MEMORIAL INC	MANITOWOC	WI-06	WI	0	X
	MCHS OAKRIDGE	OSSEO	WI-03	WI	0	X
	ASPIRUS STANLEY HOSPITAL	STANLEY	WI-07	WI	0	X
WEST VIRGINIA 7	LOGAN REGIONAL MEDICAL CENTER	LOGAN	WV-01	WV	X	0
	WELCH COMMUNITY HOSPITAL	WELCH	WV-01	WV	X	0
	BROADDUS HOSPITAL ASSOCIATION	PHILIPPI	WV-02	WV	X	0
	MINNIE HAMILTON HEALTH CARE CENTER	GRANTSVILLE	WV-01	WV	X	0
	GRAFTON CITY HOSPITAL	GRAFTON	WV-02	WV	0	X
	MONTGOMERY GENERAL HOSPITAL	MONTGOMERY	WV-01	WV	X	0
	JACKSON GENERAL HOSPITAL	RIPLEY	WV-01	WV	X	0
WYOMING 2	SUMMIT MEDICAL CENTER LLC	CASPER	WY-00	WY	0	X
	PLATTE COUNTY MEMORIAL HOSPITAL	WHEATLAND	WY-00	WY	0	X

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Echo Health Ventures	Venture Capital	Minority	Oct 2023		#3. Early Stage VC: Oct 2023, $315.00M, New I...
Elevance	VC-Backed Company	Minority	Oct 2023		#3. Early Stage VC: Oct 2023, $315.00M, New I...
Gershon Capital	Venture Capital	Minority	Oct 2023		#3. Early Stage VC: Oct 2023, $315.00M, New I...
HLM Investment Partners	Growth/Expansion	Minority	Oct 2023		#3. Early Stage VC: Oct 2023, $315.00M, New I...
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Frist Cressey Ventures	Venture Capital	Minority	Jun 2021	✔	#1. Early Stage VC (Series A): Jun 2021, $27.00... **Contact:** William Frist MD

CHAPTER 11

The Medicare Advantage program: Status report

CHAPTER 11

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program, which gives Medicare beneficiaries the option of receiving benefits from private plans rather than from traditional fee-for-service (FFS) Medicare. In 2024, the MA program included 5,678 plan options offered by 175 organizations, enrolled about 33.6 million beneficiaries (54 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated $494 billion (not including payments for drug coverage offered by MA plans). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and payments for MA plan enrollees relative to spending for beneficiaries enrolled in FFS Medicare. We also provide updates on risk adjustment, risk-coding practices, favorable selection of enrollees into MA, the structure of the MA market, and the current state of quality reporting in MA.

The Commission strongly supports the inclusion of private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in FFS Medicare, while others may prefer features of MA, like reduced

In this chapter

- Robust MA enrollment, plan availability, and rebates
- Higher payments to MA plans stem from favorable selection and coding intensity
- Industry concentration, integration, and financial condition
- Quality in MA
- Commission recommendations to improve MA payment policies
- Technical Appendix 11–A: Favorable selection
- Technical Appendix 11–B: Coding intensity

premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket spending limit that is not included in FFS Medicare, and plans can reduce cost-sharing liability, offer integrated Part D benefits, and provide supplemental benefits that generally are not available to beneficiaries in FFS unless they purchase additional health insurance coverage or pay for the services out of pocket. The Commission has separately expressed concerns about the FFS program, including a benefit design that exposes beneficiaries to substantial financial risk, use of low-value care that can stem from open networks and the general absence of utilization management, and Medigap policies that include first-dollar coverage. Because Medicare pays private plans a partially predetermined rate that is risk adjusted for each enrollee rather than a per service rate, plans should have greater incentives than FFS providers to deliver more efficient care.

The MA program is quite robust, with growth in enrollment, increased plan offerings, and a nearly record-high level of supplemental benefits. From 2018 to 2024, the share of eligible Medicare beneficiaries enrolled in MA rose from 37 percent to 54 percent. In 2025, the average Medicare beneficiary has a choice of 42 plans offered by an average of eight organizations.

In 2025, we estimate that Medicare will spend 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion. The higher payments we estimate relative to FFS vary significantly across MA parent organizations and are not an estimate of plan profits and administrative expenses. These increased payments to MA plans are the primary source of funding for supplemental benefits, which include coverage of non-Medicare services (services not covered by Part A and Part B) and better financial protection for MA enrollees relative to beneficiaries in FFS Medicare without supplemental coverage. The rebates that plans use to finance these benefits have nearly doubled since 2018 and account for a projected 17 percent of payments to all MA plans (some of which goes to plan administrative expenses and profit).

In 2025, the Medicare program pays conventional plans $2,255 per beneficiary for supplemental benefits (including $180 for plan administrative expenses and profit). On average, plans project using about 38 percent of these funds to reduce cost sharing for MA enrollees, 25 percent for non-Medicare services, about 23 percent to enhance plans' Part D benefit through lower

premiums or reduced cost sharing, about 6 percent to reduce MA enrollees' Part B premiums, and about 8 percent for administrative expenses and profit. However, currently there is no reliable information about the extent to which beneficiaries use these benefits or about their value.

The relatively higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program. Higher MA spending increases Part B premiums for all beneficiaries, including those in FFS Medicare; the Commission estimates that Part B premium payments will be about $13 billion higher in 2025 because of higher Medicare payments to MA plans (equivalent to roughly $198 per beneficiary per year).

When risk-based payment for private plans was first added to Medicare in 1985, payments to private plans were set at 95 percent of FFS payments because it was expected that plans would share savings from their efficiencies relative to FFS with taxpayers. But, in total, private plans have never been paid less than FFS Medicare because of policies that increase payments to MA above FFS payments and distort the nature of plan competition in MA. For example, MA benchmarks are set above FFS spending in many markets in part to encourage more uniform plan participation across the country. Payments under the quality-bonus program further increase MA payments above FFS (without, the Commission has found, producing meaningful information on plan quality for Medicare beneficiaries or the Medicare program).

The two largest factors responsible for higher payments to plans in recent years are favorable selection and coding intensity. "Favorable selection" into MA occurs when beneficiaries with lower actual spending relative to their risk score tend to enroll in MA; it is the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans. "Coding intensity" refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores—and payments—for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS. Both favorable selection and coding intensity lead to pricing errors that cause CMS's risk-adjustment system to set the payment rate too high for a given MA enrollee.

Favorable selection may stem from a variety of factors, including beneficiary propensities for using care for reasons unrelated to their health, differences in health status that are not accounted for by risk scores, or provider practice styles, among other reasons. Similarly, MA coding intensity is driven by several

factors, including MA plans' documenting diagnoses more comprehensively than providers in FFS Medicare, submitting fraudulent diagnostic data, and other reasons. Separately identifying all of these different factors is challenging and in many cases is not possible given available data. However, regardless of the causes, favorable selection of enrollees in MA and higher MA coding intensity increase Medicare's payments to plans. Higher payments to MA plans fund more generous benefits, but those higher payments increase Medicare spending and create an imbalance, and policymakers must weigh the added cost with the unmeasured value of the added benefits. Past experience with reductions in MA payments has demonstrated that plans can adjust their bidding behavior and lessen effects on plan participation and beneficiary enrollment while achieving program savings.

The Commission contends that important reforms are needed to improve Medicare's policies of paying and overseeing MA plans. First, reforms are needed to reduce the level of Medicare payments to MA plans. Relatively higher levels of payment stem largely from coding intensity and favorable selection. Second, the program that is used to reward plans for better quality is administratively burdensome, adds significantly to program costs, and does not meaningfully improve quality. Relatedly, beneficiaries lack meaningful quality information when choosing among MA plans. Third, MA benchmarks generate a number of inequities, including "cliff" effects from dividing counties into quartiles, caps on benchmarks, and benchmarks that are skewed by the inclusion of FFS-spending data for beneficiaries with only Part A coverage. Fourth, Medicare must address the challenges, burdens, and care disruptions for beneficiaries that stem from the process of choosing between plans and from changes to provider networks. Finally, the Commission finds that plan-submitted data about beneficiaries' health care encounters are incomplete, and we lack information about the use of many MA supplemental benefits. Without these data, policymakers cannot fully understand enrollees' use of services, which limits policymakers' ability to oversee the program and assess the value that enrollees get from supplemental benefits.

Over the past few years, the Commission has made several recommendations to improve the program. These recommendations call for the Congress and CMS to address coding intensity, replace the quality-bonus program, establish more equitable benchmarks, and improve the completeness of encounter data. In addition, because of Medicare's fiscal situation, the growth in subsidization of supplemental benefits should be considered with attention to their value.

In the Commission's view, current policy does not allow policymakers to understand and assess how beneficiaries are using or valuing those benefits.

Medicare payments to plans—In 2025, Medicare's payments to MA plans will total a projected $538 billion (about $507 billion excluding projected payments for enrollees with end-stage renal disease). As noted above, we project that Medicare's payments to MA plans in 2025 (including rebates that finance supplemental benefits) will be $84 billion more, or about 20 percent higher, than if MA enrollees were enrolled in FFS Medicare. This estimate reflects higher MA coding intensity, even after the annual CMS coding adjustment; favorable selection of beneficiaries in MA; setting benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—above FFS spending in low-FFS-spending counties; and payments associated with benchmark increases under the quality-bonus program, which the Commission contends does not effectively promote high-quality care.

Favorable selection—When setting MA benchmarks, CMS implicitly assumes that if MA enrollees were in FFS, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. Favorable selection into MA causes risk scores to systematically overpredict spending for MA enrollees; that is, spending on the average MA enrollee is lower relative to what their risk score—and MA-plan payment—would suggest. This lower-than-predicted spending is evident in the years prior to a beneficiary enrolling in an MA plan and thus cannot be attributed to any plan activity (such as utilization management or coding practices). Favorable selection can pertain to health status (relative to the risk-based payments that MA plans receive) but can also pertain to factors such as beneficiary propensities for seeking care for reasons that are unrelated to their health.

We estimate that favorable selection increased MA payments in 2022 by roughly 10 percent above what the program would have paid under FFS Medicare. We project that in 2025, favorable selection will increase MA payments by roughly 11 percent above what the program would have paid under FFS Medicare, or $44 billion of the $84 billion in higher total payments to MA plans. We found relatively little variation in favorable selection by MA market penetration; that is, we estimate that favorable selection persists as the share of MA enrollees in a market increases. In addition, there were larger favorable-selection effects on MA enrollees with higher risk scores, implying that selection persists even as beneficiaries with more chronic conditions

enroll in MA. These two findings highlight the fact that selection can grow even when sicker beneficiaries join MA because selection is driven by the tendency for risk scores to overpredict what FFS spending would have been for MA enrollees, not the average risk. In other words, Medicare's payments to MA plans can be too high even for enrollees with expensive health conditions. In fact, beneficiaries with higher risk scores can exhibit greater selection because there is more potential for overprediction.

The Commission's estimates of favorable selection are reasonably robust and in line with a growing body of research that also estimates substantial effects from favorable selection on Medicare payments to MA plans.

Risk adjustment and coding intensity—Medicare payments to MA plans are specific to each enrollee, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. In both MA and FFS Medicare, claims include both procedure and diagnosis codes; however, most FFS Medicare claims are paid using only procedure codes, which offers little incentive for providers to record more diagnosis codes than necessary to justify providing a service. Indeed, research has shown that diagnoses are reported inconsistently from year to year even for FFS beneficiaries with chronic conditions such as kidney failure or paraplegia. Instead, FFS providers may be more likely to focus on diagnoses that are a primary reason for a visit. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because adding new risk-adjustment-eligible diagnoses raises an enrollee's risk score and results in higher payments to the plan. Plans have several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees, including chart reviews (which document diagnoses not captured through the usual means of reporting diagnoses) and health risk assessments (which sometimes rely on unverified enrollee-reported data). In addition, whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment. There are no data available to parse the share of higher MA coding intensity that is due to lower coding incentives in FFS Medicare, variation in diagnostic discretion, fraud, or other reasons. However, because the risk-adjustment model is calibrated on FFS claims, relatively higher MA coding intensity—regardless of the reason—increases payments to MA plans above FFS spending. In response to a congressional request, we include in this chapter an analysis of the differences in incentives between FFS Medicare and MA plans to document

diagnoses, as well as estimated rates of documenting chronic conditions in subsequent years in MA and FFS Medicare.

We estimate that in 2023, MA risk scores were about 17 percent higher than scores for similar FFS beneficiaries due to higher coding intensity. (Last year, the Commission adopted a new method of estimating the effects of coding intensity; see Chapter 13 of our March 2024 report and Technical Appendix 11-B (p. 388) for more information on our method of estimating coding intensity.) We project that in 2025, MA risk scores will be about 16 percent higher than scores for similar FFS beneficiaries after accounting for the phase-in of the V28 risk-adjustment model. By law, CMS reduces all MA risk scores by the same amount to make them more consistent with FFS coding; CMS has the authority to impose a larger reduction than the minimum required by law but has never done so. In 2025, the adjustment will reduce MA risk scores by the minimum amount, 5.9 percent, resulting in MA risk scores that will remain about 10 percent higher than they would have been if MA enrollees were in FFS Medicare. Those higher scores will result in a projected $40 billion of the $84 billion in higher total payments to MA plans.

We continue to find that coding intensity varies significantly across MA plans: 15 percent of MA enrollees are in plans that have coding intensity that falls below the 5.9 percent reduction (and even below FFS levels), and other plans code far above that amount, including 16 MA organizations with average coding intensity that is more than 20 percent higher than FFS levels. Among the 10 largest MA organizations, we estimate a 26 percentage point variation in average coding intensity. Higher coding intensity allows some plans to offer more supplemental benefits—and attract more enrollees—than other plans. That result distorts both the nature of plan competition in MA and plan incentives to improve quality and reduce costs.

The Commission previously recommended changes to MA risk adjustment that would exclude diagnoses collected from health risk assessments, use two years of MA and FFS diagnostic data, and apply an adjustment to MA risk scores to address any residual impact of coding intensity. In analysis of risk scores for 2020 through 2023, we find that about half of higher MA coding intensity could result from use of diagnoses from chart reviews and health risk assessments and that these two mechanisms are primary factors driving coding differences among MA plans. Thus, the Commission expects that our recommendation, along with the exclusion of chart reviews from risk adjustment, would reduce the heterogeneity in observed coding intensity across MA organizations.

Quality in MA—The MA quality-bonus program increases MA payments by about $15 billion annually. In 2025, 69 percent of MA enrollees are in a plan that received a quality-bonus increase to its benchmark. At the same time, beneficiaries in MA and FFS report similar satisfaction with their coverage. Enrollees in both MA and FFS tend to rate their coverage and access to care highly—a trend that has held over time. For example, scores for all measures on the MA and FFS Consumer Assessment of Healthcare Providers and Systems surveys, except annual flu vaccine, were above 80 percent from 2018 to 2023. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. MA plans typically have flexibility to use alternative payment models, negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery, and provide incentives for beneficiaries to seek care from more efficient providers. By contrast, traditional FFS Medicare has lower administrative costs but has fewer incentives to coordinate care and is limited in its ability to make care delivery more efficient.[1]

The Commission strongly supports including private plans in the Medicare program. Beneficiaries should be able to choose among Medicare coverage options since some may prefer to avoid the constraints of provider networks and utilization management by enrolling in FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. MA plans are required by statute to offer an out-of-pocket spending limit that is not included in FFS Medicare. MA plans also can offer integrated Part D benefits, provide supplemental benefits not covered by Part A or Part B of Medicare, and reduce cost-sharing liability and premiums. For 2025, we estimate that conventional MA plans (those available to all MA enrollees) will receive an average rebate from CMS of $2,255 per enrollee (or $2,075 after subtracting plan projections for administrative costs and profit for these services) to provide supplemental benefits during the year and that more than half of that amount will be allocated to reducing beneficiaries' cost sharing or Part B and Part D premiums. In exchange for these benefits, MA plan enrollees accept provider networks and utilization-management tools such as higher cost sharing to access providers who are not in their plan's network. Because private plans and FFS Medicare have structural aspects that appeal to different segments of the Medicare population, the Commission supports payment policies that do not unduly favor MA or FFS.

The Commission has expressed concern about the FFS benefit design and has recommended changes to give beneficiaries better protection against high out-of-pocket (OOP) spending and to create incentives for them to make better decisions about their use of discretionary care. Protecting beneficiaries against high OOP spending would enhance the overall value of the FFS benefit and mitigate the need for beneficiaries to purchase supplemental insurance (Medicare Payment Advisory Commission 2012a). The Commission's recommendation also creates clearer incentives for beneficiaries to make better decisions about their use of care through adjustments and refinements in cost sharing based on evidence of service value while holding the aggregate beneficiary cost-sharing liability about the same as under current law. Finally, our recommendation would add a charge on supplemental insurance (such as Medigap) to recoup at least some of the additional costs resulting from the higher service use that supplemental insurance imposes on the Medicare program while still providing beneficiaries the choice to buy supplemental coverage if they wish to do so.

Each year, as required by law, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, plan generosity (including enhanced financial protections and supplemental benefits), and payments for MA plan enrollees relative to spending for beneficiaries enrolled in traditional FFS Medicare. We also provide updates on risk adjustment, risk-coding practices, favorable selection of enrollees into MA, the structure of the MA market, and the current state of quality reporting in MA.

Types of MA plans

Our analysis of the MA program uses the most recent data available, and we report our results by plan type.[2] The analysis does not include non-MA private-plan options such as cost plans that may be available to some beneficiaries. The primary MA plan types are:

- ***HMOs and local preferred provider organizations (PPOs)***—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use.[3] They can choose individual counties to serve and can vary their premiums and benefits across counties.
- ***Regional PPOs***—These plans must offer a uniform benefit package and premium across CMS-designated regions made up of one or more

states. Regional PPOs have more flexible provider-network requirements than local PPOs. For instance, regional PPOs may meet Medicare access requirements by arranging for enrollees to obtain plan-covered services through noncontracted providers at in-network cost-sharing levels for enrollees.

Two additional plan classifications cut across plan types: special-needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (that is, beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Each SNP must be an HMO or PPO plan. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. Employer plans do not submit bids and are not available to all Medicare beneficiaries, so they are not included in our analysis of bids or plan availability.

How Medicare pays MA plans

In contrast to FFS Medicare's fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each enrolled beneficiary, which is the product of a base rate and a risk score. Risk scores adjust a plan's base rate to account for differences in expected beneficiary medical costs by increasing a plan's payment rate for beneficiaries who are likely to have higher medical expenses and decreasing a plan's payment rate for beneficiaries who are likely to have lower medical expenses. The general purpose of risk adjustment is to accurately predict costs on average for a group of beneficiaries with similar attributes that affect health care costs, thereby reducing incentives for plans to avoid beneficiaries with certain unprofitable attributes and to attract those with profitable attributes.

A plan's base rate is determined by the MA plan's bid and the benchmark for the county in which the beneficiary resides. The bid is intended to represent the dollar amount that the plan estimates will cover its costs of providing the Part A and Part B benefit package for a beneficiary of average spending. The benchmark is the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.[4] (Medicare also pays many plans for providing the Part D drug benefit, but those payments are determined through the Part D bidding process and are not discussed here.) Plans with higher quality ratings are rewarded with a higher benchmark (although the increase to the benchmark can be limited by the Affordable Care Act of 2010 (ACA) benchmark caps).

For 2025, almost 100 percent of plans bid below their benchmarks. For these plans, the base rate is the plan's bid plus a "rebate" equal to a share of the difference between the plan's bid and the benchmark (as low as 50 percent but typically either 65 percent or 70 percent, depending on a plan's quality ratings).[5] The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for paying the Medicare Part B premium).

The rebate that plans receive must be used to provide supplemental benefits to enrollees in the form of lower cost sharing, lower premiums, or coverage of non-Medicare services (benefits not covered by Part A or Part B). Plans also devote some of the rebate to their administrative costs and profit. Plans can choose to include additional supplemental benefits that are not financed by the rebate in their benefit packages and charge premiums to cover those additional benefits.[6] (A more detailed description of the MA program's payment system can be found in our *Payment Basics* series at https://www.medpac.gov/document-type/payment-basic/.)

How Medicare calculates MA benchmarks

Under the ACA, each county's benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the county's beneficiaries.[7] Each county's benchmark is determined by organizing the counties into quartiles based on their FFS spending. Low-FFS-spending counties have benchmarks higher than their county's FFS spending level to help attract plans and enable enrollees to receive supplemental benefits, and high-FFS-spending counties have benchmarks lower than FFS spending with the goal of generating Medicare savings because MA plans have greater

opportunity to produce spending efficiencies in these areas. Counties are assigned to quartiles based on average FFS spending; the highest-spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next-highest-spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest-spending quartile has benchmarks set at 115 percent of local FFS spending. U.S. territories are treated like counties in this lowest-spending quartile. Counties that move among quartiles from year to year receive a blended quartile factor. For example, a county that moved from the 100 percent quartile in 2024 to the 107.5 percent quartile in 2025 would have a blended rate of 103.75 percent in 2025.

By statute, plans that are awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans awarded quality bonuses are 10 percent higher than the standard benchmarks.[8] Unlike nearly all of Medicare's FFS quality-incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars and beneficiary premiums. The Commission has repeatedly recommended that an MA quality-incentive program be budget neutral (that is, financed with a share of plan payments) and focused on measures tied to clinical outcomes and patient experience (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004).

How Medicare calculates risk scores

Risk scores are beneficiary-level index values that indicate the expected Medicare costs for an enrollee relative to the national average FFS beneficiary. How well Medicare's payments to MA plans match their enrollees' costliness depends in large part on how well the risk scores predict the expected costs for the plans' enrollees.

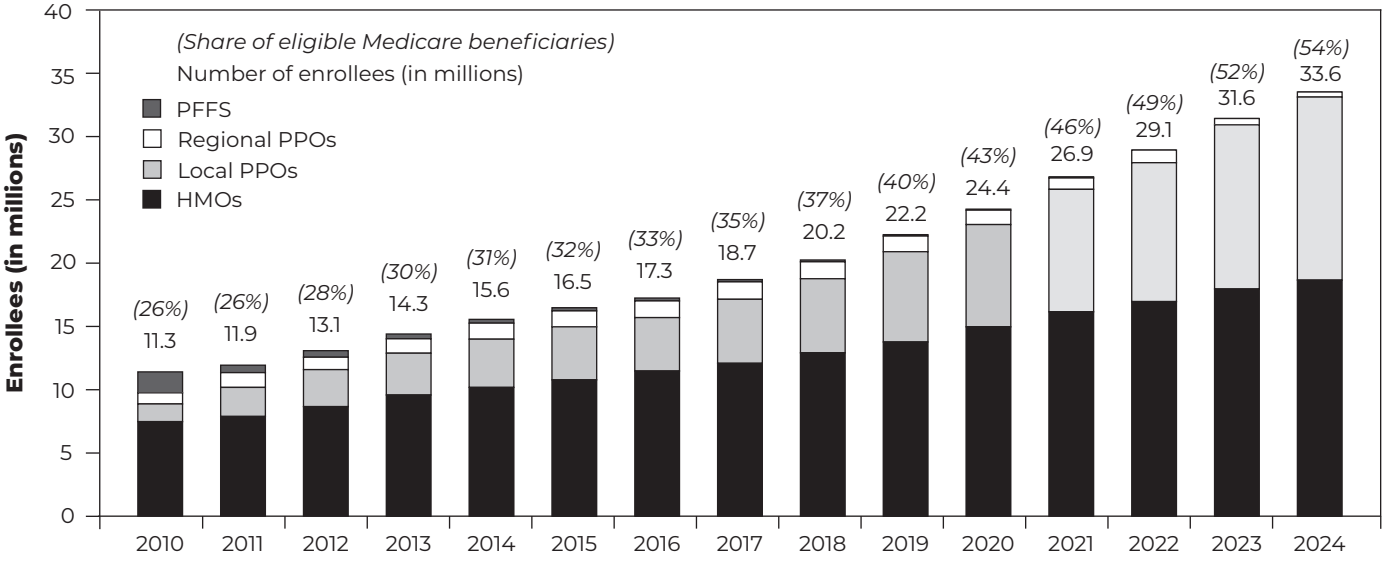
CMS calculates risk scores with the CMS hierarchical condition category (CMS–HCC) risk-adjustment model, which uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Some conditions have more than one HCC, which differ by severity of the condition and are arrayed in a hierarchy. For example, the CMS–HCC model has four HCCs for chronic kidney disease listed here in order of highest severity: Stage 5, Stage 4, Stage 3B, and Stage 3 (except Stage 3B). The "hierarchical" aspect of HCCs means that if a beneficiary's diagnoses map to more than one HCC in a condition hierarchy, CMS applies only the HCC that has the largest effect on the beneficiary's risk score—the highest-severity HCC applicable to that beneficiary.

CMS tracks beneficiary demographic information, but MA plans submit diagnostic information to CMS through encounter records, which contain basic information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee.[9] Diagnostic data collected from encounters in one year are used to predict Medicare costs for the following year.

CMS designed this risk-adjustment model to maximize its ability to predict annual medical expenditures for FFS Medicare beneficiaries while also ensuring that the model's diagnostic categories were clinically meaningful and "sufficiently clinically specific to minimize opportunities for gaming or discretionary coding" (Pope et al. 2004). CMS has two requirements aimed at ensuring the validity and reliability of the diagnostic data used in an enrollee's risk score: Diagnoses must (1) appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional, and (2) be supported by evidence in the patient's medical record.[10] Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio and video telecommunication that enables real-time communication with the beneficiary. To verify that diagnoses are supported by evidence in the patient's medical record, CMS conducts risk-adjustment data validation (RADV) audits. RADV audits have been limited so far, but the available results show significant issues with medical-record support for risk-adjustment

FIGURE 11–1

Share of eligible Medicare beneficiaries enrolled in Medicare Advantage has more than doubled since 2010



Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in this figure.

Source: MedPAC analysis of CMS enrollment files, July 2010 to July 2024.

diagnoses (Schulte and Hacker 2022).[11] For example, the Department of Health and Human Services Office of Inspector General has conducted RADV-like audits of high-risk diagnoses for at least 30 MA contracts and found that 70 percent of all diagnosis codes audited were not supported by medical records and that some diagnoses were not supported over 90 percent of the time (Office of Inspector General 2023). (See text box for update on RADV audits, pp. 364–365.)

The CMS–HCC model is calibrated using FFS claims data so that each beneficiary's risk score reflects the expected spending that would occur for a beneficiary relative to the national average spending in FFS Medicare. Therefore, risk scores do not reflect geographic spending variation, a beneficiary's propensity to seek care, differences between MA and FFS Medicare (including variation in plans' benefit design or initiatives to influence spending), or differences in diagnostic-coding practices between MA and FFS Medicare and across MA plans. These factors do drive differences between actual spending for MA enrollees and the expected spending based on MA risk scores. Some of these factors are reflected in our estimates of the effects of favorable selection into MA and of higher diagnostic-coding intensity in MA.

Robust MA enrollment, plan availability, and rebates

Substantial growth in MA-plan enrollment, availability, and rebates indicates a robust MA program. As of 2024, more than half of eligible Medicare beneficiaries were enrolled in MA plans. For 2025, the average beneficiary has access to 42 plans sponsored by eight organizations. Rebates that finance supplemental benefits are at nearly record-high levels.

TABLE 11–1

Enrollment growth in local PPOs continued to outpace growth in other plan types in 2024

	MA enrollment (in millions)		Percent change in enrollment (2023–2024)
	July 2023	July 2024	
Total MA-eligible beneficiaries	**60.4**	**61.7**	**2%**
Total MA enrollment	**31.6**	**33.6**	**6**
Plan type			
HMO	18.1	18.7	3
Local PPO	12.9	14.5	12
Regional PPO	0.5	0.4	–27
PFFS	<0.05	<0.05	–8
Restricted-availability plans included in totals above			
SNPs*	6.1	6.9	13
Employer group*	5.5	5.8	6

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred-provider organization), PFFS (private fee-for-service), SNP (special-needs plan). The total Medicare population used to calculate enrollment shares in this table excludes the approximately 8 percent of beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. Totals and calculated values may be affected by rounding.
* SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

In 2024, 6 percent growth in MA plan enrollment; 54 percent of eligible Medicare beneficiaries enrolled in MA plans

Between July 2023 and July 2024, enrollment in MA plans grew by 6 percent—or 2 million enrollees—to 33.6 million enrollees, while the total MA-eligible population (beneficiaries with both Part A and Part B coverage) grew only 2 percent. Between 2023 and 2024, MA enrollment rose from 52 percent to 54 percent of eligible Medicare beneficiaries (Figure 11-1). The share of eligible Medicare beneficiaries enrolled in MA has more than doubled since 2010. MA has become increasingly attractive to beneficiaries because plans provide cost-sharing reductions, non-Medicare benefits, and a cap on out-of-pocket expenses at little or no premium. Many beneficiaries with care needs that are met within plan networks and coverage policies will likely have lower total financial liability (premiums and cost sharing) compared with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage (Ippolito et al. 2024). Some MA enrollees with high care needs do experience greater cost liabilities compared with beneficiaries in FFS (e.g., greater cost sharing for in-network and out-of-network services compared with Medigap premiums) (Keohane et al. 2015).[12]

Among plan types, recent growth in MA enrollment has been disproportionately higher among local PPOs. Although HMOs continued to enroll the most beneficiaries (19 million) in 2024, enrollment in local PPOs grew faster (12 percent) than in HMOs (3 percent) (Table 11-1). Between 2023 and 2024, enrollment in local PPOs grew by 1.6 million, accounting for more than three-quarters of the overall increase in MA enrollment. Local PPOs may appeal to beneficiaries

because they provide a greater degree of coverage for services received outside of a plan's provider network (relative to the lack of out-of-network coverage provided under HMOs). (Enrollees in PPOs pay higher cost sharing for services received out of network than for services received in network.)

Increased SNP enrollment accounted for nearly 40 percent of all MA enrollment growth between 2023 and 2024. In 2024, SNP enrollment grew by 13 percent—a continuation of the rapid growth (above 10 percent per year) observed over the last five years. HMOs accounted for nearly three-quarters of the SNP enrollment growth (data not shown). While enrollment in non-SNP HMOs was essentially unchanged, enrollment in SNP HMOs grew by 11 percent (data not shown). Local PPO SNPs have proliferated since 2018, rising from 4 percent of SNP enrollment to 19 percent in 2024. Altogether, in 2024, Medicare beneficiaries who were eligible to enroll in SNPs were predominantly enrolled in HMOs, while enrollment of beneficiaries who did not qualify for a SNP was more evenly distributed between HMOs and PPOs.

Enrollment patterns differ in urban and rural areas. In 2024, the majority (56 percent) of eligible urban beneficiaries were enrolled in MA compared with 47 percent of eligible beneficiaries residing in rural counties.[13] However, the growth of MA enrollment in rural areas has been faster in recent years. In 2024, MA enrollment in rural areas grew by 8 percent (compared with 6 percent growth in urban areas). The predominant plan type often differs between urban and rural areas as well. In 2024, 39 percent of rural MA enrollees were in HMO plans compared with about 59 percent of urban enrollees. By contrast, 58 percent of rural enrollees were in local PPOs compared with 40 percent of urban enrollees.

Geographic variation in the growth of MA has resulted in some areas having a very high share of eligible Medicare beneficiaries enrolled in MA and other areas having a relatively low share. In some states (including Iowa, Kansas, Maryland, Massachusetts, and Nebraska), less than 40 percent of eligible Medicare beneficiaries are enrolled in MA; however, a relatively small share of the MA-eligible population (less than 10 percent) lives in such states. In contrast, in 30 states (including California, New York, Ohio, Pennsylvania, and Texas) and Puerto Rico, home to more than three-quarters of eligible Medicare beneficiaries, more than half of the eligible population was enrolled in an MA plan in 2024. In 10 of these 30 states (including Alabama, Florida, Georgia, Louisiana, and Michigan), encompassing roughly 20 percent of eligible beneficiaries, the share enrolled in MA exceeded 60 percent. MA enrollment is particularly high in some metropolitan areas (e.g., El Paso, TX; Grand Rapids, MI; Greensboro, NC; Miami, FL; Pittsburgh, PA; Rochester, NY) and in Puerto Rico, where more than 75 percent of eligible Medicare beneficiaries were enrolled in MA plans. MA benchmarks are computed at the county level, and in an increasing number of counties, more than half of eligible Medicare beneficiaries are enrolled in MA plans.

Availability of MA plans remains high in 2025

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2025, with most Medicare beneficiaries having access to many plans. Measures of availability were similar relative to 2024. While almost all beneficiaries have had access to some type of MA plan since 2006, local HMOs and PPOs have become more widely available in recent years (Table 11-2). In 2025, nearly 100 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, unchanged from 2024.[14]

The availability of SNPs continues to be high across the types of special-needs populations served (Table 11-2). In 2025, 95 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (unchanged from 2024), 85 percent live where SNPs serve beneficiaries with chronic conditions (up from 72 percent in 2024), and 80 percent live where SNPs serve institutionalized beneficiaries (up from 78 percent in 2024). Overall, 99 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown). Our measure of SNP availability reflects only the share of MA-eligible beneficiaries residing in a county served by a SNP. However, individuals must meet additional coverage criteria to be eligible to enroll in a SNP; for example, to enroll in an institutional SNP, a beneficiary would typically reside in a skilled nursing facility that has a relationship with the plan.

TABLE 11–2

Access to Medicare Advantage plans remains high

	Share of Medicare beneficiaries with access to at least one MA plan				
Type of plan	**2021**	**2022**	**2023**	**2024**	**2025**
Any MA plan	99%	99%	>99.5%	>99.5%	>99.5%
Local CCP	98	99	99	>99.5	>99.5
Regional PPO	72	74	74	74	68
PFFS	34	35	29	30	29
Special-needs plans					
Dual eligible	92	94	94	95	95
Chronic condition	57	59	66	72	85
Institutional	72	74	77	78	80
Zero-premium plan with drug coverage	96	98	99	99	99
Average number of choices					
County weighted	18	22	26	28	28
Beneficiary weighted	32	36	41	43	42
Average number of insurers					
County weighted	4	5	5	6	6
Beneficiary weighted	7	8	8	8	8

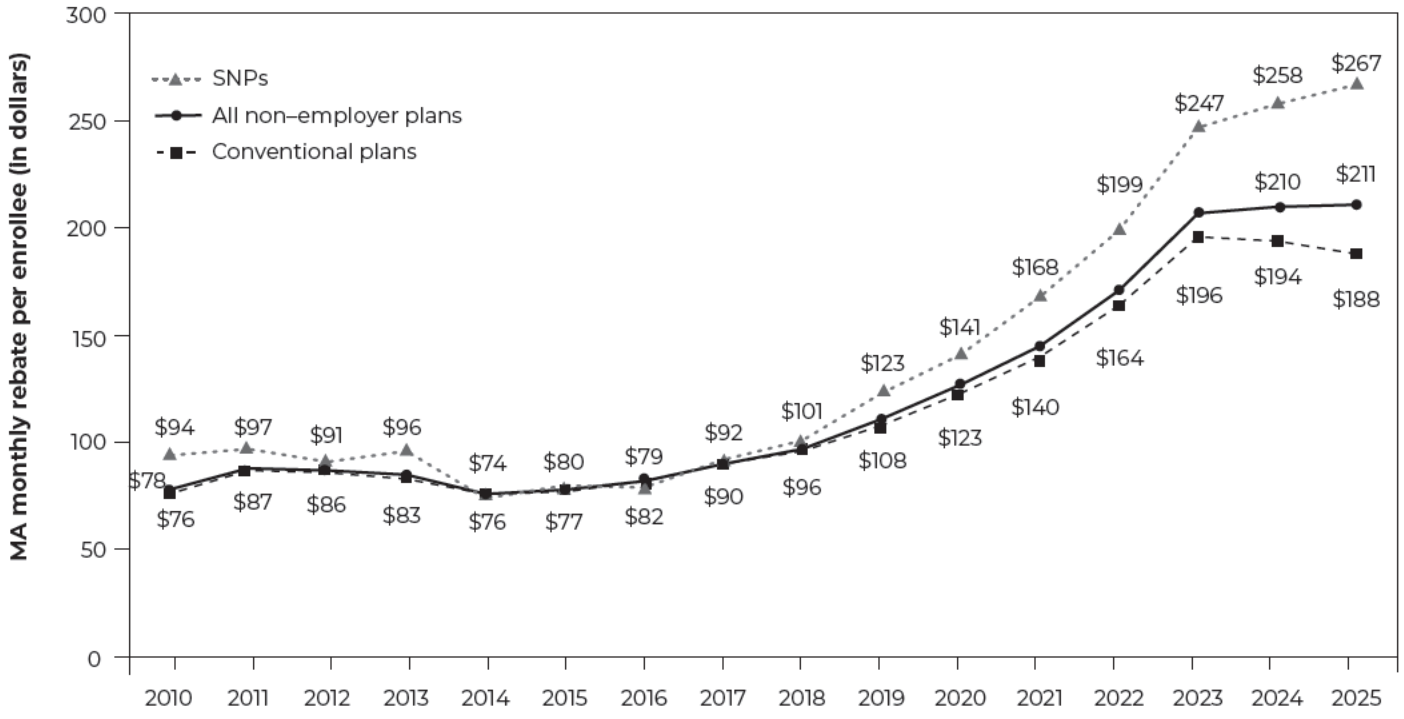
Note: MA (Medicare Advantage), CCP (coordinated-care plan), PPO (preferred provider organization), PFFS (private fee-for-service). "Local CCP" includes HMO and local PPO plans. This table's figures exclude employer-only plans and Medicare Medical Savings Account plans. Special-needs plans are included in the three rows of special-needs plans but excluded from all other rows. For 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). For 2022 through 2025, the share of Medicare beneficiaries includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries). A "zero-premium plan with drug coverage" includes Part D coverage with no Part D premium (but may include the Part B premium). "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county.

Source: MedPAC analysis of CMS bid and enrollment data.

In 2025, nearly 100 percent of eligible Medicare beneficiaries (unchanged from 2024) have access to at least one "zero-premium" plan with drug coverage—that is, a conventional (open to all MA-eligible beneficiaries) MA plan that includes Part D drug coverage and charges no Part C or Part D premium (enrollees may pay the Medicare Part B premium) (Table 11-2).[15] About 76 percent of MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2025, 99 percent of beneficiaries (unchanged from 2024) have access to at least one plan that offers some reduction in the Part B premium (data not shown); about 32 percent of 2025 conventional MA enrollment is projected to be in these premium-reduction plans (a substantial increase from 12 percent in 2024); and the average monthly premium reduction is $44 for enrollees in one of these plans (data not shown). As plans have increasingly offered Part B–premium reductions, MA enrollees may become increasingly attracted to the direct assistance these benefits provide.

FIGURE 11–2

MA rebates for conventional plans and SNPs have more than doubled since 2017



Note: MA (Medicare Advantage), SNP (special-needs plan). Employer group plans and plans that do not offer Part D coverage are not included. The plan rebate is the per beneficiary per month amount that the plan offers as premium-free supplemental benefits. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. Data for 2010 to 2020 differ slightly (by less than $2, on average) from the amounts we reported in previous years, which did not account for plans' adjustments for beneficiaries with Medicare as a secondary payer.

Source: MedPAC analysis of data from CMS on plan bids.

In most counties, beneficiaries have access to many MA plans. In 2025, the average number of plans available in a county is 28 plans (unchanged from 2024) (Table 11-2, p. 333). Plan availability can also be evaluated by the number of plan choices available to the average beneficiary. According to that calculation, the average beneficiary in 2025 has 42 available plans, similar to 43 plans in 2024. An additional measure of plan access is the number of insurers offering products to the average beneficiary. In 2025, the average beneficiary can choose from plans sponsored by eight organizations (unchanged from 2024); 97 percent of beneficiaries have access to MA plans sponsored by at least three organizations, 95 percent of beneficiaries can choose from plans sponsored by at least four organizations, and 90 percent of beneficiaries can choose from plans sponsored by at least five organizations (data not shown). Given the large number of plan choices, the Commission has expressed concern that beneficiaries may find it difficult to discern differences in plan benefit packages in order to make an optimal choice (Medicare Payment Advisory Commission 2023a).

MA rebates, which plans use to provide supplemental benefits to enrollees, remain at nearly record levels in 2025

Rebates to MA plans continue to be at nearly record levels in 2025. Plans must use those rebates to provide supplemental benefits—such as lower cost sharing, lower premiums, or benefits not covered by Part A

TABLE 11–3

Conventional MA plans project that rebates will be used to reduce cost sharing, to cover Part B and Part D premiums, and to offer non-Medicare benefits in 2025

	Rebate (per member per month)			Share of total rebate	
	2024	2025	2025 percent change	2024	2025
Total	$194	$188	–3%	100%	100%
Supplemental benefit type					
Cost sharing	75	80	6	39	43
Non-Medicare supplemental	53	53	1	27	28
Part D supplemental	34	29	–16	18	15
Part D premium	24	15	–39	13	8
Part B premium	7	11	50	4	6

Note: MA (Medicare Advantage). Employer group plans, special-needs plans, and plans that do not offer Part D coverage are not included. Amounts for cost sharing and non-Medicare supplemental benefits include plan costs for administration and profit. Cost-sharing amounts include plan projections of their liability for the cap on beneficiaries' out-of-pocket expenses. Rebate dollar amounts are based on the national average and reflect plan risk scores in plan bids but do not reflect payment adjustments for sequestration. We do not have reliable information about beneficiaries' use of these benefits. Components may not sum to totals due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

or Part B (such as vision, hearing, dental, and fitness benefits). Plans also use some of the rebate to cover their administrative costs and as profit.

Rebates for non-employer plans reached a nominal record high of $210 per enrollee per month in 2025—a slight increase from $209 per enrollee per month in 2024.[16] These rebates account for 17 percent of plan payments, unchanged from 2024. Rebates for conventional MA plans—excluding employer plans and SNPs—average $188 per enrollee per month ($2,255 annually per enrollee; $2,075 after subtracting plan projections for administrative costs and profit), a decrease from the record high $196 per enrollee per month in 2023 (Figure 11-2). While modestly declining since 2023, the average MA rebate among conventional plans remains nearly twice as high as it was in 2018. For SNPs, the average rebate is significantly higher—$267 per member per month in 2025—and has continued to increase in recent years. Since 2019, the monthly average rebate for SNPs has increasingly outpaced the rebates for conventional plans. These higher rebates have coincided with higher enrollment growth in SNPs and greater coding intensity for MA enrollees who are eligible for Medicaid (many of whom are enrolled in SNPs) relative to other MA enrollees. We will continue working to understand why rebates are increasingly diverging between SNPs and conventional plans.

We assess plans' use of rebates based on projected rebate allocations included in plans' bids, but we do not have reliable information about enrollees' actual use of supplemental benefits. In 2025, the share of plan rebates allocated toward cost-sharing reductions is projected to increase relative to 2024 levels (Table 11-3). Plans project that $80 per enrollee per month in rebates (43 percent of rebate dollars, an increase from 39 percent in 2024) will go toward reducing cost sharing for Medicare services, 6 percent more relative to 2024. Plans allocate a portion of those dollars toward their projected administrative costs and profit of providing cost-sharing reductions.[17] In addition, the projected rebates allocated to cost-sharing reductions include coverage for the beneficiary maximum out-of-

pocket (MOOP) cap on plan-approved Part A and Part B expenses. In 2025, plans project that, on average, their liability for the MOOP limit will be $14 per enrollee per month—equivalent to 7 percent of rebates (unchanged from 2024; data not shown) and 1 percent of projected plan payments (unchanged from 2024; data not shown).[18,19] Cost-sharing reductions lower a beneficiary's out-of-pocket expenses and reduce the likelihood that a beneficiary will reach their MOOP limit. All cost-sharing reductions, including the MOOP limit, are subject to plan coverage policies. In addition, for beneficiaries who switch MA insurers midyear during a special enrollment period, their MOOP limit does not include the OOP expenses accumulated earlier in the year from their previous plan.[20]

In 2025, plans project that 28 percent of rebates (averaging $53 per enrollee per month) will be used for non-Medicare-covered supplemental benefits. Plans allocate a portion of those dollars toward their projected administrative costs and profit of providing non-Medicare supplemental benefits.[21] Coverage for vision, hearing, and dental services are some of the most common types of supplemental benefits.[22] These benefits address health challenges that many seniors face as they age and for which there is limited coverage under FFS Medicare. In 2025, nearly all MA enrollees (in both non-SNPs and SNPs) are in plans that offer some coverage of dental, vision, or hearing services (Freed et al. 2024). Plans may also offer nonmedical supplemental benefits such as nonemergency transportation services, assistance paying for over-the-counter items, meals, and gym memberships. The share of plans offering these types of benefits—and the share of enrollees in such plans—has risen as MA rebates have increased.

Other uses of rebate dollars in 2025 are for Part D supplemental benefits (15 percent of projected rebates), reductions in Part D premiums (8 percent of projected rebates), and reductions in Part B premiums (6 percent of projected rebates) (Table 11-3, p. 335). MA plans cannot allocate administrative expenses or profit to Part B–premium reductions, but administrative expenses and profit for Part D–premium reductions and Part D supplemental benefits may be included in plans' Part D bids.[23] Since 2022, plans have allocated an increasing share of rebates toward reductions in Part B premiums and a decreasing share of rebates toward reductions in Part D premiums (data not shown).[24]

As Medicare spending on MA rebates grows, it is increasingly important for policymakers to understand how plans use rebates and the extent to which enrollees use the supplemental benefits that rebates fund. Based on bid data, we know how much Medicare pays to plans in the form of rebates, but little else. Although plans are required to submit encounter data for supplemental benefits, the limited data that plans have reported have been found to be unreliable.[25] Altogether, the data that Medicare collects are insufficient for examining the use of supplemental benefits, making it impossible to know how much plans spend on each type of benefit, which enrollees use each benefit (and how frequently), or whether service use differs by such factors as age, sex, race, disability status, and geographic area. Without this information, it is difficult to assess the impact of these benefits on enrollees' health and to determine whether Medicare's spending on these benefits is in line with the value they provide or the cost of providing them (Government Accountability Office 2023).[26]

Higher payments to MA plans stem from favorable selection and coding intensity

The Commission estimates that MA payments (including rebates that finance supplemental benefits) substantially exceed what would have been spent on those beneficiaries had they been in FFS, continuing the trend of higher levels of payment throughout the history of Medicare's payment policy for managed care. Before applying any adjustments for favorable selection or coding intensity, we estimate that Medicare payments to MA plans have generally been similar to historical spending for FFS beneficiaries with both Part A and Part B coverage. But the effects of favorable selection (prior to any coding differences) have consistently caused the risk scores of MA enrollees to overpredict what their spending would have been in FFS—increasing MA payments by an estimated 11 percent ($44 billion) above FFS spending in 2025. In addition, diagnostic coding by MA plans overstates the health differences between MA and FFS enrollees assumed in risk scores—further increasing MA payments by an estimated 10 percent ($40 billion) above FFS spending in 2025.

In 2025, Medicare's payments to MA plans will total a projected $538 billion (about $507 billion after

TABLE 11–4

MA payments estimated to be substantially above what FFS spending would have been due to the effects of coding intensity and favorable selection

	Share of FFS spending in 2025		
	Benchmarks	**Bids**	**Payments**
Overall estimate	130%*	100%*	120%
Estimated before coding and selection	108*	83*	100
Estimated coding effect	+10	+8	+10
Estimated selection effect	+11	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). The "overall estimate" of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission's methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. The values in the "estimated before coding and selection" row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates do not include beneficiaries with end-stage renal disease. More details on our methodology can be found later in this chapter and in the technical appendixes to this chapter. Components may not sum to totals due to rounding.
* Estimates of benchmarks and bids relative to FFS spending do not include employer plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

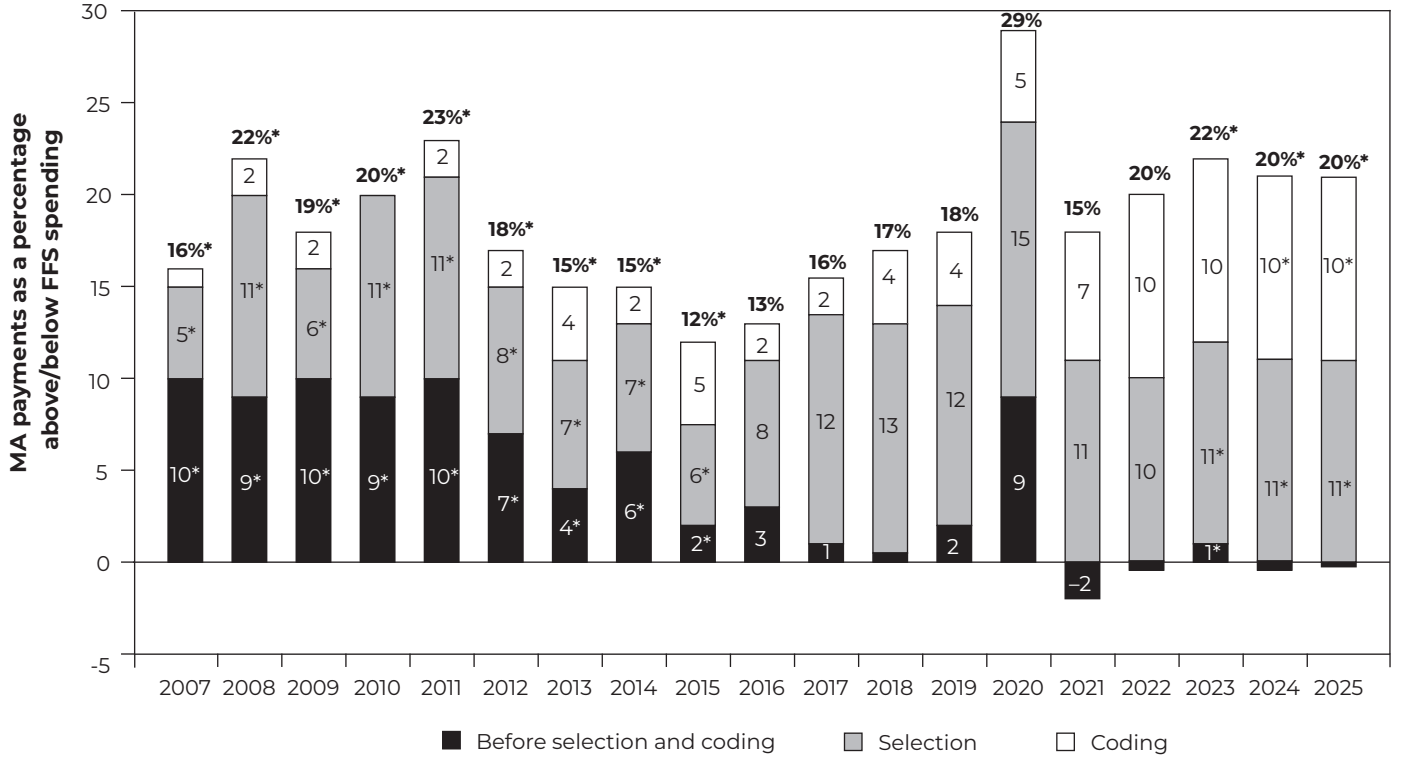
excluding projected payments for enrollees with end-stage renal disease).[27] We estimate that, because of differences between MA and FFS in coding intensity and selection, Medicare spends 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion—or 17 percent of total payments to MA plans, excluding end-stage renal disease payments—in 2025.[28] The payments above FFS spending correspond with our projections of plan rebates in 2025, which we also estimate to be 20 percent of FFS spending and 17 percent of total payments to plans. These higher payments relative to FFS Medicare vary significantly across MA organizations (as shown by the variation in the effects of coding intensity across MA organizations, among other factors). In addition, these payments above what would have occurred in FFS are not an estimate of plan profits and administrative expenses. Instead, these additional payments are the primary source of funding used to provide more generous supplemental benefits and better financial protection for MA enrollees, which help attract enrollees and increase plans' total revenues.

We reach this estimate by first projecting actual payments to MA plans in 2025. We project that those payments, on average, will be equal to about 100 percent of CMS's projections of FFS spending in 2025 (Table 11-4) and that benchmarks and bids will be 108 percent and 83 percent of FFS spending, respectively.

However, to accurately compare MA and FFS spending, we must ensure that the two populations are comparable by accounting for differences in coding intensity and favorable selection. "Coding intensity" refers to the tendency for more diagnosis codes to be recorded for MA enrollees, which causes risk scores for the same beneficiaries to be higher when they are enrolled in MA than they would be in FFS. "Favorable selection" into MA occurs when beneficiaries with lower actual spending relative to their risk scores tend to enroll in MA; it is the extent to which risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans (including coding intensity). As in prior years, we have made technical refinements to our methods for estimating coding intensity and favorable selection, and these updates are reflected in both projected and historical comparisons of MA payments and FFS spending.[29]

FIGURE 11–3

Higher MA payments relative to what estimated spending would have been in FFS since 2007



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than 0.5 percent for 2018, 2022, 2024, and 2025. Estimates of MA payments related to coding are less than 0.5 percent for 2007 and 2010. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. * Specified values were derived from projected data (for 2023 to 2025) or earlier versions of the methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

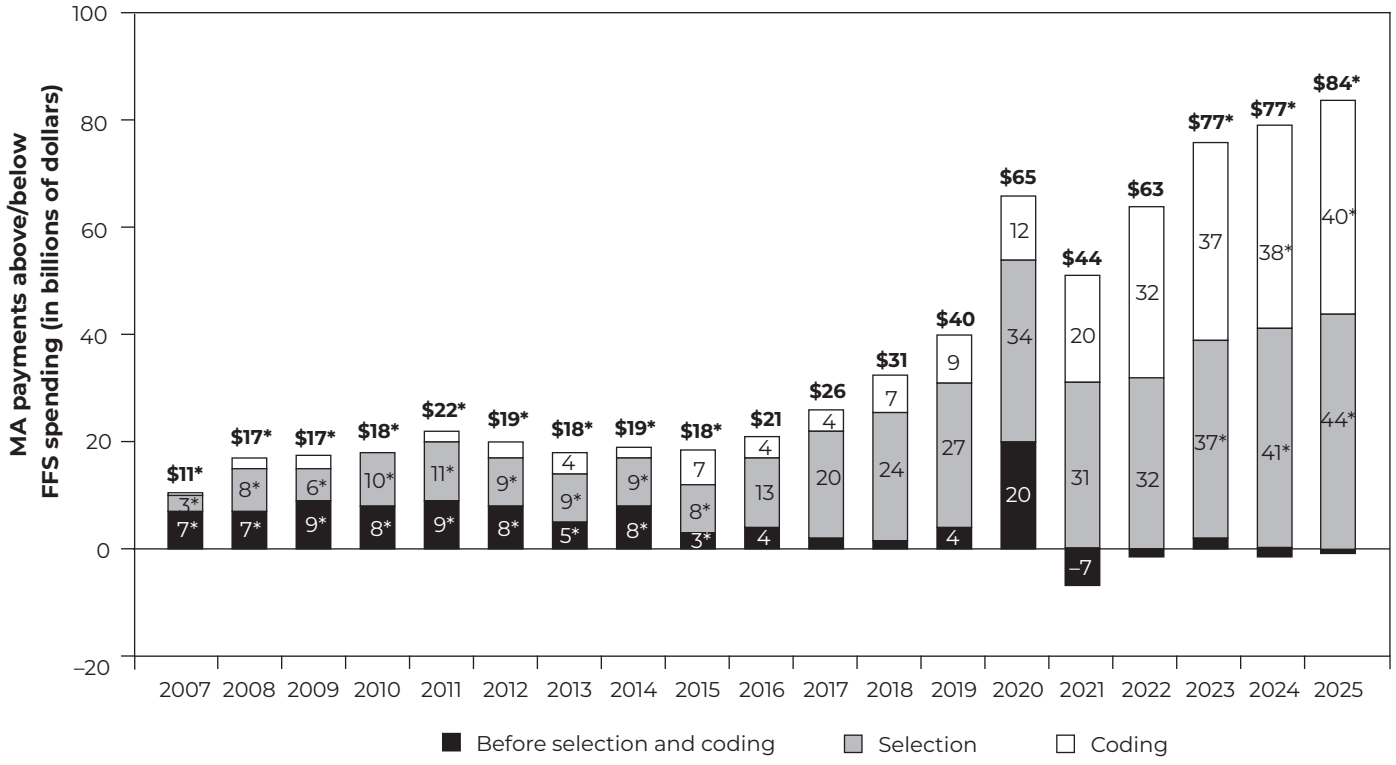
Accounting for greater coding intensity and favorable selection in MA increases our projections of benchmarks, bids, and plan payments as a share of FFS spending. Indeed, we project that benchmarks in 2025 are 130 percent of FFS spending, indicating that Medicare could spend up to 30 percent more, in aggregate, for beneficiaries enrolled in MA than it would if those same beneficiaries were in FFS Medicare. Actual MA payments are 120 percent of FFS spending because most plans bid below those benchmarks.

We project that—after accounting for coding intensity and favorable selection—plan bids in 2025 are 100 percent of FFS spending, meaning that under the existing payment system, on average, plans estimate that their costs to provide the standard Medicare benefit are about the same as FFS Medicare's costs. On average, 13 percent of plans' bids are projected to be nonmedical expenses for administration and profit.

Our review of private-plan payments suggests that over a 40-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Evaluations of private-plan payment rates under Medicare demonstrations occurring before 1985 found that payment rates were 15 percent to 33 percent higher than FFS Medicare spending (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate, and researchers estimated that

FIGURE 11–4

Estimated coding and selection have increased MA payments above what spending would have been in FFS



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates of MA payments relative to what spending would have been in FFS before selection and coding are less than $3 billion for 2017, 2018, 2022, 2023, 2024, and 2025. Estimates of MA payments related to coding are less than $3 billion for 2007, 2008, 2009, 2010, 2011, 2012, and 2014. We exclude MA payments for beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding.
* Specified values were derived from projected data (for 2023 to 2025) or earlier versions of the methodologies for estimating each component (for 2007 to 2015). Values without an asterisk were estimated using historical data and the current and most comprehensive version of the methodology for estimating each component. See text for details.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files.

private-plan payments were 5 percent to 7 percent higher than FFS Medicare spending in the late 1980s and through the mid-1990s (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996).

Figure 11-3 shows that since 2007, payments to MA plans have been substantially above the amount FFS Medicare would have spent for the same beneficiaries, primarily due to the effects of favorable selection and coding intensity. Throughout the 19-year period from 2007 through 2025, we estimate that MA payments were at least 8 percent more than FFS spending for comparable beneficiaries in each year. Between 2011 and 2017, relative MA payments decreased from 23 percent above FFS spending to 16 percent above FFS spending. This change is largely explained by declining benchmarks resulting from ACA policies. However, after changes to benchmarks were fully implemented in 2017, MA payments increased relative to FFS spending through 2025—driven by the combined effects of coding intensity and selection.

Figure 11-4 shows the higher payments to MA relative to what spending would have been in dollar terms if enrollees were in FFS. (In estimating the payment amount above FFS spending, we removed MA payments for beneficiaries with end-stage renal disease (ESRD), which we exclude from all of our analyses and estimate

will account for about 6 percent of MA payments in 2025.[30]) We estimate that Medicare will pay MA plans a total of $84 billion more in 2025 than the program would have spent if enrollees had been in FFS Medicare.

Our current methodology for estimating MA payment comparisons has three components. These three components are estimated separately and are then combined in a single calculation of MA spending relative to FFS. First, we estimate a base comparison of MA payments relative to an estimate of FFS spending that is standardized for differences in average risk scores and geography but does not account for the effects of coding intensity and favorable selection. Second, we estimate the effect of favorable selection and use that estimate to adjust the base comparison of MA payments with FFS spending. Third, we estimate the effect of coding intensity and use that estimate to make an additional adjustment to the base comparison. We use historical data to estimate the effect of each of the three components on MA payments for the most recent year for which data are available (2022 for the base-comparison and favorable-selection components, 2023 for coding intensity) and earlier years. We then project what we expect each component to be through 2025 in years for which data are not yet available, to provide the Congress with our best estimate for the current year. Those projections are subject to uncertainty. In future reports, we will provide updated payment comparisons for those years using historical data. More details on the methods used for estimating each of the components can be found later in this chapter and in the technical appendixes to this chapter.

Before accounting for the effects of coding intensity and favorable selection, MA payments are generally similar to what FFS spending would have been

The first component of the Commission's payment comparison involves constructing a base comparison of MA payments with FFS spending for beneficiaries with similar risk scores and counties of residence. We begin with that base comparison because it aligns with how CMS constructs its estimates of risk-standardized FFS spending that are used to set county benchmarks. However, that base comparison does not account for how coding intensity and favorable selection cause CMS's estimates of risk-standardized FFS spending to overpredict costs for the average MA enrollee. Those effects are incorporated as separate components in the Commission's payment comparisons.

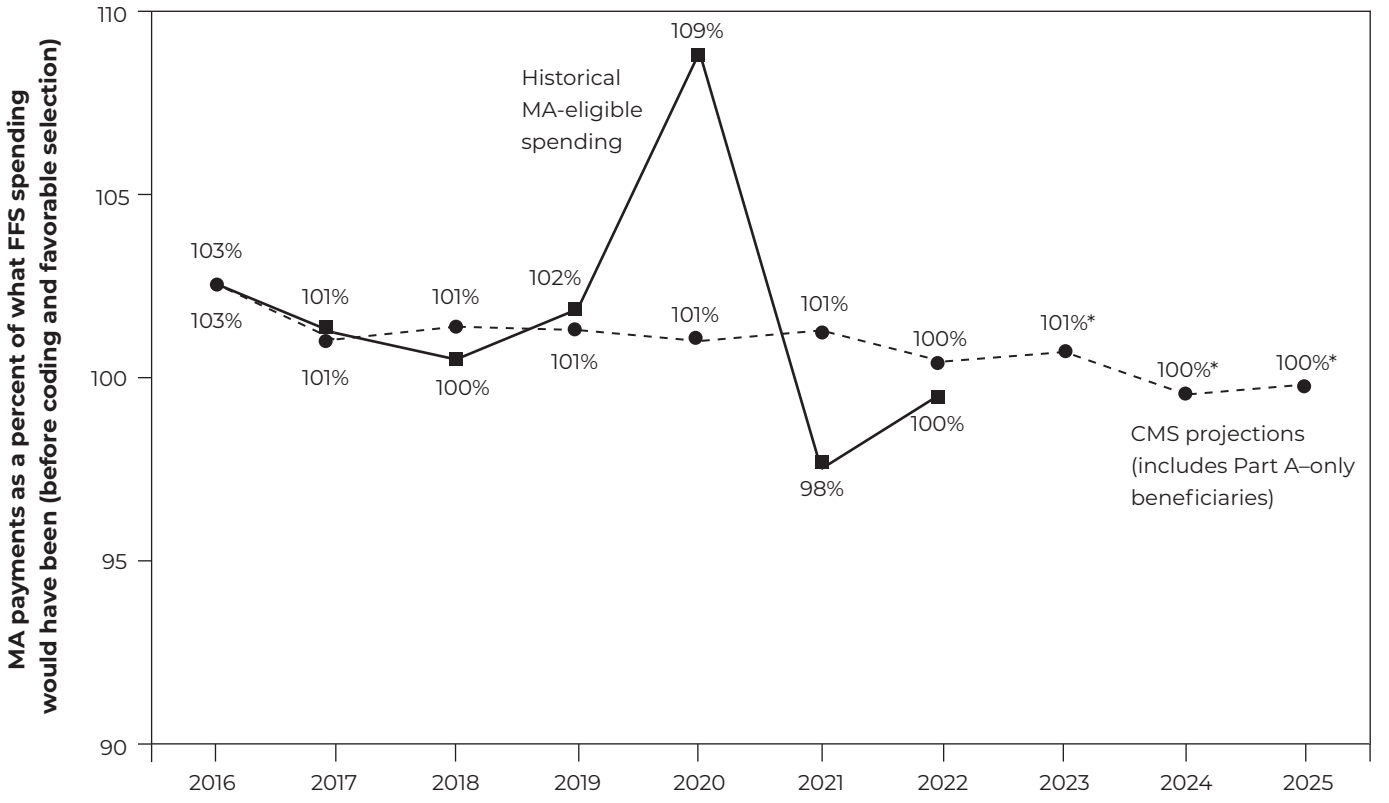
The Commission's estimate that Medicare payments to MA plans in 2025 average 100 percent of projected FFS spending—without any adjustments for coding intensity or favorable selection—reflects several aspects of MA payment policy (Table 11-4, p. 337). First, benchmarks are set above projected FFS spending in some counties and below FFS spending in other counties. Second, benchmarks are increased based on plan quality scores—resulting in quality-bonus payments that are financed with additional program dollars. We estimate that quality bonuses will account for about 3 percent (an estimated $15 billion) of MA payments in 2025. Combining both of those factors, we project benchmarks to be 108 percent of FFS spending in 2025 before accounting for coding and selection. Third, payments to MA plans are below benchmarks because bids are generally lower than benchmarks, and plans receive a percentage (based on quality score) of the difference between bids and benchmarks in additional payment.

The Commission uses historical data on the actual FFS spending of beneficiaries with both Part A and Part B coverage (that is, people who would be eligible to enroll in MA) to estimate the base payment comparison for the most recent year for which data are available (2022).[31] Our estimates of the base payment comparison for years in which we do not have historical data (2023 to 2025) rely instead on CMS's projections of FFS spending. Those projections differ from the actual FFS spending of MA-eligible beneficiaries for several reasons, including that the projections include Part A–only enrollees and that CMS's projection of the FFS-spending trend is subject to uncertainty. The method that CMS uses to produce its FFS projections has been criticized because it includes beneficiaries who have Part A but not Part B coverage, while MA enrollees are required to have both Part A and Part B coverage. The Commission has recognized this shortcoming in the CMS methodology and previously recommended that CMS calculate MA benchmarks using FFS-spending data only for beneficiaries with both Part A and Part B coverage (Medicare Payment Advisory Commission 2021a, Medicare Payment Advisory Commission 2017).

Despite the shortcomings in CMS's projections, our analysis of historical data shows that the projections

FIGURE 11–5

Part A–only beneficiaries included in CMS's projections had no systematic effect on the Commission's base comparison of MA payments with FFS spending



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates have not been adjusted for MA coding intensity and favorable selection of beneficiaries who choose to enroll in MA plans (i.e., underlying differences in risk-adjusted spending between the MA and FFS populations that are not captured by risk scores and would increase MA payments relative to FFS spending). Relative to prior estimates, estimates using historical data have been corrected to reflect no sequestration adjustment on MA payments from CMS in 2021. Estimates include both claims and nonclaims FFS spending. Estimates of actual MA payments in 2020 include remittances related to plans' medical loss ratios. Relative to estimates originally published from 2016 through 2019, prospective estimates are revised to reflect payments to employer plans and adjustments for MA enrollees with Medicare as a secondary payer. Prospective estimates use the figures for FFS per beneficiary spending that CMS's Office of the Actuary generates to determine the MA benchmarks that plans use when submitting bids. Those FFS-spending figures are calculated by summing (1) risk-adjusted Part A FFS monthly spending for all Part A enrollees and (2) risk-adjusted Part B FFS monthly spending for all Part B enrollees.
* Specified values used projected data.

Source: MedPAC analysis of bid data, Medicare enrollment, Medicare claims spending, and risk-adjustment files.

have not systematically impacted our base comparison of MA spending with FFS payments.[32] We estimated the base comparison of MA payments with FFS spending using both CMS's projections and the observed FFS spending of MA-eligible beneficiaries in each year from 2016 to 2022 (Figure 11-5). Both methods produced results that were within 1 percentage point of each other for every year except 2020 and 2021, which were affected by the coronavirus pandemic. The similarity of the estimates for the two methods indicates that relying on CMS's projections of FFS spending (including adjustments for Medicare as a secondary payer) for estimating differences in MA and FFS spending has not introduced meaningful error in our analysis, and we expect that relying on CMS's projections has a minimal effect on our payment comparisons for 2023 to 2025.[33]

We will continue to compare how our estimates differ between using CMS's projections and using historical data. Should a systematic difference between the two emerge, we will consider incorporating an adjustment to our base payment comparison for the years that rely on projected data.

Prior to coding differences, favorable selection causes risk-based payments to overpredict spending for MA enrollees

The second component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for favorable selection. When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. However, applying MA risk scores to FFS spending averages may overpredict the actual spending that MA enrollees would have had in FFS for two reasons: coding intensity and favorable selection. The Commission's estimates of coding intensity are discussed in the next section of this chapter.

"Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even for beneficiaries with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries' propensities to seek care for reasons that are unrelated to their health (Medicare Payment Advisory Commission 2024).

Risk models are imperfect, and beneficiaries with the same risk score typically have a wide distribution of actual spending relative to the spending predicted by their risk score (Lieberman et al. 2023). Each year, a mix of beneficiaries enroll in MA who either have lower spending than predicted by their risk score or higher spending than predicted by their risk score. The MA program as a whole will experience favorable selection if the average MA enrollee has less spending than predicted by their risk score (prior to any effects from plans' utilization management and coding efforts). Because favorable selection occurs when beneficiaries systematically spend less than is predicted by their risk score, higher-risk beneficiaries (including dually eligible beneficiaries) are not necessarily unfavorable to MA plans. Indeed, our estimates show evidence of favorable selection for beneficiaries with both low risk scores and high risk scores.

The effect of favorable selection may vary over time. Our estimates reflect some periods of relatively high favorable selection and some periods with lower favorable selection. Those differences over time reflect a combination of factors, including changes to Medicare's risk-adjustment model and changes in the composition of beneficiaries who choose MA and FFS. If the share of beneficiaries in MA continues to increase, it is not clear how favorable selection will change. It is possible that as MA grows, the favorability of the MA program will converge with the population remaining in FFS, and favorable selection will decrease. Alternatively, it is possible that as fewer beneficiaries remain in FFS, benchmarks will be set on an increasingly small group that is not representative of the Medicare population. For example, remaining beneficiaries in FFS may have a much higher rate of comprehensive supplemental coverage, which would tend to increase their preference for care and may increase favorable selection in MA. Our analysis finds that favorable selection persists as the share of MA enrollees in a market increases, which is consistent with another study that found that selection was prevalent in counties with high MA penetration (Lieberman et al. 2023).

The Commission has developed and refined its methodology for estimating the effect of favorable selection over several years (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a). We use our current methodology to estimate an aggregate selection percentage for the entire population of MA enrollees—except for those with ESRD, who are paid for under a different model—in each year beginning in 2016. That methodology produces a comprehensive estimate that accounts for favorable selection prior to enrolling in MA, the attrition of unfavorable enrollees out of MA, and the change in selection (including regression to the mean) for beneficiaries who remain enrolled in MA.[34,35]

A substantial body of research has found evidence of favorable selection in MA and provides support for the Commission's estimates and methodology (Brown et al. 2014, Curto et al. 2021, Curto et al. 2019, Fuglesten Biniek et al. 2024, Goldberg et al. 2017, Government Accountability Office 2021, Jacobs and Kronick 2018, Jacobson et al. 2019, Lieberman et al. 2023, Medicare Payment Advisory Commission 2023a, Medicare Payment Advisory Commission 2012a, Meyers et al. 2019, Newhouse et al. 2015, Rahman et al. 2015, Riley 2012, Ryan et al. 2023, Teigland et al. 2023). The Commission's method uses data from the portion of the MA population who previously switched (i.e., "switchers") to MA from the FFS program to estimate selection for the entire population of MA enrollees, including those who enrolled upon their initial eligibility for Medicare. Analyses of switchers have been used in other studies (Jacobson et al. 2019, Lieberman et al. 2023, Newhouse et al. 2015, Teigland et al. 2023). A recent white paper also estimated favorable selection among MA beneficiaries who enrolled upon their initial eligibility for Medicare and found estimates that were even larger than our estimates for switchers in similar years (Teigland et al. 2023).[36] That study provides support for our approach that generalizes estimates based on switchers to the newly eligible population.

We made several technical improvements to our methods this year, including updating certain components to more comprehensively account for mortality differences between the MA and FFS populations. More detail on our methodology for estimating favorable selection can be found in Technical Appendix 11-A (p. 377).

Evidence of favorable selection throughout the period from 2007 to 2022

We estimate that favorable selection of the overall MA population resulted in MA payments that were 10 percent above FFS spending in 2022, a slight decrease from 11 percent above FFS spending in 2021 (Figure 11-6, p. 344). The selection percentage was below 100 percent in every year during the 2016 to 2022 period, indicating that the spending that the FFS program would incur for the MA population would be lower than what would be predicted by their risk score. Between 2017 and 2022, the selection percentage increased from 89 percent to 91 percent. On net, favorable selection persisted throughout the study period even as a larger share of Medicare beneficiaries enrolled in MA, including enrollees who had higher risk scores. The estimates presented in Figure 11-6 use the Commission's comprehensive method. We discuss that method in greater detail in Technical Appendix 11-A accompanying this chapter.

Below, we present several analyses using a simple version of our favorable-selection method that compares the FFS spending of beneficiaries who switched from FFS to MA in the following year ("recent switchers") with the spending of beneficiaries who remained in FFS ("stayers"), standardizing for differences in risk score and county of residence. Using this simple method allows us to estimate favorable selection over a longer period and to examine patterns of favorable selection by beneficiary characteristics to provide more information about factors affecting favorable selection.

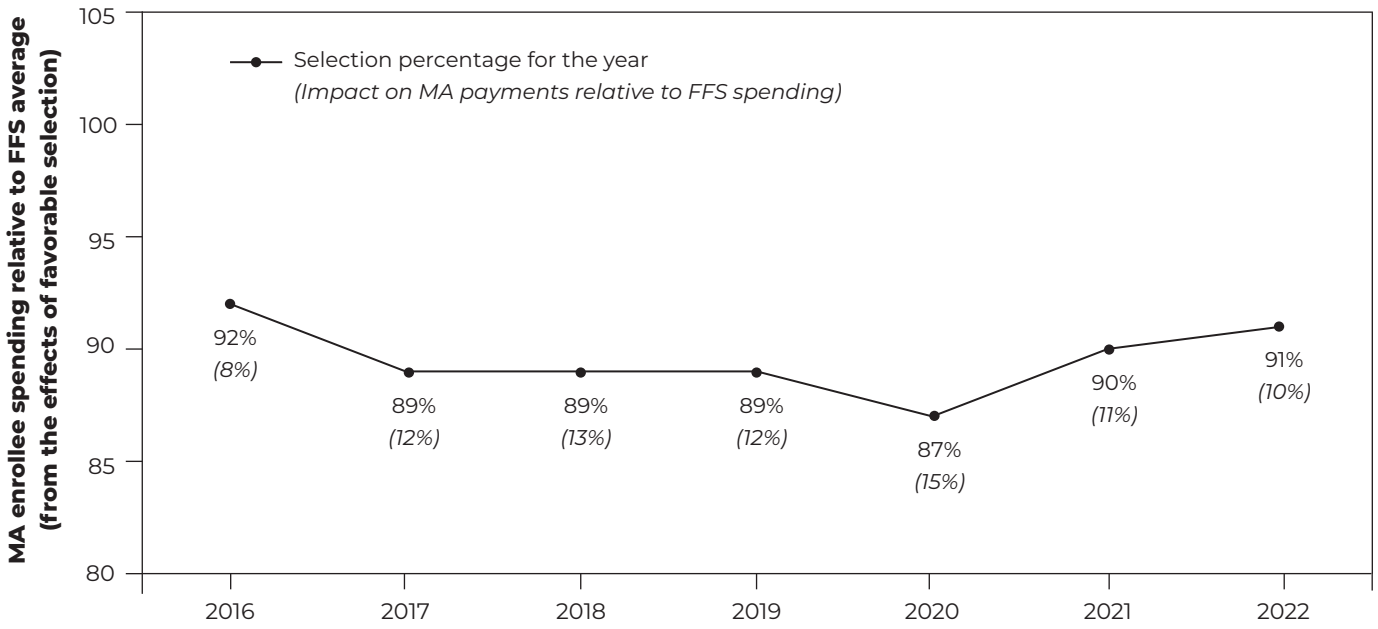
Using the simple method, we found evidence of favorable selection among recent switchers into MA during their last year in FFS throughout the period from 2007 to 2022 (Figure 11-7, p. 345). We estimate that the selection percentage ranged from 87 percent to 96 percent during the period. Favorable selection was highest in 2022 (MA enrollee local-area spending was 12.6 percent less than predicted by their risk score, a selection percentage of 87.4).

Beneficiaries with high risk scores before MA entry had the most favorable selection in 2022 We examined whether the level of risk score that beneficiaries had before entering MA influenced the level of favorable selection in 2022. We grouped beneficiaries into categories based on their risk score in the year prior to enrolling in MA.[37] The selection percentage of each category was calculated as the sum of FFS spending for future MA enrollees in their respective risk-score category divided by the sum of their predicted spending (adjusted for their county of residence). We found that beneficiaries with higher risk scores prior to MA enrollment had more pre-entry favorable selection (Figure 11-8, p. 346).

In 2022, MA entrants had higher levels of favorable selection as their risk scores increased. In other words,

FIGURE 11–6

Evidence of substantial favorable selection annually from 2016 to 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates were constructed using the Commission's comprehensive method for estimating favorable selection. Selection percentages are computed as the ratio of the estimated spending that the FFS program would have would have incurred for MA enrollees relative to the spending predicted by their county benchmark and Medicare's risk-adjustment model. Selection percentage values further below 100 percent indicate greater favorable selection. Estimates are rounded to the nearest percent.

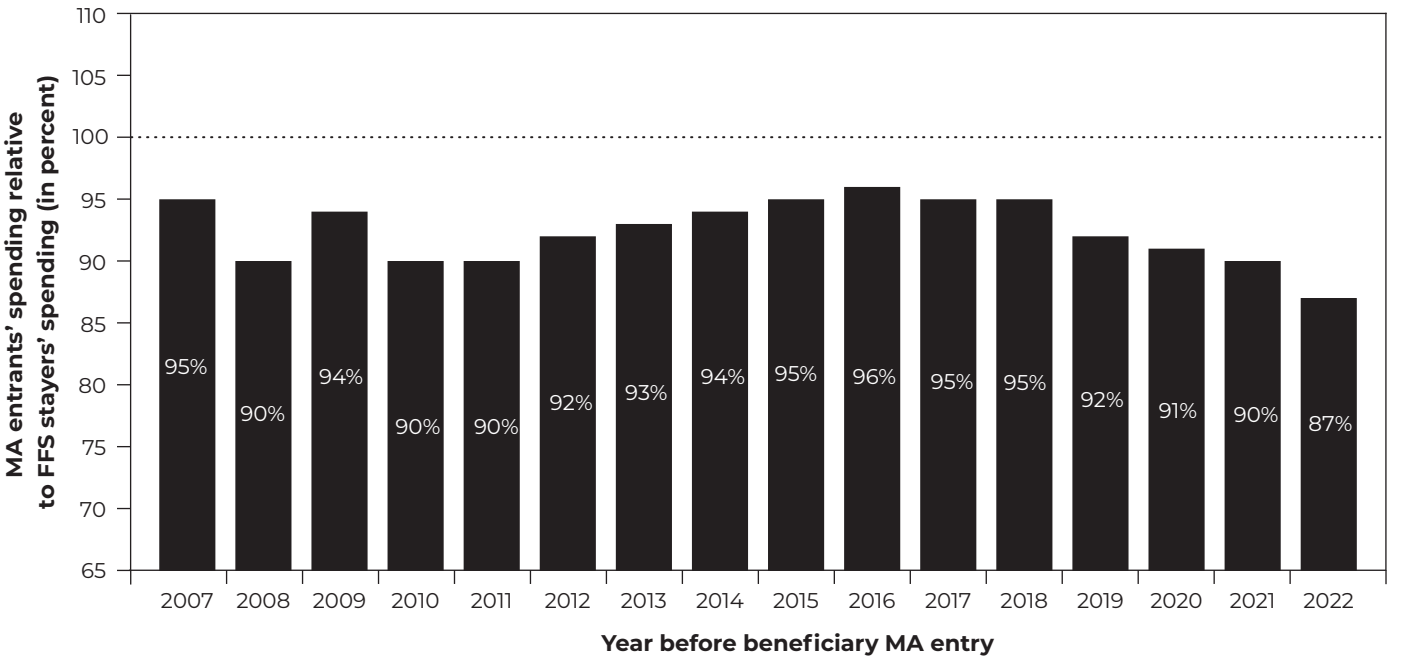
Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

Medicare's payments to MA plans can be too high even for enrollees with expensive health conditions. For example, beneficiaries in the three highest categories of risk scores had the lowest selection percentages (85 percent and below, meaning the highest levels of favorable selection). This finding indicates that those categories (corresponding to beneficiaries with high severity of chronic illness) all had the highest levels of pre-entry favorable selection. In contrast, beneficiaries in the three lowest categories of risk scores before entering MA had the highest selection percentages (98 percent and above), suggesting that beneficiaries with low severity of chronic illness tended to be unfavorable in 2022.

These findings indicate that favorable selection can occur even among those beneficiaries with high risk scores. In fact, we estimate that in 2022, MA enrollees with high risk scores tended to be the most favorable to MA plans. Several factors could account for favorable selection among future MA entrants with high risk scores. One potential factor is the race and ethnicity of those beneficiaries. Black and Hispanic beneficiaries may have high risk scores due to their incidence of chronic illness and rates of dual enrollment in Medicare and Medicaid. One recent study found that the CMS–HCC model overpredicted the risk-standardized spending for Black and Hispanic beneficiaries, on average, suggesting that these groups have below-average service use relative to their risk scores (McWilliams et al. 2023). That suggests that as MA plans enroll a higher share of Black and Hispanic beneficiaries, the average risk-standardized spending of their enrollees may become more favorable.

FIGURE 11–7

Beneficiary FFS spending in the year before MA enrollment indicates favorable selection for recent entrants from 2007 to 2022



Note: FFS (fee-for-service), MA (Medicare Advantage). Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. "Spending" reflects the year prior to MA entry and is risk standardized. Values further below 100 percent indicate greater favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

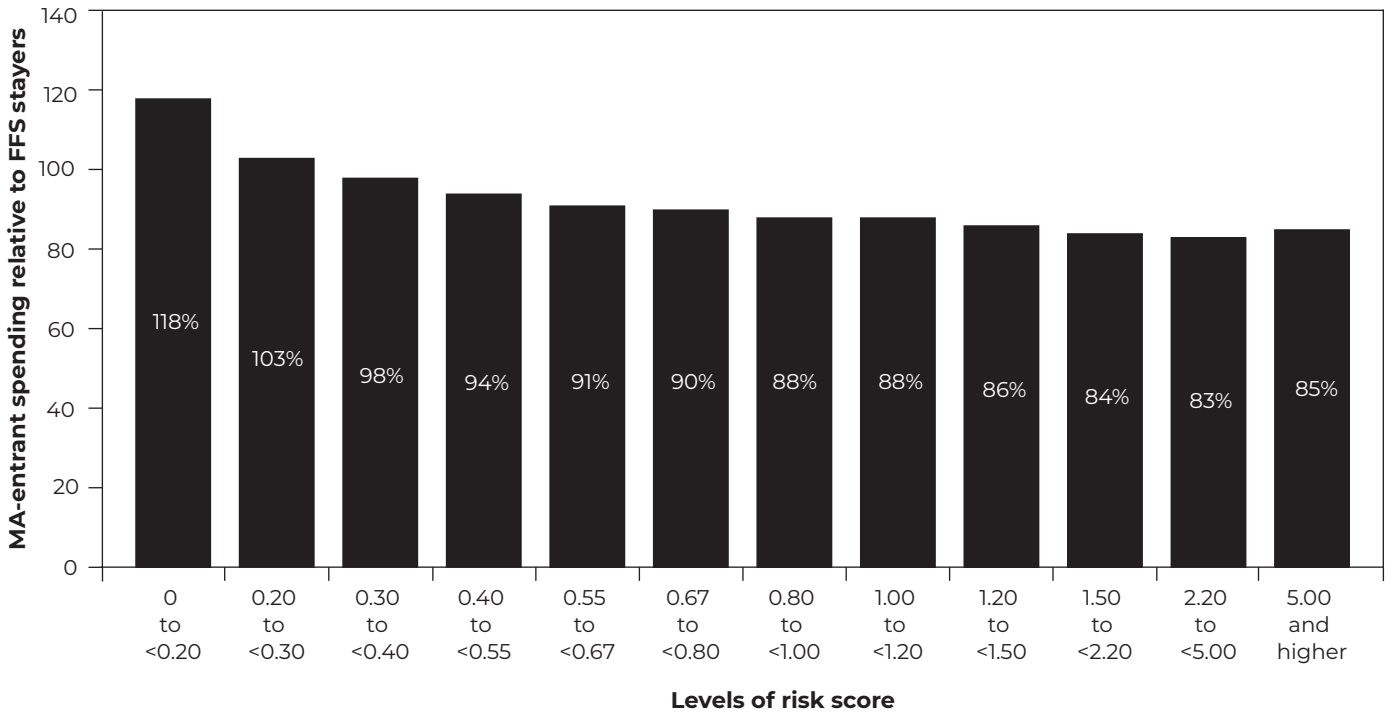
Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

Similarly, as MA plans enroll populations with higher levels of chronic illness, the level of favorable selection may increase rather than decrease. We did not adjust our analyses of favorable selection to control for race and ethnicity or social risk factors beyond the factors included in the CMS–HCC model used for MA risk adjustment and payment. Controlling for additional factors would reduce the accuracy of our estimates and could increase our estimate of favorable selection.[38]

Favorable selection of recent MA entrants was similar in counties with high and low MA penetration Some observers have posited that favorable selection will decrease as the share of Medicare beneficiaries enrolling in MA continues to increase. To analyze this hypothesis, we examined whether the level of a county's MA penetration influenced the level of favorable selection in 2022 using our simple method that focuses on recent MA entrants. We found very little difference in selection between markets with low MA penetration and markets with high penetration (Figure 11-9, p. 347). In 2022, MA entrants in markets with high penetration had the same pre-entry selection percentage (89 percent) as MA entrants in markets with low penetration. Thus, we do not find evidence that high MA penetration affects MA favorable selection. In markets where MA penetration increases to very high levels, MA benchmarks will be set based on an increasingly small group of FFS beneficiaries. It is not clear whether the smaller share of FFS beneficiaries will continue to be different in ways that are not

FIGURE 11–8

Beneficiaries with high risk scores before MA entry had the highest estimated favorable selection in 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Risk-score levels reflect the pre-entry risk scores for MA enrollees. Due to scaling, values for risk scores of less than 0.20 may appear truncated. Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. Spending reflects the year prior to MA entry and is risk standardized. Lower MA-entrant spending relative to FFS stayers' spending reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment (2021–2023), Medicare claims spending (2022), and risk-adjustment files (2022).

captured by risk adjustment and be unfavorable relative to beneficiaries who enter MA.

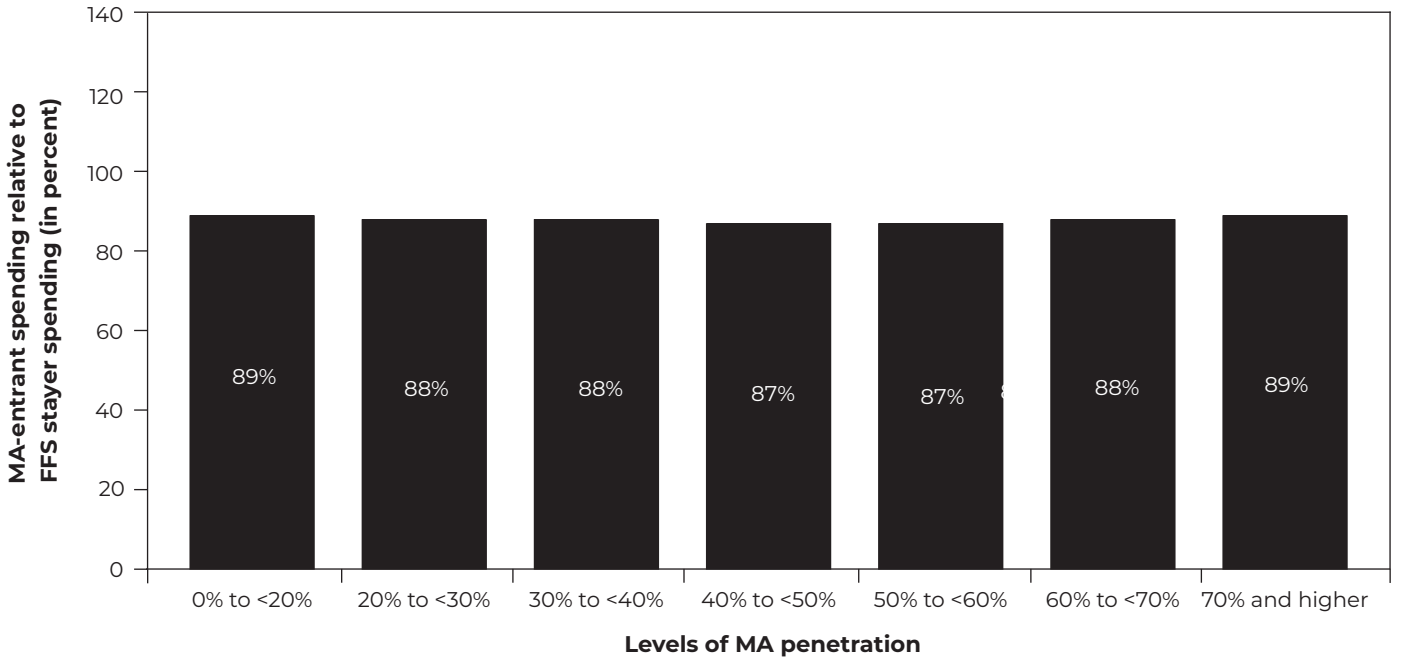
Coding differences increase payments to MA plans in 2025 by an estimated $40 billion and continue to generate inequity across plans

The third component of the Commission's payment comparison adjusts the base comparison of MA payments relative to FFS spending for coding intensity. Payments to MA plans are risk adjusted to account for differences in health status. Higher risk scores increase payments to plans for enrollees with higher expected Medicare spending. MA enrollees' risk scores are based on demographic information and diagnoses that plans submit to CMS. Our estimates of coding intensity are independent of our estimates of the effects of favorable selection because we estimate selection prior to MA enrollment and subsequent changes in selection using FFS data.

Documenting additional diagnosis codes raises plan-enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing the monthly payments that MA plans receive from Medicare and (2) increasing the rebates plans use to provide supplemental benefits to enrollees. Plans that document relatively more diagnosis codes have a competitive advantage over other plans.

FIGURE 11–9

Estimated favorable selection before MA enrollment was similar in counties with high and low MA penetration in 2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates were constructed using the Commission's simple method for estimating favorable selection. "MA entrants" are beneficiaries who switched from FFS to MA in the following year. "FFS stayers" are beneficiaries who remained in FFS in the following year. Spending reflects the year prior to MA entry and is risk standardized. Lower MA-entrant spending relative to FFS stayers' reflects a greater effect of favorable selection. The analysis excludes beneficiaries without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory).

Source: MedPAC analysis of Medicare enrollment (2021–2023), Medicare claims spending (2022), and risk-adjustment files (2022).

Documenting an additional HCC for an enrollee can significantly increase Medicare's payment to a plan for that enrollee. Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools, such as health risk assessments and chart reviews, that MA plans use to capture diagnoses—tools that are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended.

For 2025, we project that MA risk scores will be about 16 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by CMS's coding-intensity adjustment that reduces MA risk scores by 5.9 percent. The net effect is a 10 percent increase in MA risk scores due to coding intensity, leading to $40 billion in higher projected payments to MA plans in 2025. Between 2007 and 2025, we estimate that MA coding intensity will have generated $224 billion in aggregate higher payments to MA plans.

The Commission's approach to estimating coding intensity compares MA and FFS risk scores, controlling for age, sex, Medicaid eligibility, and institutional status and then identifying differences in risk scores as due to differences in coding intensity. More details on the methodology can be found in Technical Appendix 11-B (p. 388).

Coding intensity varies significantly across MA organizations. As a result, CMS's across-the-board adjustment for coding intensity, which reduces all MA

risk scores by the same amount, generates inequity across organizations by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences between MA and FFS, improve the equity of the adjustment across MA contracts, and improve incentives to reduce costs and improve quality. The Commission's approach to reducing MA coding intensity has been to address the mechanisms that generate coding differences first (e.g., remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment would be consistent with the Commission's approach.

Documenting more diagnosis codes increases payments to plans

Among the 20 most common HCCs in MA—which have payment amounts ranging from roughly $1,000 to $5,500—the average additional payment per HCC is about $3,400 per year. Documenting each additional HCC for an enrollee can thus significantly increase Medicare's payment to a plan. We can illustrate how coding additional HCCs increases payment to a plan for Medicare-covered services using average FFS Medicare spending.[39] For example, in 2022, the annual Medicare payment to an MA organization for a non-Medicaid-eligible 80-year-old male (where the demographic component of the risk score is valued at $6,726) with diabetes without complication (HCC 19, valued at $1,284) would have been $8,010. If the same 80-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at $3,620), the Medicare annual payment to the MA organization would increase to $11,630.

Because the CMS–HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic-coding patterns. Most diagnoses are reported on physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes, thus providing little financial incentive to document diagnoses for FFS beneficiaries. This distinction can lead to relative underreporting of diagnoses in FFS. If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated above the value they would have been if the diagnoses had been more completely reported. Because Medicare's risk model is based on diagnostic-coding patterns in FFS, when MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS.

Because of the increased financial incentives for MA plans to code more diagnoses and the additional tools that MA plans use to capture diagnoses—tools that are not features of FFS Medicare—coding intensity is higher in MA than in FFS and payments to MA plans are higher than intended. Although Medicare's accountable care organization (ACO) programs and some other alternative payment models (APMs) offer incentives to increase diagnostic-coding intensity in FFS Medicare, we continue to see higher coding intensity in MA, and that difference continues to increase. The tools that ACOs and APMs have available result in less coding intensity than those available to MA plans; notably, chart reviews, in-home health risk assessments, and subcapitation to medical groups are used only in MA. Furthermore, CMS limits annual risk-score growth for ACO enrollees when calculating shared savings or losses. Thus, we expect that FFS coding will continue to identify fewer diagnosis codes than MA coding does. (See text box "Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices," for more information about how MA and FFS coding practices differ for specific conditions.)

Higher MA payments due to coding differences have been under scrutiny for more than a decade. Research has consistently found that the impact of coding differences on MA risk scores produces higher payments for MA plans (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018,

Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices

The House Committee on Appropriations requested that the Commission report on differential coding in Medicare Advantage (MA) and fee-for-service (FFS) Medicare. The Committee requested that MedPAC analyze how different incentives in FFS and MA contribute to different relative rates of diagnostic coding for beneficiaries enrolled in the two parts of the program. The Committee also requested an analysis of associated effects on payment differences.

Committee report language

Differential Coding in Medicare Fee For Service.—The Committee is aware of the dynamic noted in MedPAC's 2024 Report to the Congress that FFS Medicare claims offer little incentive to record all relevant diagnoses of FFS patients. The Committee directs MedPAC to, within 12 months of enactment of this Act, issue a report estimating the extent to which this incentive results in different relative rates of diagnostic coding for Medicare Advantage and FFS beneficiaries and the extent to which such coding differences may result in payment differentials between Medicare Advantage and FFS.

Evaluating diagnostic-coding differences between MA and FFS Medicare

Diagnostic-coding differences for MA and FFS beneficiaries can arise for several reasons. Coding differences can reflect MA plans' ability to document more diagnoses than FFS providers, potentially because plans have an incentive to report every diagnosis for an enrollee, whereas FFS providers may be more likely to focus on more significant diagnoses that are primary reasons for a visit. In some cases, the additional diagnosis codes submitted by plans may reflect fraudulent diagnoses, those for which the patient did not meet clinical criteria. Whistleblowers and the Department of Justice allege that some MA plans have submitted fraudulent diagnoses for risk adjustment (Department of Justice 2022, United States of America ex rel. Benjamin Poehling v. UnitedHealth Group Inc. et al. 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017). Lawsuits and risk-adjustment data-validation audits seek to address higher MA coding due to fraud or insufficient documentation, but even if fraudulent diagnoses were eliminated, other sources of differential diagnostic coding would remain.

Applying diagnostic criteria to individual patients can involve judgment, and diagnostic criteria may be interpreted differently by MA plans compared with providers treating FFS patients. CMS developed a set of diagnostic-coding principles to ensure that diagnostic codes were applied appropriately in risk adjustment (Pope et al. 2004). Principle 10 addresses the varying specificity in diagnostic criteria, which could allow for different diagnostic criteria to be applied in MA compared with FFS Medicare, especially for diagnoses with more clinical discretion. Principle 10 states, "Discretionary diagnostic categories should be excluded from payment models. Diagnoses that are particularly subject to intentional or unintentional discretionary

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Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). One study found that when controlling for differences in health status using Part D prescription drug data, from 2008 to 2015, MA risk scores grew by about 1 percent more per year than FFS risk scores (Jacobs and Kronick 2018). A second study used a difference-in-difference approach on risk-adjustment data for 2008 to 2013 to estimate that risk scores for enrollees remaining in MA grew about 1.2 percent faster per year than for beneficiaries in FFS Medicare (Hayford and Burns 2018). A third study, using county-level data, found that in the first year

Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

coding variation or inappropriate coding by health plans/providers . . . should not increase cost predictions. Excluding these diagnoses reduces the sensitivity of the model to coding variation and coding proliferation." CMS excluded some codes that exhibited the greatest differences in MA- and FFS-coding rates from the most recent risk-adjustment model (V28), introduced in 2024, but other diagnostic codes included in the model are likely to have some degree of discretion.

Providers generally have fewer incentives to submit diagnosis codes for their FFS patients compared with the incentives that MA plans have to submit codes for their enrollees. In MA, plans receive higher payments when additional diagnosis codes are recorded on inpatient, outpatient, and professional claims, or when additional diagnoses are submitted through health risk assessments and chart reviews. In FFS, providers generally do not receive higher payments when additional diagnoses are recorded on outpatient and professional claims or on health risk assessments, and chart reviews are not submitted through FFS Medicare. That difference in incentives suggests that at least some of the relatively higher coding intensity in MA that the Commission and others have estimated is because fewer FFS patients are coded with diagnoses that would be applicable to them, which is sometimes referred to as "incomplete coding."

While the difference in incentives to submit diagnosis codes in the two programs is clear, it is challenging to estimate how much of the difference in coding intensity between the two programs arises because of differing incentives. Without analyzing data from medical records, it is impossible to know whether beneficiaries would have met the criteria for all diagnosis codes that were not recorded.

Parsing the reasons for diagnostic-coding differences is challenging, and in some cases data do not exist. In responding to the Committee's request, we assessed the available measure of coding completeness that we think is most related to different incentives to document diagnoses: the rates of follow-up coding for chronic conditions that are expected to persist from year to year. For the chronic conditions that we analyze, nearly all patients who are diagnosed with a condition in one year are expected to meet the clinical criteria for the condition in the following year. Therefore, we can reasonably classify diagnoses that were not recorded in the following year as instances of incomplete coding. This analysis, however, is not able to estimate all instances of incomplete coding in MA and FFS, such as the coding of chronic conditions that are never diagnosed for a beneficiary and the coding of conditions that are not expected to persist from year to year.

We find evidence of incomplete coding for nearly all of the 52 chronic conditions that we analyzed for both FFS and MA beneficiaries, with substantial variation in the rates of follow-up diagnoses across the different conditions. The rates of follow-up coding were lower (that is, coding was less complete) for FFS beneficiaries for 35 out of the 52 conditions we analyzed, and 12 of the conditions had follow-up rates that were more than 5 percentage points lower in FFS than MA. However, two conditions had follow-up rates that were more than 5 percentage points higher in FFS than MA. This analysis suggests that while diagnoses are coded incompletely in both MA and FFS, incomplete coding is somewhat more common in FFS than in MA.

Because the Commission's analysis of follow-up coding focuses on only one mechanism whereby coding completeness may influence payments to MA plans, we are unable to estimate specifically how much payments to plans are affected by differences in coding completeness or accuracy. The Commission estimates that, in 2025, payments to MA plans will be $40 billion (10 percent) higher due to differences in coding intensity that arise

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

for any reason. That estimate is discussed in more detail in the main text. Regardless of the reasons, higher coding intensity in MA relative to FFS causes payments to MA plans to be higher than they would be if coding practices were comparable.

Analysis of follow-up coding in the MA and FFS programs

To evaluate the completeness of follow-up coding in FFS and in MA, our staff physician reviewed the diagnosis codes associated with each hierarchical condition category (HCC) and identified 52 HCCs (of 86 HCCs in the V24 CMS–HCC model) that represent chronic conditions for which we would expect the condition, if coded in one year, to persist in the following year for nearly all beneficiaries. First, we looked at beneficiaries in FFS with Part A and Part B for 2022 and 2023 and analyzed how often beneficiaries who had those chronic-condition HCCs coded in 2022 were coded with the same HCC or a related, higher-severity HCC in 2023. (Related HCCs are ranked into hierarchies based on severity, and only the highest-severity HCC counts toward a risk score when more than one HCC in the hierarchy is identified for a beneficiary.) Next, we performed the same analysis for beneficiaries in MA for 2022 and 2023. Figure 11-10 (p. 352) shows the estimates from that analysis.

We found wide variation in the rates of follow-up coding within both the MA and FFS populations. In FFS Medicare, seven chronic-condition HCCs had follow-up rates above 90 percent and seven had follow-up rates below 50 percent. In MA, five chronic-condition HCCs had follow-up rates above 90 percent and five had follow-up rates below 50 percent. HCCs contain a large variety of conditions, both symptoms and diseases, some of which may resolve over time or may become so chronic or stable that practitioners no longer need to actively treat the condition and therefore do not code the condition according to coding guidelines.[40] These results are similar to those found by other researchers assessing chronic conditions in the V22 risk model for 2017 to 2019 (Ghoshal-Datta et al. 2024).

In addition, we find that most of the chronic-condition HCCs have similar rates of follow-up coding in MA and FFS Medicare. Of the 52 chronic-condition HCCs, 38 had MA follow-up coding rates within 5 percentage points of FFS. Among these HCCs, the rates of follow-up coding were more often higher in MA, with 23 HCCs having higher MA follow-up rates and 11 having higher FFS follow-up rates (and 4 showing no difference in follow-up coding rates).

To help assess why some chronic-condition HCCs had larger differences in MA and FFS follow-up coding rates, we consider whether an HCC is part of a hierarchy and the relative MA and FFS coding rates in a single year when accounting for differences in age, sex, and Medicaid eligibility (Figure 11-11, p. 353).

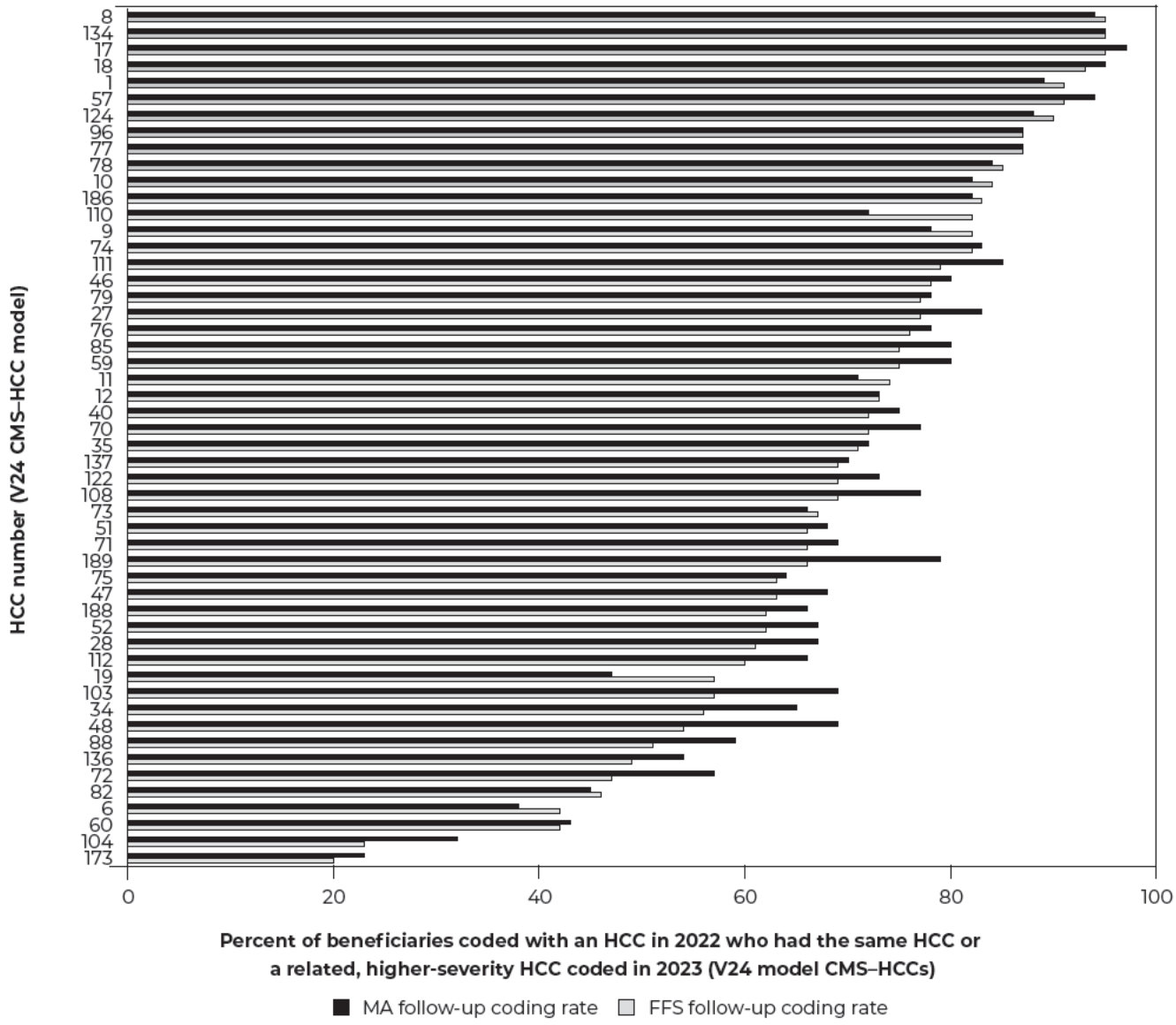
We first consider the two HCCs that had follow-up rates that were 10 percentage points higher in FFS than in MA: diabetes without complication (HCC 19) and cystic fibrosis (HCC 110). Diabetes without complication is the lowest-severity HCC in a hierarchy that includes diabetes with chronic complications (HCC 18) and diabetes with acute complications (HCC 17).[41] Comparing MA and FFS coding rates for a single year, we find that the three diabetes HCCs collectively are coded 38 percent more often in MA than in FFS (accounting for differences in age, sex, and Medicaid eligibility), demonstrating higher overall coding of diabetes in MA. However, we find that coding rates for diabetes with chronic complications are 52 percent higher in MA than in FFS, and coding rates for diabetes with acute complications are 12 percent higher, while coding rates for diabetes without complications are 19 percent lower (see Figure 11-11). MA had a 10 percentage point lower rate of follow-up coding for diabetes without complication (47 percent compared with 57 percent).

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

FIGURE 11–10

Wide variation in the persistence of coding chronic-condition HCCs for MA and FFS, but more conditions had higher persistence in MA, 2022–2023



Note: HCC (hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service). Beneficiaries were either enrolled in FFS Medicare for all of 2022 and 2023 or MA for all of 2022 and 2023. Follow-up rates of diagnostic coding were calculated as the share of beneficiaries with an HCC coded in 2022 who were also coded with the same HCC or a related, higher-severity HCC in 2023. For V24 HCC descriptions and coefficients, see Table VI-1 of CMS's announcement of MA payment rates for calendar year 2020.

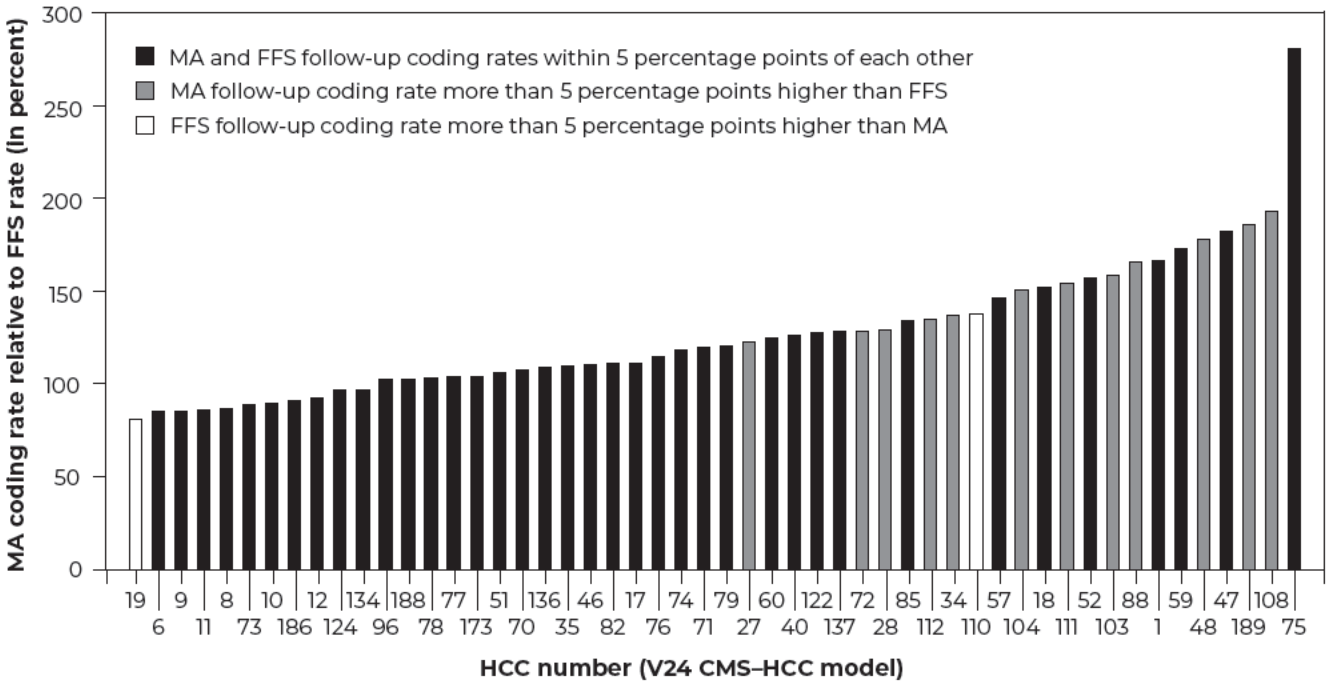
Source: MedPAC analysis of Medicare enrollment and risk-score files for 2022 and 2023.

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

FIGURE 11–11

Chronic conditions with higher MA follow-up coding rates compared with FFS also have higher demographic-adjusted MA coding rates, 2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Beneficiaries were either enrolled in FFS Medicare for all of 2022 and January of 2023 or in MA for all of 2022 and January of 2023. Differences in MA and FFS HCC-coding rates account for differences in age, sex, and Medicaid eligibility. For V24 HCC descriptions and coefficients, see Table VI-1 of CMS's announcement of MA payment rates for calendar year 2020. For each HCC, the figure shows the ratio of the MA coding rate over the FFS coding rate, where 100 percent indicates similar rates of coding.

Source: MedPAC analysis of Medicare risk score and enrollment files for 2022 and 2023.

Cystic fibrosis is the highest-severity HCC in a hierarchy along with chronic obstructive pulmonary disease (HCC 111) and fibrosis of lung and other chronic disorders (HCC 112). Beneficiaries with cystic fibrosis account for only 0.1 percent of all beneficiaries with one of the HCCs in this hierarchy. For a single year, we find that MA rates of coding cystic fibrosis are 38 percent higher than in FFS Medicare, and MA rates of coding for any of these three HCCs are 53 percent higher than in FFS Medicare. However, MA had a 10 percentage point lower rate of follow-up coding for cystic fibrosis, 72 percent versus 82 percent in FFS.

Next, we consider the 12 HCCs that had follow-up rates that were more than 5 percentage points higher in MA than in FFS. These HCCs tended to have lower follow-up rates for all beneficiaries (these HCCs tend to be on the left side of Figure 11-11), and all have higher single-year coding rates in MA than in FFS, ranging from 23 percent higher to 94 percent higher (accounting for differences in age,

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Congressional request on Medicare Advantage and fee-for-service diagnostic-coding practices (cont.)

sex, and Medicaid eligibility), shown in medium gray in Figure 11-11. Higher single-year MA coding rates appear to be associated with higher MA follow-up rates. One possible reason for this association is that higher MA coding may be caused by plans using a simple diagnostic tool in a way that lacks clinical consensus. For example, if a diagnosis is based on a noninvasive test that can be conducted in a beneficiary's home, MA plans may incorporate this test into an in-home health risk assessment, leading to higher overall MA coding for that condition. At least one MA insurer has been using a noninvasive device to test for vascular disease during in-home visits. The manufacturer of the test states that it is a stand-alone device for diagnosing vascular disease, but some doctors disagree. Noninvasive testing for this disease more than doubled in MA between 2018 and 2021 while remaining relatively stable in FFS Medicare (Ross et al. 2024). We find that vascular disease (HCC 108) is documented almost twice as often in MA than in FFS when accounting for differences in age, sex, and Medicaid eligibility (Figure 11-11).

Conclusion

Because the risk-adjustment model is calibrated on FFS spending and diagnoses, when MA coding intensity is higher than in FFS Medicare—regardless of the reason—it increases payments to MA plans above FFS spending. Estimating the share of diagnostic-coding differences associated with any one reason is difficult. In our analysis, we attempt to assess the impact of different incentives to document diagnosis codes in MA and FFS Medicare by estimating rates of follow-up coding in MA and FFS Medicare. We found that follow-up coding rates were somewhat lower for FFS beneficiaries for most, but not all, chronic conditions. Our analysis suggests that while diagnoses are coded incompletely in both MA and FFS, "incomplete coding" is somewhat more common in FFS than in MA. Finally, we caution that neither MA nor FFS coding practices are likely to produce "accurate" diagnostic coding given the incompleteness in diagnosis codes that we found in both FFS and MA and the allegations of fraudulent diagnostic-coding practices in MA made by the Department of Justice and a number of industry whistleblowers. ■

after MA enrollment, risk scores increased about 6 percent faster than FFS and about 2 percent faster in the second year (Geruso and Layton 2020). The Government Accountability Office used a risk-score-prediction model to estimate coding intensity for 2010 through 2012, and those estimates align very closely to the Commission's estimates over that same time period (Government Accountability Office 2013). A new study focusing on diagnoses submitted on hospital claims has found higher levels of MA coding intensity for beneficiaries who subsequently had a health assessment in a skilled nursing facility (Kosar et al. 2024).

Starting in 2010, a series of congressional mandates require CMS to reduce MA risk scores to address the impact of MA and FFS coding differences on payments to MA plans. Because of these mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which rose gradually to about 5.9 percent in 2018, where it will remain until the Secretary of Health and Human Services implements risk adjustment using MA diagnostic, cost, and use data (which is generally thought to mean a risk model that has coefficients estimated using MA encounter data, rather than FFS claims data). Although larger reductions are allowed

under the legislation, CMS reduced MA risk scores by only the minimum amount required by law for 2014 through 2025.[42]

The Commission's method for estimating coding intensity compares MA and FFS risk scores, controlling for age, sex, Medicaid eligibility, and institutional status, and identifies differences in risk scores as due to differences in coding intensity. We introduced that method in 2024. After revising our method of estimating coding intensity, the Commission found that the new method and the older method the Commission had been using, despite different methodological approaches, produced substantially similar estimates of plan coding intensity over the period 2007 through 2021. A detailed description of those methods can be found in Chapter 13 of our March 2024 report to the Congress, along with the research leading to the revisions. This year, we made additional revisions to exclude Puerto Rico from our coding-intensity estimate because accurate data on Medicaid eligibility are not available.[43] This revision reduced our coding-intensity estimates by about 1 percentage point from what we previously reported. We also modified how we weight new enrollees so that the estimate more accurately reflects the share of payments associated with new and continuing (those with risk scores based on diagnosis codes) enrollees. More details on our methodology for estimating MA coding intensity can be found in Technical Appendix 11-B.

Figure 11-12 (p. 356) shows the impact, for 2007 through 2023, of differences in coding intensity on MA risk scores relative to FFS and the size of the coding-intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity). MA coding intensity has been above FFS levels since 2007 and has increased steadily, with a few exceptional years, to about 17 percent in 2023. CMS's coding-intensity adjustment began in 2010 and has been lower than overall MA coding intensity since 2011.

We estimate that MA coding intensity increased, on average, by 1.1 percentage points per year from 2007 through 2013 and by 1.4 percentage points per year for 2017 through 2021. Deviations from the typical trend of growing MA coding intensity occurred in 2014, 2016, and 2017, which we attribute to two factors: (1) A new version of the risk-adjustment model was phased in for 2014, 2016, and 2017 that reduced the gap in MA and FFS diagnostic-coding differences; and (2) FFS risk scores grew faster (matching or nearly matching MA risk-score growth rates) in 2016 and 2017 than in the previous or subsequent years, likely due to Medicare's transition from using International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes in October 2015. See our March 2021 report's MA chapter for a more detailed explanation of these factors (Medicare Payment Advisory Commission 2021b).

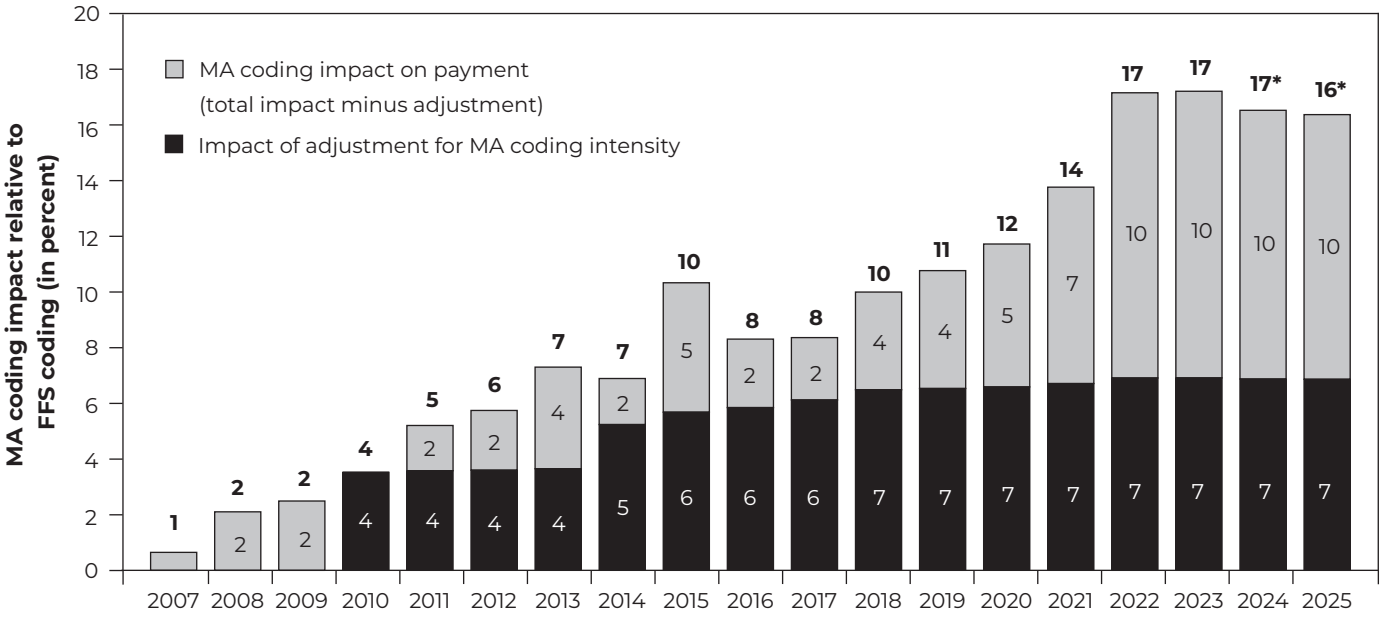
Average MA risk scores in 2021 (which were based on diagnoses on claims for services provided in 2020) were lower than 2020 risk scores, reflecting the reduction in service use in the first year of the pandemic. However, because the reduction in MA risk scores in 2021 was less than the reduction in risk scores for comparable FFS beneficiaries, estimated MA coding intensity continued to increase in 2021. We estimate a 3.4 percentage point increase in coding intensity from 2021 to 2022, which may have reflected efforts by plans to raise MA risk scores, in part through the use of health risk assessments and chart reviews as described below, after MA risk scores had fallen in the prior year.

Between 2022 and 2023, we estimate that overall MA coding intensity remained steady at 17 percent. Over this period, FFS risk scores grew much faster than in prior years (more than three times faster than from 2021 to 2022) and slightly outpaced the rate of MA risk-score growth. It is possible that postpandemic risk-score trends returned to normal rates a year earlier for MA than FFS due to MA plans' coding efforts in 2021 (affecting 2022 risk scores). Coding intensity increased by about 1.7 percentage points on average between 2021 and 2023, which is similar to the trend from 2017 through 2021.

Because the data required to estimate coding intensity are not yet available for 2024 and 2025, we project coding intensity for those years based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. We estimate that phasing in the V28 risk-adjustment model effectively reduced the coding-intensity estimate for 2024 by −2.3 percentage points and by −1.8 percentage points in 2025 for a net change in coding intensity of −0.7 percentage points from 2023 to 2024 and of −0.2 percentage points from 2024 to 2025. (See Technical Appendix 11-B, section titled "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details.) There is uncertainty

FIGURE 11–12

Estimated impact of coding intensity on MA risk scores was larger than the coding adjustment, 2007–2025



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico are excluded. The annual adjustment for MA coding began in 2010. MA coding intensity has increased MA risk scores annually, but increases were offset by new versions of the risk-adjustment model in 2014, 2016, and 2017 and by increased FFS coding in 2016 and 2017. The impact of the coding adjustment is calculated as the MA coding-intensity estimate relative to FFS, multiplied by the coding adjustment. For 2025, we calculate 1.16 × 5.9 percent = 0.069 or about 7 percent. Components may not sum to totals due to rounding.
* For 2024 and 2025, we project coding intensity based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the phase-in of the V28 risk-adjustment model, which is –2.3 percentage points in 2024 and –1.8 percentage points in 2025. See Technical Appendix 11-B section titled, "Impact of phasing in the V28 risk-adjustment model" (p. 390) for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files.

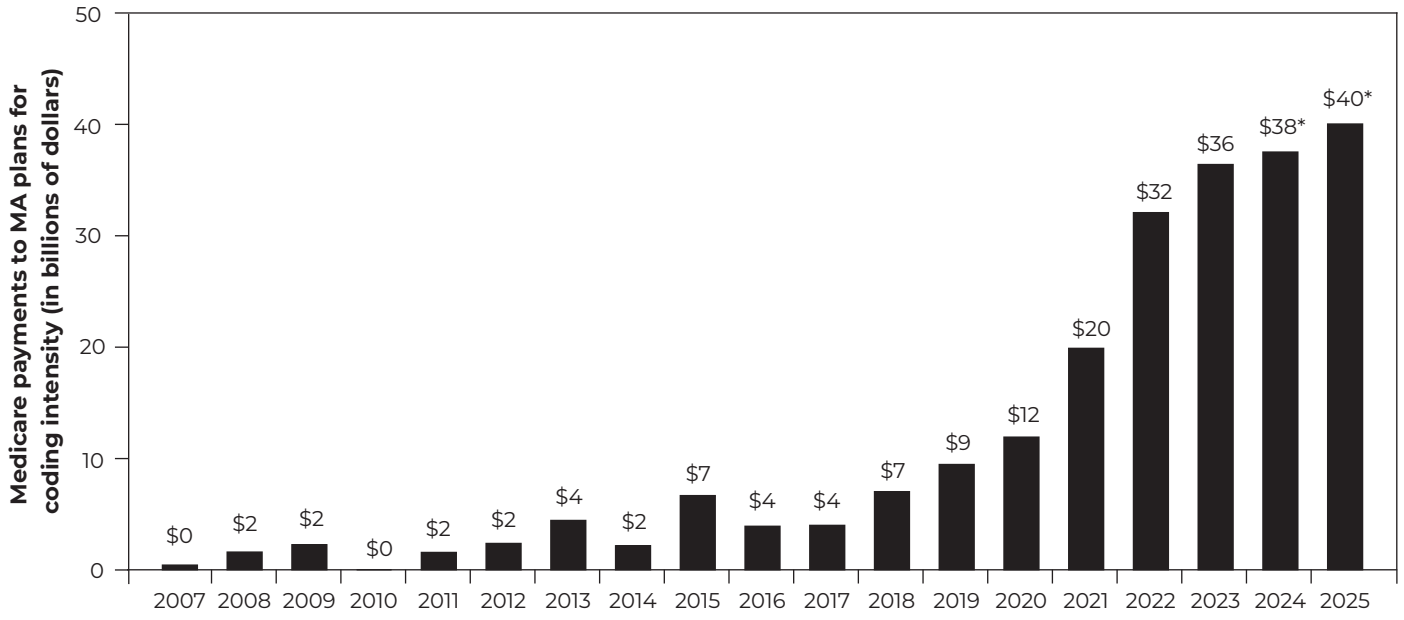
about the impact of moving to the V28 model for MA coding intensity. We will continue to monitor those effects and will update our analysis as we are able. We expect to have risk-score data for 2024, the first year of the V28 implementation, for our March 2026 report.

For 2025, we project that MA risk scores will be about 16 percent above risk scores for comparable FFS beneficiaries. This difference is only partially offset by CMS's coding-intensity adjustment, which reduced MA risk scores by 5.9 percent. The net effect is a 10 percent increase in MA risk scores due to coding intensity, leading to $40 billion in higher projected payments to MA plans.

Between 2007 and 2023, MA coding intensity resulted in $146 billion in increased payments to MA plans (Figure 11-13). Using our projection, we estimate that MA coding intensity in 2024 and 2025 will increase program spending by another $38 billion and $40 billion, respectively. In total, we estimate that between 2007 and 2025, MA coding intensity will have generated $224 billion in higher aggregate payments to MA plans.

FIGURE 11–13

MA coding intensity has increased payments to plans by an estimated $146 billion through 2023 and is projected to generate nearly $78 billion more in 2024 and 2025



Note: MA (Medicare Advantage). Estimates for 2007 through 2023 are based on the Commission's estimate of coding intensity after accounting for CMS's coding adjustment. In all years, Medicare spending for MA plans is based on the Medicare Trustees' reports and excludes spending for beneficiaries with end-stage renal disease.
* For 2024 and 2025, we project coding intensity based on the annual trend from 2019 through 2023, an increase of 1.5 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the phase-in of the V28 risk-adjustment model, which is –2.3 percentage points in 2024 and –1.8 percentage points in 2025. See Technical Appendix 11-B, section titled "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees' reports.

Documenting additional diagnosis codes increases plan rebates and can distort competition among plans

Documenting additional diagnostic codes increases the size of MA plans' rebates, which in turn allows plans to offer their enrollees more supplemental benefits than plans that document fewer additional diagnoses. For a plan submitting a bid below its benchmark (nearly all plans in 2025), the plan's rebate is based on the difference between the plan's bid for its expected enrollee population and the plan's risk-adjusted benchmark, which is the standard benchmark (for a beneficiary of average risk, with a 1.0 risk score) multiplied by the plan's expected average risk score. Raising a plan's average risk score raises the plan's risk-adjusted benchmark and widens the difference between the plan's bid and the risk-adjusted benchmark, thereby increasing the plan's rebate amount and ability to offer more supplemental benefits. In sum, plans can translate greater coding intensity into the ability to offer more supplemental benefits, giving them a competitive advantage over their competitors in attracting enrollees.

MA payment policies aim to give plans an incentive to lower spending and improve quality by allowing them to offer more supplemental benefits. By reducing health care costs, plans can reduce their

TABLE 11–5

Illustrative example: A plan that codes more diagnoses can offer its enrollees more supplemental benefits

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	Monthly MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted monthly benchmark (benchmark multiplied by risk score)	Difference in risk-adjusted benchmark and plan bid	Monthly value of supplemental benefits (rebate amount)*
Nonbonus plans						
Plan A (3.5 stars)	$900	0.97	$952	$923	$23	$15
Plan B (3.5 stars)	900	1.03	952	981	81	52
Bonus plan						
Plan Z (5 stars)	900	0.97	1,000	970	70	49

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is $900 monthly for each of the three plans and that the plans serve the same beneficiaries. Plan B's risk score of 1.03 is inflated due to greater diagnostic-coding effort.
* Plan A and Plan B at 3.5 stars have a rebate percentage of 65 percent. Plan Z at 5 stars has a rebate percentage of 70 percent.

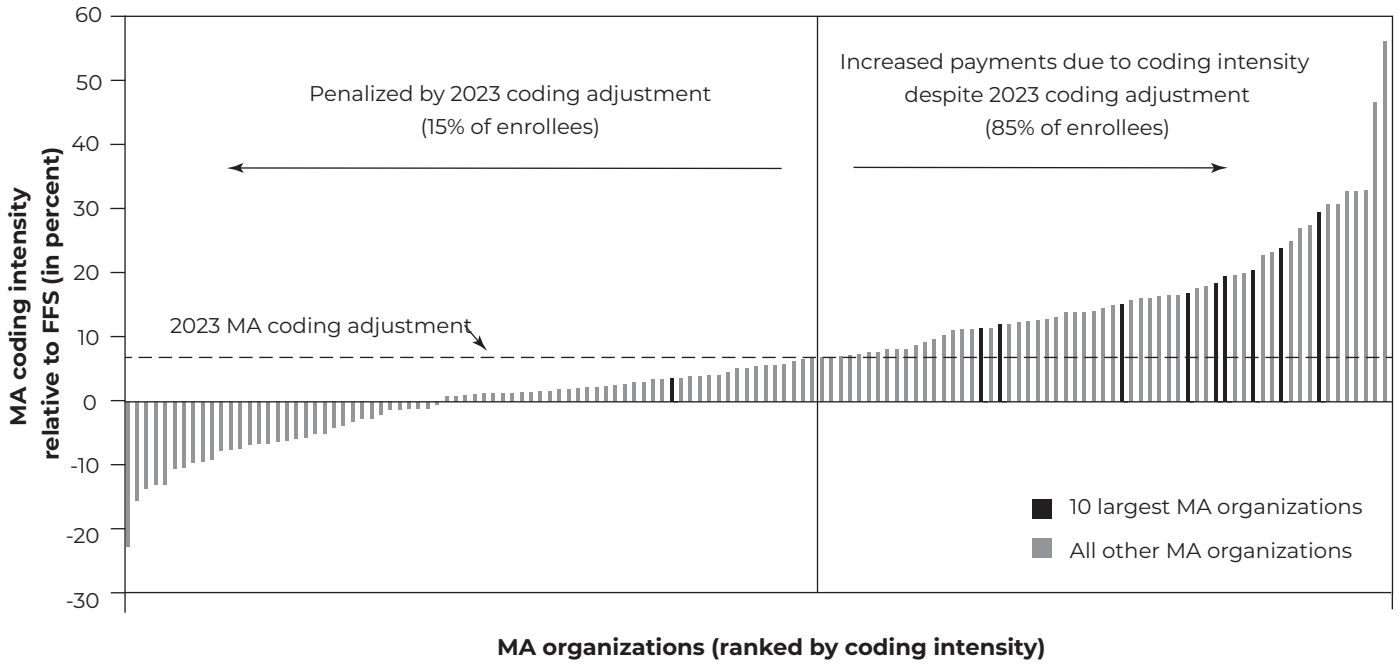
bids, increasing their rebate and supplemental benefit value. By improving quality scores, plans can be rewarded with a 5 percent or 10 percent increase in their benchmark or with an increase in the rebate percentage (the percentage of the bid and benchmark difference that determines the rebate amount).[44] These policies are intended to benefit beneficiaries through improved quality, more supplemental benefits, and reduced premiums, as well as lower taxpayer funding for the Medicare program. Greater MA coding intensity, however, distorts these incentives by allowing plans to offer more supplemental benefits regardless of whether they reduce costs or improve quality.

Table 11-5 illustrates the relationship between coding intensity and rebate amounts using a hypothetical example of three plans covering the same set of enrollees for whom the expected cost of care is the same, at $900 per member per month. Plan A and Plan Z have an expected risk score of 0.97, while Plan B has an expected risk score of 1.03 due to coding more diagnoses. All three plans have bids below the risk-adjusted benchmark and provide supplemental benefits funded by rebates. However, because Plan B has a higher risk score, its rebate is larger than Plan A's rebate ($52 per month vs. $15 per month), so it can offer enrollees more supplemental benefits. Plan B's coding efforts have therefore given it an unfair competitive advantage over Plan A.

In addition, increased coding intensity can influence the size of the rebate more than MA quality bonuses can. The higher risk score of Plan B, which has only 3.5 stars, gives it an advantage over bonus-level Plan Z, which has 5 stars: Plan B's rebate amount is higher than Plan Z's ($52 per month vs. $49 per month). Thus, by inflating its risk score from 0.97 to 1.03, Plan B can offer more supplemental benefits than are provided through quality bonuses.

The plans illustrated in Table 11-5 have a risk-score difference of 6 percentage points, reflecting different coding practices. We estimated coding intensity for MA organizations and found much greater variation in coding for 2023.[45] Figure 11-14 shows MA coding intensity relative to FFS coding, broken out by MA parent organization, excluding beneficiaries who reside in Puerto Rico or are enrolled in chronic-condition special-needs plans and organizations with fewer than 2,500 enrollees in the analysis.

FIGURE 11–14 **Coding intensity relative to FFS varied widely across MA organizations, 2023**



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Consistent with prior years, we find that about half of organizations (covering 15 percent of MA enrollees) have coding intensity below CMS's 2023 coding adjustment and are thereby penalized by the adjustment, while the other half of organizations (covering 85 percent of MA enrollees) have coding intensity that increases their payment even after accounting for the 2023 coding adjustment. These differences demonstrate that CMS's across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates further inequity across contracts by reducing net revenue for plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

We also find significant variation in coding intensity across the 10 largest MA organizations (covering 81 percent of MA enrollees), from about 4 percent to 29 percent above FFS levels. Nine of the 10 largest MA organizations had greater coding intensity than the 2023 coding adjustment and therefore received a net increase in payment due to their coding practices. These differences are large enough to give MA organizations with higher coding intensity a significant competitive advantage by increasing the size of plan rebates and helping them to attract more enrollees. Our finding that coding intensity varies across MA organizations is consistent with other research (Geruso and Layton 2020, Kronick and Chua 2021, Kronick and Welch 2014).

MA plans have several tools that are unavailable in FFS to code more diagnoses

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. They can identify enrollees likely to have

an HCC that has not yet been documented using data the plan already has: an enrollee's historical claims, risk-score data, and prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Of all the mechanisms to document more diagnosis codes, evidence continues to highlight MA plans' use of health risk assessments and chart reviews as major sources of plan revenue from coding intensity.

Pay-for-coding programs and patient-assessment forms Some plans try to ensure that providers submit all possible diagnoses for their enrollees through pay-for-coding programs, in which plans send physicians a patient-assessment form that includes diagnosis codes that the plan has identified for a beneficiary. Plans ask physicians to confirm the existence of plan-identified diagnoses on the form and document those diagnoses on subsequent claims. Plans pay physicians based on completing the form or as a dollar amount per diagnosis code submitted, and some plans include a bonus payment for submitting every code that the plan identifies for a beneficiary.[46]

Capitated arrangements in California and Florida may exacerbate coding intensity In the course of reviewing our coding-intensity estimates by MA organization, we found that several organizations with the highest levels of diagnostic coding are located in California and Florida. Of the 24 MA organizations offering plans primarily in California and Florida (i.e., organizations with a majority of their enrollment in California or Florida), 7 were among the 17 organizations with the highest estimated coding intensity across the nation, including 4 of the 8 organizations with the highest levels of estimated coding intensity (Figure 11-15). These four organizations had MA risk scores that ranged from 29 percent higher to 56 percent higher than scores for comparable FFS beneficiaries.

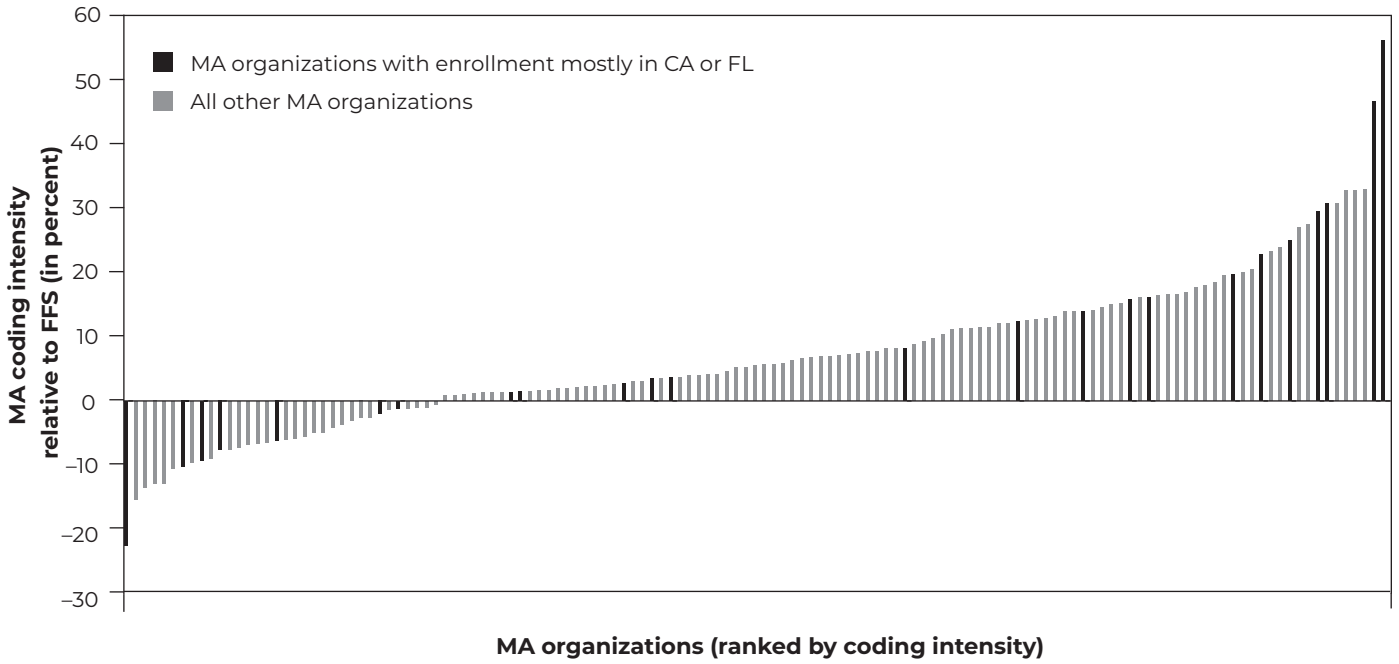
Health plans in California and (to a somewhat lesser extent) Florida have long participated in a form of capitated payment for providers known as the "delegated model," which may explain why these California- and Florida-focused organizations account for so many of the highest-coding organizations. Under the delegated model, the responsibility for health care delivery and the associated financial risk are delegated by the plan to a medical group or independent physician association. Typically, a plan pays a medical group a risk-adjusted sum per enrollee, which is often calculated as a share of a plan's total Medicare revenue. Because a plan's revenue increases when more diagnoses are documented, the capitated payments to providers (determined as a percentage of the plan's revenue) increase proportionately. In these arrangements, the financial incentive to document more diagnoses is passed on to the medical group, which has direct access to an enrollee's medical records and diagnostic information.

Although we do not have data that would allow us to confirm that the plans offered by the highest-coding California and Florida organizations use the delegated model, we reviewed the share of 2022 provider payments that were capitated for the top seven such organizations. Of these seven organizations, four organizations had a greater share of provider payments that were capitated than the national average (36 percent in 2022), including three organizations for which more than half of provider payments were capitated. We note that the alignment of clinical and financial accountability under the delegated model may provide a number of beneficial incentives to constrain costs, avoid low-value care, and coordinate care. However, these potential benefits do not justify increased payments due to coding intensity, and such payments are not necessary to sustain the model's incentives.

MA plans' use of health risk assessments to increase diagnostic coding Health risk assessments are provided to Medicare beneficiaries as part of an annual wellness visit, and, for MA enrollees, health risk assessments are often provided during a plan-initiated home visit.[47] Health risk assessments may be part of a plan's care-management approach and should continue to be used for that purpose when they are used to improve patient care. However, when health risk assessments identify diagnosis codes that are not documented on subsequent encounters with providers, which would demonstrate that the condition was under active management, those codes should not be used for risk adjustment and for making payments to plans. Health risk assessments sometimes rely on patient self-reporting of medical conditions, which may result in HCCs based on inaccurate diagnoses, diagnoses that are no longer active (and therefore not eligible for risk adjustment), or diagnoses without sufficient evidence to conform to ICD coding guidelines (Department of

FIGURE 11–15

MA organizations offering plans primarily in California or Florida account for many of the organizations with the highest estimated coding intensity



Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age, sex, Medicaid eligibility, and institutional status between MA and FFS populations. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. Beneficiaries residing in Puerto Rico or enrolled in a chronic-condition special-needs plan are excluded from the analysis, as well as organizations with fewer than 2,500 enrollees.

Source: MedPAC analysis of CMS enrollment and risk-score files.

Justice 2022). (More information about these concerns is in the chapter on MA in our March 2023 report.)

We analyzed 2022 encounter records to identify HCCs that were supported only by a health risk assessment, meaning that there was no physician or hospital service provided to treat a beneficiary for a specific health condition during the same calendar year.[48] In 2022, about 7.7 million MA enrollees had a health risk assessment that identified at least one HCC, and a total of 17.1 million unique HCCs were identified through health risk assessments. Of those, 3.5 million beneficiaries had a health risk assessment that was the only source for at least one of the HCCs identified, and a total of 5.7 million HCCs (one-third of all HCCs identified on health risk assessments) were identified only on a health risk assessment. Six HCCs each generated more than $900 million in payments from these assessments, accounting for about half of all payments generated by health risk assessments.[49] We found that diagnostic coding that was associated with only health risk assessments accounted for $15 billion in payments to MA plans in 2023, or a little more than 3 percent of all payments to MA plans. About 80 percent of these payments were from health risk assessments conducted as part of an annual wellness visit or initial preventive physical examination, while the rest of these payments were from in-home health risk assessments. Other researchers found similar estimates of the impact of health risk assessments, contributing about $12 billion in payments to MA plans in 2020 (James et al. 2024). That research also found differences in the use of health risk assessments across parent organizations.

MA plans' use of chart reviews to increase diagnosis coding Some MA plans devote significant effort to conducting chart reviews to increase MA payments. Because chart reviews are not used in FFS Medicare, all diagnoses newly documented through chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to increased payments to MA plans. Chart reviews allowable for risk adjustment document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): diagnoses that are not reported on the provider's claim sent to the MA plan, diagnoses made during an encounter in which the MA plan does not submit a record of the encounter to CMS, or diagnoses made during an encounter in which the total number of diagnoses from that encounter exceeds the number of diagnosis fields on the encounter record. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record (chart), chart reviews are one way for plans to identify diagnoses not captured through provider claims or in plan encounter data.

Like health risk assessments, some MA plans treat chart-review programs as an independent revenue stream that yields a positive return on investment because the additional Medicare payments from newly documented diagnoses far exceed the costs of paying nurses and medical assistants to review medical charts.[50] Several lawsuits allege that MA plans use chart reviews to identify new diagnosis codes but not to verify the accuracy of already submitted codes. Some lawsuits allege that an MA organization is aware that diagnoses submitted to CMS are not supported by the medical chart and therefore violate Medicare's rules governing the reporting of diagnoses (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group Inc. et al. 2016, United States of America ex rel. James M. Swoben v. Secure Horizons 2017, United States of America v. Anthem Inc. 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and use artificial intelligence to more accurately identify likely revenue-producing charts (Blue Health Intelligence 2020, Optum 2020). While the financial return is worth plan sponsors' effort and financial investment, chart-review programs increase the financial burden for the taxpayers and beneficiaries who fund the Medicare program.

We analyzed 2022 encounter records to identify HCCs that were supported by a chart review but not through any other record of a physician or hospital encounter during the same calendar year. In 2022, about 12.0 million MA enrollees had a chart review that identified at least one HCC, and a total of 33.2 million unique HCCs were identified on chart reviews. Of enrollees with a chart review, 5.8 million beneficiaries had a chart review that was the only source of an HCC, and a total of 9.0 million HCCs (about 27 percent of all HCCs identified on chart reviews) were identified only through a chart review. Eight HCCs each generated more than $1 billion in Medicare payments from chart reviews, accounting for more than half of all chart review–based payments.[51] We found that in 2023, chart reviews alone accounted for about $24 billion in payments to MA plans, or about 6 percent of all payments to MA plans.

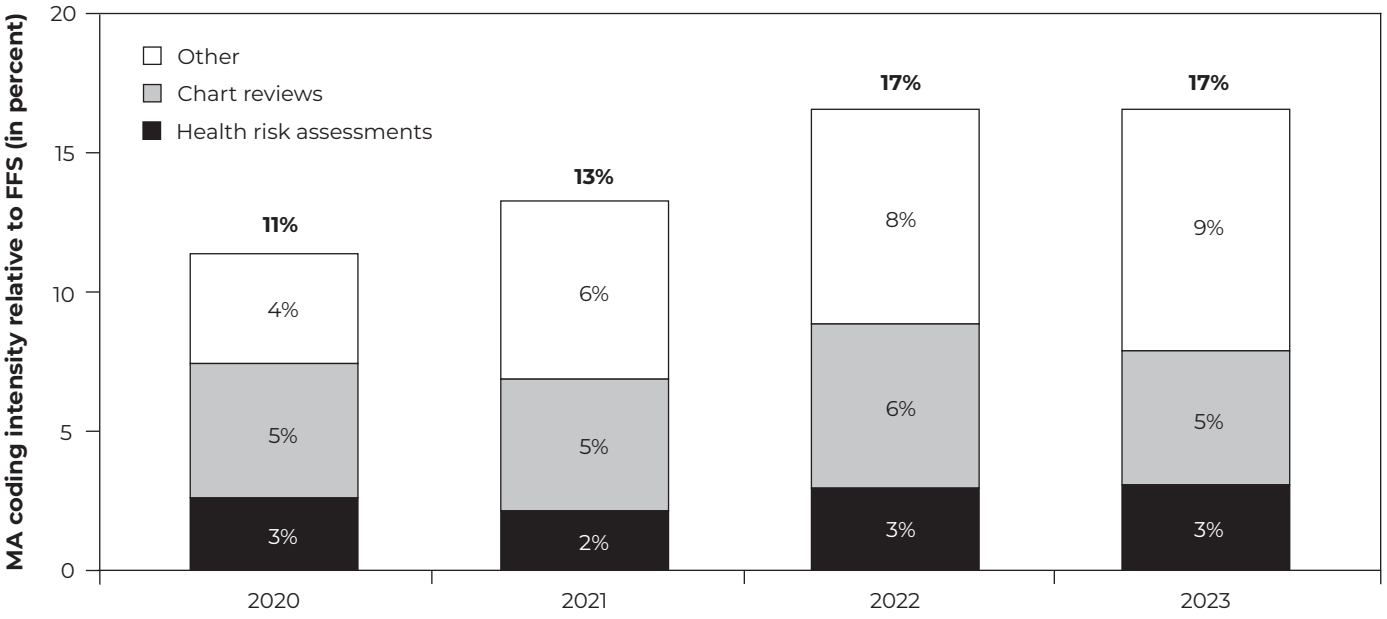
We estimate that chart reviews and health-risk assessments together accounted for about $34 billion in payments to MA plans, or about 8 percent of all payments to MA plans in 2023.[52] Combined with our finding that all sources of coding intensity resulted in MA risk scores that were about 17 percent higher than risk scores for comparable FFS beneficiaries in 2023, we conclude that health risk assessments and chart reviews together accounted for about half of all MA coding intensity (Figure 11-16). Our estimates are similar to the results of another researcher's analysis in terms of the overall magnitude of the impact and of the trend in the growing impact of health risk assessments and chart reviews on payments to MA plans from 2016 to 2021 (Jacobs 2024).

The Commission's 2016 recommendation on coding intensity

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences, improve the equity of the adjustment across MA contracts, and increase incentives to reduce costs and improve quality. The Commission's approach to reduce MA coding intensity has been to address the mechanisms that generate coding differences first (e.g.,

FIGURE 11–16

Chart reviews and health risk assessments accounted for about half of overall MA coding intensity, 2020–2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Figure shows the impact of coding intensity on payments to MA plans for the years 2020 through 2023. The underlying diagnoses were reported during health care encounters in the previous year, 2019 through 2022, respectively. "Other" sources of coding intensity can result from pay-for-coding programs, patient-assessment forms, transferring coding incentives from plans to providers via subcapitation, and other mechanisms. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS enrollment and risk-score files and the Medicare Trustees' reports.

remove health risk assessments and reduce year-to-year coding variations by using two years of diagnostic data) and then address remaining differences with either an across-the-board or tiered adjustment. The Commission's 2016 recommendation did not address the use of chart reviews because data were not available at that time, but eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach.

The recommendation, which would replace the existing mandatory minimum coding-intensity adjustment (which has reduced MA risk scores by 5.9 percent since 2018), has three parts:

- develop a risk-adjustment model that uses two years of FFS and MA diagnostic data,
- exclude diagnoses that are documented only on health risk assessments from either FFS or MA, and then
- apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—and excluding chart-review data from risk adjustment (consistent with the Commission's approach) would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. As noted earlier, health risk assessments and chart reviews alone account for roughly half of MA coding intensity. The Commission carefully considered

Update on risk-adjustment data-validation audits

Medicare payments to Medicare Advantage (MA) plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. MA organization leadership signs an attestation stating that the submitted diagnostic data are accurate.

CMS conducts risk-adjustment data-validation (RADV) audits after payments have been made to the plan to check whether plan-submitted diagnoses are supported by the medical record as required by Medicare. If diagnoses do not meet requirements, plans are required to return payments to Medicare. These overpayments for diagnoses that do not meet program requirements are not the same as payments for higher MA coding intensity; however, there is an unknown amount of overlap between them.

For RADV audits through 2017, CMS has been using a protocol that audits roughly 5 percent of MA contracts per year, uses a sample of 201 enrollees in each contract across three strata of beneficiaries with low, medium, and high risk scores, calculates an error rate for the sample population, and then calculates the overpayment amount for the sample of audited beneficiaries. RADV audits of MA contracts have been limited, and their results are largely unreported. Audits of 2007 risk-adjustment data identified diagnoses that did not meet risk-adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS

(continued next page)

options for addressing coding intensity and supports this approach because it balances implementation feasibility, administrative burden, and effectiveness.

Part of the cause of coding intensity is that providers do not report all possible diagnosis codes for their FFS beneficiaries. We note that using two years of diagnostic data would help address the underreporting of chronic conditions for FFS beneficiaries by helping to capture conditions that are not reported consistently year to year. Theoretically, conducting chart reviews for FFS beneficiaries could also reduce differences in MA and FFS coding; however, such a strategy would need to carefully consider the number of chart reviews necessary to have a meaningful impact, the administrative burden to providers if they were required to assist with the collection of medical charts for FFS beneficiaries, and the resources required for the Medicare program to review those charts to identify diagnoses allowable for risk adjustment. Alternatively, chart reviews could be eliminated from risk adjustment altogether, thereby aligning the data sources used as sources of diagnoses for risk adjustment.

Adjusting for any remaining coding-intensity differences could also improve equity across MA contracts. Under one illustrative approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding-intensity adjustment would be applied based on each tier's average level of coding intensity (Medicare Payment Advisory Commission 2016a). CMS has used a similar approach to select MA contracts for RADV audits.[53] This policy would improve the overall equity of the coding-intensity adjustment relative to the single, across-the-board adjustment used today. Finally, we note that in 2016, when the Commission voted

Update on risk-adjustment data-validation audits (cont.)

recovered $13.7 million in overpayments from audits of 37 contracts, based on overpayments for only the 7,437 beneficiaries included in the audit sample (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008, 2009, or 2010. Kaiser Health News obtained, through a Freedom of Information Act request, summaries of the preliminary results for 90 audits completed during 2011, 2012, and 2013 and found that 71 audits uncovered net overpayments, with 23 audits finding overpayments of $1,000 or more per beneficiary (Schulte and Hacker 2022).

For audits of 2018 and subsequent years, CMS finalized an audit method that would allow CMS to recover overpayments by extrapolating the error rate of the sampled enrollees to a larger population of audit-eligible enrollees in the contract. The majority of MA enrollees would be eligible for audit, as nearly 70 percent of MA enrollees had at least one hierarchical condition category (HCC) in 2022, and only a small fraction of these enrollees would be excluded from the audit sample for other reasons.[54] However, in November 2024, CMS released a guidance document restricting the audit-eligible population to a much narrower set of enrollees in a given contract. Audits of 2018 data will focus only on two sets of beneficiaries: beneficiaries in the top decile of a contract's enrollees based on the greatest expected reduction in their risk score as a result of a RADV audit (based on CMS's improper-payment prediction model) or contract enrollees who had all of their HCCs supported only by chart reviews (Centers for Medicare & Medicaid Services 2024c). The first group of beneficiaries is roughly one-tenth of the beneficiaries who would have been audit eligible under pre-2018 methods. For the second group, we estimate that between 2 percent and 3 percent of all MA enrollees (or between 3 percent and 4 percent of MA enrollees with at least one HCC) had all of their HCCs supported by only chart reviews, and those enrollees had an average of 1.5 HCCs. ■

on this recommendation, estimates of MA coding intensity net of CMS's coding adjustment were much smaller than they are for 2025. Given that the impact of the Commission's recommendation, which would fully account for the effects of higher MA coding intensity, has grown substantially, policymakers could contemplate phasing in the Commission's recommendation.

Industry concentration, integration, and financial condition

In 2024, the MA program included 5,678 plan options offered by 175 organizations. However, enrollment is highly concentrated at the local level and increasingly concentrated at the national level: The largest organization in a county typically enrolls between 40 percent and 50 percent of the market, and just three organizations enrolled more than half of all MA enrollees nationally in 2024. The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans' ability to provide generous supplemental benefits point to continued strong financial health in the MA sector. The Commission has historically analyzed the margins that MA plans report in their bids. However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics of financial health), given that the margins reported in plan bids may provide an incomplete picture of insurers' financial condition. Given our declining confidence in the salience and accuracy of plan-reported margins, we focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment. As noted above, substantial growth in MA plan availability and enrollment indicates a robust MA program.

MA market was heavily concentrated locally and nationally in 2024

Enrollment in MA is highly concentrated at the local level and increasingly concentrated at the national level. High enrollment concentration—particularly at the local level—can be a cause for concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits. Researchers have shown that markets with more competition are associated with increased MA-benefit generosity and lower MA premiums (Cabral et al. 2018, Pelech 2018, Pizer and Frakt 2002, Song et al. 2013). In extreme cases, dominance by a single firm (or small set of firms) may make it difficult for competitors to enter or remain active in a market (Frakt et al. 2012, Pelech 2017).[55]

Over the last decade, enrollment in MA has become increasingly concentrated at the national level in plans owned by a small set of large insurers that serve a majority of markets in the country. Between 2008 and 2024, the share of total MA enrollment in the three largest firms (UnitedHealth Group, Humana, and CVS Health) rose from 32 percent to 59 percent. Much of the growth of these firms—particularly UnitedHealth Group and Humana—has been driven by enrollment increases in counties in which the insurers have offered plans for many years (Hnath et al. 2024). However, all three have also significantly expanded the number of counties in which they offer plans. For example, UnitedHealth Group expanded from offering coordinated-care plans (i.e., HMO or PPO plans) in 41 percent of counties (a service area covering 68 percent of MA-eligible beneficiaries) in 2013, to 54 percent of counties (covering 81 percent of eligible enrollees) in 2020, to 85 percent of counties (covering 95 percent of eligible enrollees) in 2024 (Table 11-6).[56] Humana and CVS Health have also expanded their service areas, and all three organizations now offer plans in counties that are home to more than 85 percent of MA-eligible beneficiaries. A recent study found that some of the service-area expansions for these three insurers were due to the companies acquiring existing MA contracts from another insurer (Hnath et al. 2024).[57] For example, acquisitions accounted for 30 percent of new county participation for UnitedHealth Group between 2012 and 2023 (acquisitions accounted for 16 percent and 5 percent of new county participation for CVS Health and Humana, respectively) (Hnath et al. 2024). However, the study found that nationally, for all MA insurers, only 15 percent of total market-entry events were attributable to acquisitions. These findings suggest that the service-area expansions of large national insurers have (at the time of market entry) generally served to introduce new competition into local markets and are not simply an artifact of changes in ownership of existing competitors.

Between 2023 and 2024, the share of enrollees covered by these top three organizations rose by 1 percentage point to 59 percent (4 percentage points higher than in 2020) (Table 11-6).[58] Among conventional plans (i.e., plans available to all Medicare beneficiaries, excluding SNPs and employer group plans), the top three organizations nationwide had 57 percent of enrollment in 2024—an increase from 56 percent in 2023.[59]

Given the relevance of local competition for MA enrollees, we place greater importance on examining competition at the county level (Table 11-6). Measures of local market concentration were mixed in 2024. Excluding employer plans and SNPs, in 2024, enrollment in the largest organization in each county (regardless of the insurers' national enrollment) accounted for 42 percent, on average, of all MA enrollment in the county. Enrollment in the top three organizations in each county accounted for 81 percent, on average, of all MA enrollment (unchanged from 2023 but less than the 83 percent observed in 2020). However, the share of MA enrollees living in counties with highly concentrated markets (as measured using the Herfindahl–Hirschman Index (HHI), a common measure of market concentration) increased from 94 percent in 2023 to 95 percent in 2024 (data not shown).[60] The geographic expansion of large national insurers has contributed to the changing concentration in local markets. When measured using the HHI, average county-level enrollment concentration has fallen over the last decade, despite the rising share of enrollees covered by the three largest firms nationally (data not shown).

Overall, local MA markets tend to be highly concentrated, although the level of concentration has trended downward in recent years. This trend coincides with insurers entering new markets and steadily gaining market share in areas that have historically been very concentrated. Estimates for 2025 indicate that the average beneficiary will have access

TABLE 11–6

Medicare Advantage enrollment became increasingly concentrated nationally but slightly less concentrated at the county level, July 2020–July 2024

Plan type	Share of MA-eligible beneficiaries living in counties in which insurer offers an MA plan*			Percentage point change in share	
	2020	2023	2024	2020–2024	2023–2024
Conventional plans					
Top 3 nationwide					
UnitedHealth Group Inc.	81%	94%	95%	+14%	+1%
Humana Inc.	87	92	93	+5	+1
CVS Health Corporation	78	84	88	+10	+4

	Share of enrollment			Percentage point change in share	
	2020	2023	2024	2020–2024	2023–2024
All MA plans					
Top 3 nationwide	**55%**	**58%**	**59%**	**+4%**	**+1%**
UnitedHealth Group Inc.	26	29	28	+2	–1
Humana Inc.	18	18	18	0	0
CVS Health Corporation	11	11	13	+2	+2
Conventional plans					
Top 3 nationwide	**54**	**56**	**57**	**+3**	**+1**
UnitedHealth Group Inc.	23	25	24	+1	–1
Humana Inc.	22	22	21	–1	–1
CVS Health Corporation	9	9	12	+3	+3
County level (weighted average)**					
Top organization	45	43	42	–3	–1
Top 2 organizations	69	67	66	–3	–1
Top 3 organizations	83	81	81	–2	0

Note: MA (Medicare Advantage). Includes only MA plans (coordinated-care plans, private-fee-for-service plans, and Medical Savings Account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. "Conventional plans" excludes special-needs plans and employer group plans, which have restricted availability. Components may not sum to totals, differences, and market shares due to rounding.
* Counties in Connecticut are excluded due to changes over time in how the state's counties are tabulated.
** County-level shares of MA enrollment reflect the beneficiary-weighted average of the top organizations in each county.

Source: MedPAC analysis of July 2020–2024 enrollment data and CMS Landscape files.

to many MA plans offered by a substantial number of organizations, as illustrated earlier in this chapter. However, large national insurers, and some regional or local insurers, frequently enroll a large fraction of MA enrollees in an area. Such concentration may dampen competition, a topic the Commission will continue to explore and monitor.

Vertical integration of Medicare Advantage plans and providers

MA organizations are increasingly integrating vertically, with provider and insurer lines of business having common ownership (or other financially aligned arrangements). The Commission has previously found that vertical integration is highest in organizations in which a provider-based organization owns and operates a health plan, although the share of enrollees in such vertically integrated plans has eroded over time (Chartis Group 2024, Johnson et al. 2017, Medicare Payment Advisory Commission 2024).

However, insurer-led integration has accelerated in recent years, and several of the largest MA organizations (MAOs) have invested significantly in the acquisition of provider businesses, suggesting that insurers see advantages to owning a greater share of the health care supply chain (CVS Health 2023, Humana 2022, Humana 2021, Humana 2020, Signify Health 2023, UnitedHealth Group 2023, UnitedHealth Group 2022).

MA payment policy—though not the only factor influencing firms' decisions to integrate—likely promotes such arrangements by incentivizing efficient care delivery, rewarding plans that record diagnoses more thoroughly, and providing bonuses to plans that perform well on quality measures (Medicare Payment Advisory Commission 2024). Although the evidence regarding the relationship between plan–provider integration and efficiency, coding intensity, and quality is limited, MAOs may view integration as a way to influence providers' activities more directly to achieve the outcomes incentivized under MA's capitated payment structure. Researchers have also suggested that payments to plan-owned providers may offer an opportunity for MAOs to retain a higher share of profits within the parent organization while meeting medical loss ratio requirements (Frank and Milhaupt 2023, Frank and Milhaupt 2022).

No public data provide a systematic accounting of ownership relationships between MA plans and health care providers, which poses a significant barrier to studying the effects of vertical integration. However, CMS requires MAOs to submit limited information about the extent of their financial relationships with providers and other entities as part of the bidding process. Specifically, plans submitting bids are required to report the amount (including medical costs and nonbenefit expenses) per member per month that they expect their members to receive from a related party.[61] While the submitted data are projections and not a report of actual utilization in a completed year, they provide insight as to the MAO's own assessment of its integration with other entities. Figure 11-17 illustrates that the degree of vertical integration in MA varies widely across parent organizations and is highest in provider-owned plans. Among these plans, the share is highest in plans owned by health systems (data not shown).[62]

The data show that large national insurers, on average, remain significantly less vertically integrated than their provider-owned competitors. However, at least one large national insurer is now significantly more vertically integrated than many provider-owned plans. This finding is particularly noteworthy given that large national organizations insure a significant share of MA enrollees nationwide, so trends in the organization of the businesses can affect millions of beneficiaries. While the information presented here is reported at the parent-organization level, health care markets operate primarily at a local level, and national statistics do not necessarily describe the markets in which most beneficiaries live.

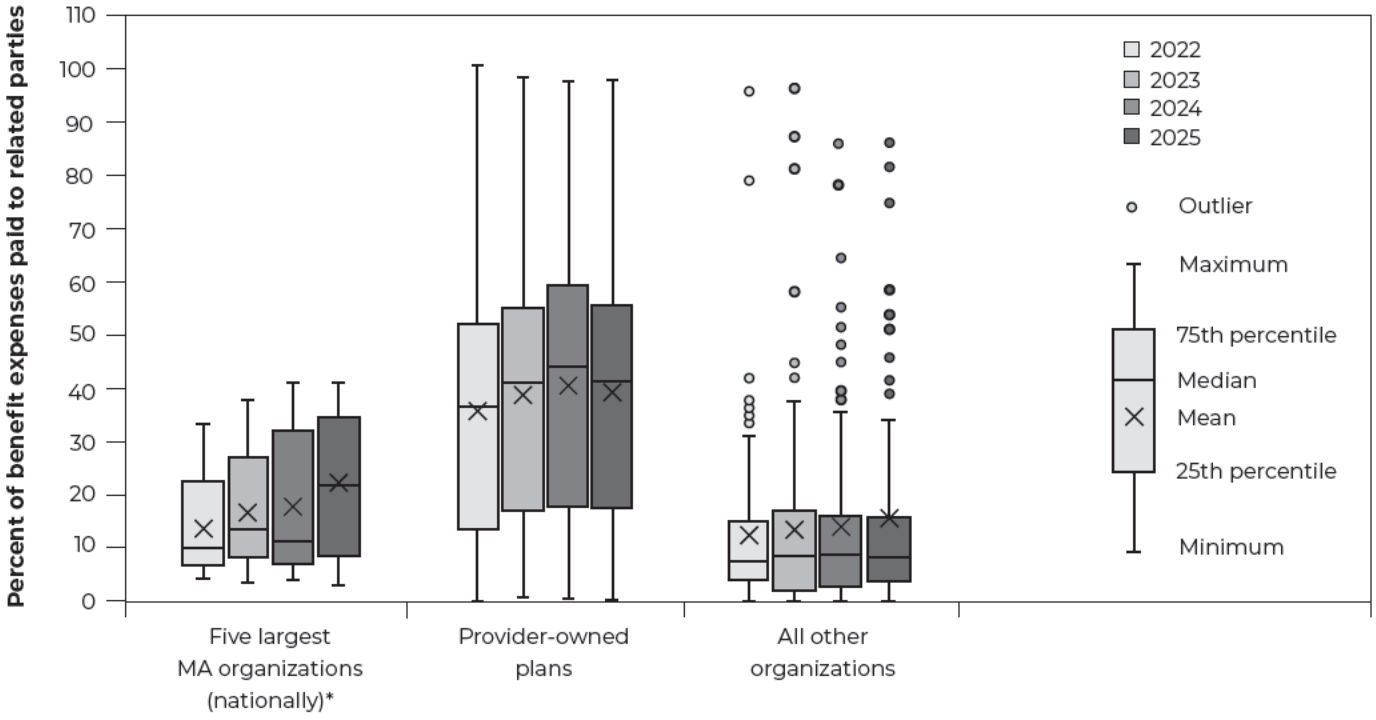
Altogether, we find that the MA industry is increasingly vertically integrated and that such integration may enable MAOs to achieve higher profitability under current MA payment policy. The Commission plans to continue monitoring trends in integration in MA and evaluating its effects on enrollees and the function of the program.

MA margins

The continued growth in MA enrollment, the substantial number of plans offered by several organizations, and plans' ability to provide generous supplemental benefits point to continued strong financial health in the MA sector. We have historically analyzed the margins that MA plans report in their bids. We have consistently reported that the data do not include plans' expected costs and revenues for providing Part D (which nearly all MA plans offer) and do not include employer plans (17 percent of MA enrollment in 2024). However, we have become increasingly concerned about the appropriateness of focusing on plan margins (instead of other metrics

FIGURE 11–17

Vertical integration is increasing and is highest in plans owned by provider organizations



Note: MA (Medicare Advantage). Excluded are cost-reimbursed plans, Medicare–Medicaid demonstration plans, and employer group plans.
* The five largest non–provider-owned plans are UnitedHealth Group, Humana, CVS Health, Elevance Health, and Centene. Kaiser Foundation Health Plan enrolls more beneficiaries than Centene but is categorized as a provider-owned plan in the figure. "Outliers" are values greater than 1.5 times the difference between the values at the 75th and 25th percentile. "Maximum" and "minimum" are the values for the category when outliers are excluded.

Source: MedPAC analysis of data from CMS on plan bids, MMIT Directory of Health Plans.

of financial health) and about whether the margins reported in bids are sufficient for characterizing insurers' financial condition.

One concern is that MA margins may not be comparable with the margins of other health insurance lines of business. For example, MA gross profits (measured in total MA revenue dollars per enrollee after subtracting MA expenses) tend to be much higher than other lines of health insurance business (Ortaliza et al. 2024, Ortaliza et al. 2023). Because Medicare beneficiaries have higher costs than other populations, an organization that has the same profit margin (measured as the share of remaining revenue after subtracting medical expenses) across its various insurance lines of business will likely have higher gross profits (measured in dollars per enrollee) in MA, particularly if the organization's fixed costs (e.g., rent, utilities, information technology infrastructure, and base salaries and benefits) are similar across lines of business. Thus, the per enrollee revenues that remain after covering medical costs may tend to be higher in MA relative to individuals covered under other lines of business. Gross profits per MA enrollee may be a more salient indicator than margin because high gross profits would enable a plan to increase the amount of revenue allocated to employee and broker compensation, investments, advertising, lobbying, infrastructure, and returns to shareholders (in for-profit plans).

A second concern with the margins reported in MA bids is whether the margin data collected through the bidding process appropriately characterize insurers' profits. This concern is particularly acute for vertically integrated firms—those in which plans and providers are owned by the same organization. For a vertically integrated organization, the margin for the insurance line of business might not reflect the margin for the parent organization. For example, payments from a plan to a provider owned by the same parent organization would count as medical expenses for the plan (putting downward pressure on plan margin) but contribute positively to the margin of the parent organization. Because plan bids include margin information only for the plan, they may understate insurers' financial health. The degree to which provider revenues are shared with plans under these arrangements is unclear, but limited financial data suggest a substantial shifting of revenues and expenses for at least one large health plan (Frank and Milhaupt 2022, Milhaupt 2023). In addition, we have observed some provider-sponsored plans that consistently report negative MA margins despite consistent growth in MA enrollment. These reported margins have become difficult for us to reconcile with CMS's requirement that MA plans with negative margins must submit a business plan to achieve profitability and CMS's stated expectation that MA plans meet or exceed the year-by-year margin targets in the business plan. Because plan bid data do not necessarily reflect the expenses and margins of their affiliated providers, we have diminishing confidence in the margins reported in plan bids. This problem is likely to grow as vertical integration between insurers and providers increases. The Commission stated in its March 2024 report to the Congress that it would consider not reporting plan margin data in future years. Given our declining confidence in the salience and accuracy of plan-reported margins, we omit these data and focus on more reliable indicators of the financial health of the MA program, such as plan availability and enrollment (Medicare Payment Advisory Commission 2024).

Quality in MA

The Commission has long held that MA presents opportunities for innovation to achieve higher-quality care at lower cost. It is important for the Medicare program to monitor MA plan performance and quality to ensure that beneficiaries have access to high-quality health care. Beneficiaries also need good information about the quality of and access to care provided by MA plans in their local market. However, the Commission has determined that the current system for MA quality reporting and measurement is flawed and does not provide a reliable basis for evaluating quality across MA plans (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019). Nonetheless, these measures are the basis for the MA quality-bonus program (QBP), which increases MA payments by about $15 billion annually. However, because it is important to understand beneficiaries' experience with their coverage in the MA and FFS programs, this year we report patient-experience scores, which are less subject to the challenges of current Medicare quality reporting for MA and FFS beneficiaries. Here we provide a brief overview of the current MA QBP and indicators of patient experience in MA compared with FFS from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys of these groups.

CMS assessment of MA quality

It is important for Medicare to ensure that MA plans provide good quality care to their enrollees. Quality measurement and rewards can promote better plan quality and support beneficiary choice of plans. In 2006, CMS introduced the MA star-rating system composed of measures tied to clinical quality, administrative capability, and patient experience.[63] Medicare currently collects close to 100 MA quality measures, over 40 of which are used to determine a star rating from 1 to 5 for each MA contract.[64,65] These ratings are made available through the Medicare Plan Finder website to enable beneficiaries to compare across plans. As required by the ACA, since 2012 the MA star-rating system has been the basis of the QBP, which increases benchmarks for MA contracts rated 4 stars or higher.[66] The star rating also contributes to the level of rebate payments. Plans with higher star ratings retain a higher share of the difference between a plan bid and the benchmark when bids are below the benchmark. Beneficiaries enrolled in an MA plan with less than 5 stars can use a once-a-year special enrollment period to switch to a 5-star plan outside of the open enrollment period.

The share of MA contracts receiving quality bonuses has been declining in recent years but remains consistently high. Forty-one percent of rated MA contracts are in bonus status for 2025, a decrease from 44 percent in 2024 and 51 percent in 2023 (Centers for Medicare & Medicaid Services 2024a).[67] Sixty-nine percent of MA enrollees are enrolled in bonus-status contracts in 2025, compared with 75 percent in 2024 and 72 percent in 2023. Under the coronavirus public health emergency (PHE), CMS relaxed quality-reporting rules, boosting the average star rating from 4.06 in 2021 (before the PHE rule change) to 4.37 in 2022. The rules reverted for the 2023 plan year, and the average star rating has declined to 3.95 in 2025. The share of enrollees in plans achieving 5 stars has also returned to levels more similar to the prepandemic norm—from 27 percent in 2022 to 3 percent in 2025.

Patient-experience scores in MA and FFS Medicare

Good information on the quality and experience of care that MA enrollees receive—and how it compares with FFS Medicare—is necessary for beneficiaries and policymakers to properly evaluate program and plan options. However, several data and methodological challenges affect the ability to compare performance across MA and FFS:

- data completeness and comparability (e.g., lack of clinical data),
- differences in coding intensity across plans and between MA and FFS, and
- favorable selection in MA.

The Commission has discussed its concerns with these limitations in previous reports (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2023b, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016b). Despite these challenges, the Commission has expressed a strong interest in assessing the quality of care that Medicare beneficiaries receive. To that end, this year we include a summary of MA– and FFS–CAHPS patient-experience measures.

Patient-experience measures are an important indicator of quality of care because they assess whether something that should happen (such as getting needed care quickly) actually happened and how often it happened, from the patient's perspective. When patients have a better experience, they are more likely to adhere to treatments, return for follow-up appointments, and engage with the health care system by seeking appropriate care. Although not free from the challenges of measuring MA and FFS quality, patient-experience measures are less subject to some of the challenges in comparing MA and FFS outcomes that we have discussed in previous reports.

The Agency for Healthcare Research and Quality's CAHPS surveys generate standardized and validated measures of patient experience. CMS annually fields a CAHPS survey among a sample of FFS beneficiaries to measure beneficiaries' experience of care with Medicare and their FFS providers.[68] MA organizations are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each MA contract's enrollees. No FFS administrative claims data or MA plan-submitted encounter data are used in calculating the CAHPS scores, so issues of MA encounter-data completeness and differences in coding intensity do not pose the same degree of challenge as other quality measures when comparing MA and FFS results.

FFS–CAHPS are sampled at the state level, and MA–CAHPS are sampled from contracts. To calculate national FFS and MA scores, CAHPS measures are case-mix adjusted for beneficiary characteristics and weighted at the state and contract level, respectively.[69] Case-mix adjustment can help control for some differences in beneficiary characteristics among those surveyed, but it does not standardize for all potential differences between the two populations. For instance, differences in the geographic composition of the MA and FFS populations are not included in the adjustment.[70] Table 11-7 (p. 372) presents CAHPS measure scores for the most recent year available, 2023.

Beneficiaries in both the MA and FFS programs rated their coverage and experience favorably overall in 2023. Many CAHPS measure results were similar for the MA and FFS populations; a few showed small differences (Table 11-7, p. 372). The 2023 MA–CAHPS measure score for "getting needed care and seeing specialists" was 81 (scored on a scale of 0 to 100), which is similar to

TABLE 11–7

Differences between MA–CAHPS and FFS–CAHPS scores are small, 2023

CAHPS measure	MA	FFS
Getting needed care and seeing specialists	81	80
Getting appointments and care quickly	83	82
Care coordination (e.g., personal doctor always or usually discusses medication, has relevant medical record, helps with managing care)	86	86
Customer support	90	87
Rating of health plan	88	83
Rating of health care quality	87	85
Annual flu vaccine	71	73

Note: MA (Medicare Advantage), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FFS (fee-for-service). The first four measures are composite measures of multiple survey questions which have responses of "never," "sometimes," "usually," and "always." CMS converts these to a linear mean score on a 0 to 100 scale. The fifth and sixth measures are global rating measures in which survey questions have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. The annual flu vaccine measure has a yes/no response. "Plan" in "rating of health plan" refers to the Medicare FFS program or MA, respectively. The FFS–CAHPS response rate was 28 percent, and the MA–CAHPS response rate was 33 percent. In 2023, CMS revised which CAHPS survey items are scored in the "getting appointments and care quickly" composite measure, which may cause fluctuation in scores compared with prior years.

Source: MA–CAHPS and FFS–CAHPS national mean scores published by CMS, 2023.

the FFS–CAHPS measure score of 80. The FFS– and MA–CAHPS scores for the "care coordination" measure were both 86. MA–CAHPS scores were slightly higher than FFS–CAHPS scores for the "customer support," "rating of health plan," and "rating of health care quality" measures; however, the FFS–CAHPS score for "annual flu vaccine" was slightly higher than the MA–CAHPS score.

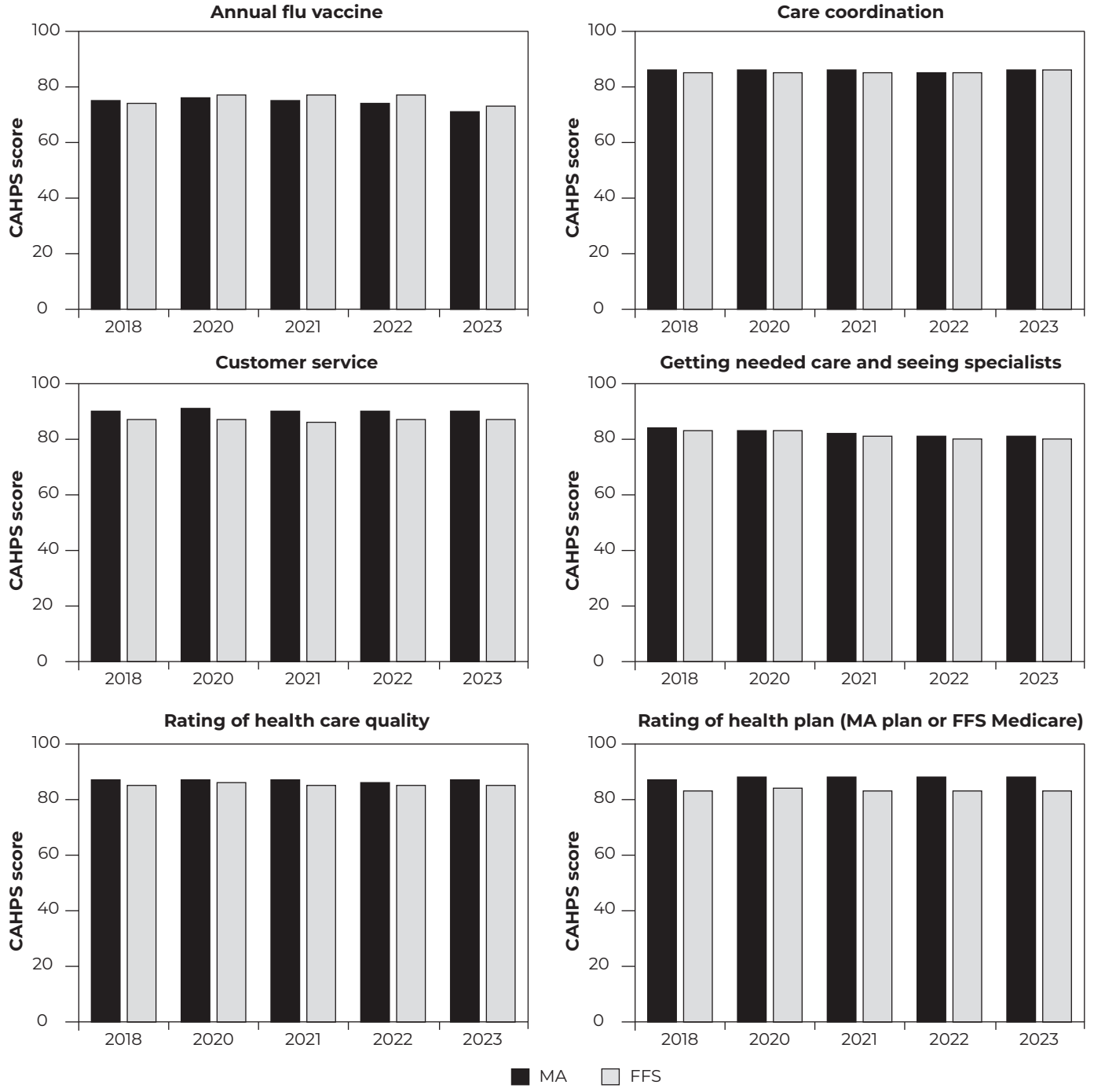
The 2023 results were in keeping with previous years; beneficiaries in both programs generally rated their coverage and experience highly, and differences in the experiences of MA and FFS beneficiaries on these measures were small. For example, the MA– and FFS–CAHPS scores for the "care coordination" measure were about the same and virtually unchanged from 2018 to 2023 (Figure 11-18). Beneficiaries reported "get[ting] needed care and see[ing] specialists" at nearly identical rates across programs and over time.

The Commission recognizes that these relatively high and consistent scores do not imply perfect access to care in either MA or FFS Medicare. CAHPS surveys target a random sample of all enrollees, not just those who have sought care during the survey period. The pattern of responses among subsets of this population (for instance, those with serious health needs) may be quite different. Certain other subsets of enrollees, such as those residing in institutional settings, are also excluded from participation. Further, CAHPS survey items focus on breadth of access to care, not the specifics of cases in which problems have been experienced. While the Commission has expressed concern that the small share of beneficiaries with the greatest health needs may disproportionately experience access problems, the CAHPS survey is not designed to capture the depth of those problems. For this reason, the Commission aims to contextualize the results of these broad, population-level surveys with findings from our annual focus groups, and we are beginning to explore other potential indicators of access and quality in MA, such as prior authorization, provider networks, and reasons for disenrollment from MA plans.

There are other ways of measuring quality outside of patient experience; however, the Commission previously reviewed the literature on studies using other measures and found the literature to be inconclusive.[71] We found wide heterogeneity in

FIGURE 11–18

MA–CAHPS and FFS–CAHPS measure scores are consistently high, 2018–2023



Note: MA (Medicare Advantage), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FFS (fee-for-service). The annual flu vaccine measure has a yes/no response. "Care coordination," "customer service," and "getting needed care and seeing specialists" are composite measures in which survey questions have responses of "never," "sometimes," "usually," and "always." CMS converts these to a linear mean score on a 0 to 100 scale. The ratings of health care quality and health plan are global rating measures in which survey questions have responses of 1 to 10, which CMS also converts to a linear mean score on a 0 to 100 scale. "Plan" in "rating of health plan" can refer to either an MA plan or the FFS Medicare program. The FFS–CAHPS response rate was 28 percent, and the MA–CAHPS response rate was 33 percent.
CMS revised which CAHPS survey items are scored in the "getting appointments and care quickly" composite measure, which may cause fluctuation in scores compared with prior years. For this reason, we did not include this measure in the time series.
The 2019 CAHPS surveys were halted due to the coronavirus pandemic. We report values for 2018 to include a prepandemic comparison year.

Source: MA–CAHPS and FFS–CAHPS national mean scores published by CMS, 2023.

terms of study populations, metrics evaluated, and data sources used. Some studies found that MA outperformed FFS, some found that FFS outperformed MA, and some were unable to conclude that one program was better than the other. In studies reporting multiple outcomes, results did not consistently point to higher performance in one program than the other. Three major challenges—data completeness and comparability, differences in coding intensity across plans and between MA and FFS, and favorable selection in MA—impacted all included studies to varying extents, limiting our ability to draw conclusions.

Earlier reviews found similarly wide heterogeneity in study design and quality and came to similar conclusions (Agarwal et al. 2021, Ochieng and Fuglesten Biniek 2022). With respect to CAHPS scores specifically, Agarwal and colleagues' review included six studies, conducted between 2009 and 2019; they concluded that the evidence on experience of care did not show meaningful differences between the aggregate performance of MA plans and FFS Medicare (Agarwal et al. 2021). Overall, MA enrollees and FFS Medicare beneficiaries reported similar levels of satisfaction with care, across these studies and the survey data we have analyzed. Despite these challenges, it is necessary to understand the quality of care that Medicare beneficiaries receive, for both beneficiary decision-making and program-monitoring purposes. The Commission will continue to explore available data sources to better understand beneficiary experiences with the MA program.

Commission recommendations to improve MA payment policies

The Commission is concerned that current Medicare policy to pay MA plans and incentivize high-quality care does not serve beneficiaries or taxpayers. The Commission has found that CMS's coding-intensity adjustment is inadequate to address the higher level of MA diagnostic coding we estimate for 2025 and the resulting higher payments to MA plans and generates inequity across MA parent organizations. At the same time, the quality-bonus program boosts plan payments for 69 percent of MA enrollees but does not effectively promote high-quality care. Further, when we account for the effects of higher coding intensity and of favorable selection in MA, we estimate that MA plan bids in 2025 are, on average, roughly equal to the costs of covering the Medicare benefit under FFS. For some enrollees, the supplemental benefits fill gaps in the Medicare benefit by adding coverage for services that are not included in traditional Medicare.[72] The generosity of the additional benefits is appealing to beneficiaries, particularly for those who are unable to afford a Medigap policy that would reduce cost sharing in FFS Medicare. But MA payment policies distort the goal of plans competing to improve quality and reduce health care costs; instead, these policies increase program spending and Part B beneficiaries' premiums. Moreover, the Commission has found that plan-submitted data about beneficiaries' health care encounters are incomplete. If these data were complete and accurate, they could be used to identify MA-plan efficiencies, improve quality measurement, and provide more robust oversight of the MA program.

The Commission remains committed to including private plans in the Medicare program so that beneficiaries can choose among Medicare coverage options. But the rapid growth of MA enrollment and spending elevates the urgent need for important reform of Medicare's policies of paying and overseeing MA plans. As MA enrollment continues to grow, higher payments to plans will worsen Medicare's fiscal sustainability.

Overall, we estimate in 2025 that Medicare is paying MA plans 20 percent, or $84 billion, more than it would spend if those enrollees were covered under FFS Medicare, which increases financial burden on the taxpayers and beneficiaries who fund the MA program. Paying MA plans more than FFS spending for beneficiary care also creates inequities among beneficiaries since beneficiaries in FFS Medicare help finance the higher payments that MA plans use to provide supplemental benefits for their enrollees (benefits that FFS beneficiaries generally must pay for out of pocket or through supplemental insurance). We estimate that aggregate Part B premiums will be about $13 billion (10 percent) higher in 2025 because of payments above FFS spending (equivalent to about $198 per beneficiary per year).[73] Further, incentives for efficient delivery of care are undermined by paying MA plans more than the program pays for FFS beneficiaries. To encourage efficiency and promote value for taxpayers and beneficiaries, an overhaul of MA payment policy should include reducing the level of Medicare payments to MA plans. Past experience

TABLE 11–8

Commission's recommendations to improve MA payment policies

Recommendation
Fully account for MA coding intensity—*March 2016* The Congress should direct the Secretary to develop a risk-adjustment model that uses two years of FFS and MA diagnostic data and does not include diagnoses from health risk assessments from either FFS or MA, and then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.
Improve encounter-data accuracy and completeness—*June 2019* The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and rigorously evaluate MA organizations' submitted data and provide robust feedback; concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and institute a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary option for all MA organizations that prefer this method starting in 2024, for MA organizations that fail to meet thresholds, or for all MA organizations if program-wide thresholds are not achieved.
Replace the quality-bonus program—*June 2020** The Congress should replace the current MA quality-bonus program with a new MA value-incentive program that scores a small set of population-based measures, evaluates quality at the local-market level, uses a peer-grouping mechanism to account for differences in enrollees' social risk factors, establishes a system for distributing rewards with no "cliff" effects, and distributes plan-financed rewards and penalties at a local market level.
Establish more equitable benchmarks—*June 2021*** The Congress should replace the current MA benchmark policy with a new MA benchmark policy that applies a relatively equal blend of per capita local-area FFS spending with price-standardized per capita national FFS spending; a rebate of at least 75 percent; a discount rate of at least 2 percent; and the Commission's prior MA benchmark recommendations—using geographic markets as payment areas, using the FFS population with both Part A and Part B in benchmarks, and eliminating the current pre–Affordable Care Act cap on benchmarks.

Note: MA (Medicare Advantage), FFS (fee-for-service).
* The June 2020 quality recommendation incorporates the Commission's prior recommendations to eliminate the doubling of the quality increases in specified counties (recommended in March 2016) and to establish a geographic basis for MA quality reporting that reflects health care market areas (June 2005, March 2010, and March 2018).
** The June 2021 benchmark recommendation incorporates the Commission's prior recommendations to eliminate the cap on benchmark amounts implemented by the Affordable Care Act of 2010 (recommended in March 2016), base benchmarks on FFS spending data only for beneficiaries with both Part A and Part B (recommended in March 2017), and establish a geographic basis for MA payments that reflects health care market areas (recommended in June 2005, March 2010, and March 2018).

Source: Medicare Payment Advisory Commission 2021a, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016c.

with reductions in MA payments under the ACA has demonstrated that plans can adjust their bidding behavior and lessen the effects on plan participation and beneficiary enrollment.

Over the past few years, the Commission has developed four recommendations (some that incorporate and update prior recommendations) that would improve the MA program for both beneficiaries and taxpayers.

Table 11-8 summarizes the Commission's standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016c); (2) ensure the completeness and accuracy of encounter data to improve the MA payment system, serve as a source of quality data, and facilitate comparisons with FFS Medicare (Medicare Payment Advisory Commission

2019); (3) replace the QBP with a market area–based, plan-financed reward program (Medicare Payment Advisory Commission 2020a); and (4) establish more equitable MA benchmarks for the Medicare program (Medicare Payment Advisory Commission 2021a). Through reforms to the MA payment system, the Commission aims to improve the program for the beneficiaries it serves and to harness plan efficiency to strengthen Medicare's long-term financial sustainability.

If payments to MA plans were lowered, plans might reduce the supplemental benefits they offer. However, because plans use these benefits to attract enrollees, they might respond instead by modifying other aspects of their bids (Cabral et al. 2018, Chernew et al. 2023, Congressional Budget Office 2022, Song et al. 2013).

The inability of the MA–QBP to meaningfully characterize the quality of care that MA enrollees receive makes it difficult for beneficiaries to make informed choices and for policymakers to assess the value that private plans bring to the Medicare program. In the June 2020 report to the Congress, the Commission recommended replacing the QBP with a value-incentive program that addresses the flaws of the QBP. First, focusing on a small set of population-based outcome- and patient/enrollee–experience measures would facilitate comparisons across MA plans, enabling beneficiaries to choose based on factors that are most meaningful to their experience. A continuous scale of performance, rather than one with "cliff" effects, would provide MA plans with the incentive to improve quality at every level. Performance evaluation at the local market level, rather than the contract level as is currently done, would similarly improve the information that beneficiaries can use for decision-making and the incentives for MA plans to improve quality in every geographic area.

The Commission also recommended that the value-incentive program address the variation in the demographics of MA enrollees across plans. By accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of beneficiaries with similar social risk profiles, plans with higher shares of these enrollees would not be disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care would not be masked. Finally, the Commission contends that MA quality-bonus payments should not be financed with additional program dollars, especially given that Medicare pays MA plans more than would have been spent on FFS for the same beneficiaries. Application of budget-neutral financing would ensure that the MA quality system is more consistent with Medicare's FFS quality-payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020a). ■

TECHNICAL APPENDIX

11–A

Favorable selection

The Commission's methodology for estimating favorable selection in MA

The risk-adjustment model that CMS uses to adjust payments to Medicare Advantage (MA) plans predicts Medicare spending using beneficiary characteristics, including demographics and medical conditions. The model is estimated using data from beneficiaries enrolled in the fee-for-service (FFS) program. For any set of characteristics, some FFS beneficiaries with those characteristics will have actual spending that is more than predicted and others will have actual spending that is less than predicted by the risk-adjustment model.

"Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even if medical conditions were recorded with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries' propensities to seek, or receive, care for reasons that are unrelated to their health.

Chapter 11 presents estimates from two methods of estimating the effect of favorable selection in the MA population. The first is a comprehensive method that we apply to estimate a selection effect for the entire MA-enrolled population—except for those with end-stage renal disease (ESRD)—in each year from 2016 to 2022. We also use estimates from that method to project the effect of favorable selection for 2023 to 2025, years in which we do not yet have data available. The second is a simple method that estimates favorable selection for the portion of MA enrollees in each year who were enrolled in the FFS program in the previous year, referred to as "recent switchers." We use that simple method, which is described in the main chapter, to estimate selection for the years before 2016 (going back to 2007). We also apply that method to more recent years of data in order to compare estimates for the two methods in similar years and conduct other analyses that examine how favorable selection varies by beneficiary characteristics and geography.

Comprehensive methodology for estimating favorable selection of the MA population

We use our comprehensive method to estimate an aggregate selection percentage for the entire population of non-ESRD MA enrollees in each year, beginning in 2016. That aggregate selection percentage represents the amount by which the predicted spending used for payment for the entire MA population (estimated using the FFS population in Medicare's risk-adjustment model) underpredicted (or overpredicted) the actual spending that population would have had if those beneficiaries had been enrolled in the FFS program in that year. It is computed as a ratio of (1) the estimated spending that the FFS program would have incurred for the MA-enrolled population had they been enrolled in the FFS program (the numerator) and (2) the estimated FFS spending that the Medicare payment system predicted for that population (the denominator). We label that ratio the "selection percentage." We cannot directly observe the selection percentage of beneficiaries during their enrollment in MA because we cannot observe what their spending would have been had they instead been enrolled in FFS in that year. We can directly estimate the selection percentage of MA enrollees who were previously enrolled in the FFS program in the year before they switched to MA. Thus, we use data from MA enrollees who were previously enrolled in the FFS program as our study population and model how their selection percentage changed between the year before they enrolled in MA and their most recent year of MA enrollment.

Our study population consists of beneficiaries who had at least two years of prior enrollment in the FFS program before switching to MA ("previous switchers"), approximately 38 percent of non-ESRD MA enrollees in 2021.[74] For those enrollees, we have complete data on their spending and risk scores while in FFS that we can use as the basis for estimating a selection effect. The remaining non-ESRD MA population either enrolled in MA upon their initial eligibility for Medicare (33 percent in 2021) or had less than two years of prior FFS enrollment (29 percent in 2021).[75] For those enrollees, we assign a selection percentage using data from switchers who joined MA in the same year and had the same mortality status in the following two years. MA enrollees with ESRD, who accounted for 1 percent of

the MA population in 2023, are assigned a selection effect equal to zero.[76]

We estimate selection for the study population of MA enrollees who were previous switchers using two main components: the selection percentage before each beneficiary was enrolled in MA ("base-year selection") and the estimated change in selection between the base year and the most recent year of MA enrollment. We describe below how we measure base-year selection and the change in selection for that population.

Study and comparison populations

We include beneficiaries in our study population if they (1) were enrolled in MA for at least one month of the year we are estimating selection for (referred to as the "target year," which is 2022 for the most recent estimate); (2) had joined MA between 2008 and 2022; and (3) had been enrolled in FFS and had both Part A and Part B coverage for at least two full calendar years prior to enrolling in MA. Because hospice enrollees receive their Medicare Part A and Part B coverage only from FFS and not from MA plans, we remove MA enrollment months while the beneficiary is in hospice (unless they were participants in CMS's value-based insurance design hospice demonstration).[77] We address the issue of decedents separately (discussed below).

Consistent with our comparisons of MA payments and coding relative to FFS spending, we include beneficiaries enrolled in conventional MA plans (available to all beneficiaries), special-needs plans, and employer plans because the Medicare program makes payments to plans for all of these populations, and they all can experience favorable selection. We require beneficiaries to have at least two full calendar years of FFS enrollment because the CMS hierarchical condition category (HCC) risk-adjustment model calculates risk scores using diagnoses from the prior year's claims. Thus, we require data on MA beneficiaries with two years of prior FFS enrollment to calculate risk scores for their last year of FFS enrollment.[78] We divide the study population for each target year into 14 annual cohorts based on the year they previously enrolled in MA (2009 through 2022). The study population of MA enrollees is used to construct the numerator of the selection percentages we estimate.

For the comparison population used to construct the denominator for the selection percentages, we include nearly all FFS beneficiaries who would have been part of CMS's MA benchmark calculation and had the necessary data to construct risk scores. We also apply an additional exclusion to the FFS population used for benchmark calculations by requiring the comparison population to have had both Part A and Part B coverage for at least one full calendar year by the end of the base year (the study population's last year of FFS enrollment). That exclusion is applied to enhance similarity to the MA-enrolled population and to align with the population used to construct the base spending component of the Commission's comparison of MA to FFS spending. In addition, we exclude beneficiaries with any Part A–only, Part B–only, or MA months during the base year.

We exclude beneficiaries from both the study and comparison populations if they had ESRD, Part A-only coverage, Part B-only coverage, or if they had another source of health coverage for which Medicare acted as a secondary payer during the reference year. CMS excludes beneficiaries with ESRD from benchmark calculations, pays MA plans state-based FFS rates for ESRD beneficiaries and adjusts benchmarks and payments for those with Medicare as a secondary payer to remove the secondary-payer effect. In addition, we exclude beneficiaries who did not reside in the 50 states and the District of Columbia.

Base-year selection percentage

Each beneficiary has a selection percentage that represents by how much their predicted spending estimated using Medicare's risk-adjustment model ("predicted spending") in year t underpredicts or overpredicts the actual spending they would have had if they were enrolled in the FFS program in that year. That individual-year-level selection percentage is denoted as $S_{i,g,t}$, for individual i, residing in county g, in time t. Time t indexes the time since individuals in each cohort of MA switchers switched from FFS to MA, with $t = 0$ representing the year before the switch occurred and $t = 1$ representing the first year the cohort was enrolled in MA. We use year $t = T$ to denote the "target year" in which we are measuring selection of the MA population. For example, consider a group of MA enrollees in 2022 who previously switched from the FFS program to MA in 2019 (and stayed in MA through at least one month in 2022). For those enrollees, $t = 0$ is 2018, $t = 1$ is 2019, and $t = T$ is 2022.

We refer to a beneficiary's selection percentage in the year before switching to MA as the base-year selection percentage and denote the base year as $t = 0$. Because MA switchers were enrolled in FFS in year $t = 0$, we can use their actual FFS spending to estimate their selection percentage in that year.

We estimate their base-year selection percentage as the ratio of each individual's actual spending relative to an estimate of their predicted spending (which is specific to their county g):

(1)

$$S_{i,g,t=0} = \frac{y_{i,g,t=0}}{\bar{y}_{g,t=0} \times r_{i,g,t=0}}$$

Where $y_{i,g,t=0}$ is the individual's actual FFS spending in year $t = 0$, $\bar{y}_{g,t=0}$ is the average risk-standardized spending of FFS enrollees in the same county g (standardized to a 1.0 risk score), and $r_{i,g,t=0}$ is the individual's risk score in year $t = 0$.[79] That initial selection percentage represents by how much Medicare's risk-adjustment model underpredicted or overpredicted the actual spending that the MA switchers had during their last year in FFS.

Selection in the base year is measured with a very high degree of accuracy for the population of MA switchers with the requisite two prior years of enrollment in FFS. However, our primary objective is to measure the degree of selection for the population of MA enrollees during the target year in which they were enrolled in MA in time $t = T$.

An individual's selection percentage at time $t = T$ could differ from their selection in the base year for several reasons, which can be seen from considering the terms in the formula above. First, the spending an individual would have had in FFS (the numerator) could get closer to their predicted spending over time, holding constant the risk model and the composition of the FFS population used to calibrate risk scores and calculate average spending. That phenomenon is known as "mean reversion."[80] Second, an individual's predicted spending in the denominator could get closer to or further from the numerator, holding the numerator constant. That could occur if changes to the risk model between $t = 0$ and $t = T$ improve the accuracy of predicted spending, or if changes in the composition of the FFS population used to calibrate the risk model and compute predicted spending change over time. The composition of the FFS population can change due to the net effect of inflows of people who newly enroll in FFS and outflows of beneficiaries who die or switch to MA. Our approach to estimating the change in selection accounts for all of those reasons.

Change in selection

We are interested in measuring the selection percentage in year $t = T$, when beneficiaries are enrolled in MA and we cannot directly estimate their selection percentage. To estimate their selection percentage in that year, we note that selection in later years can be expressed as the sum of an individual's base-year selection percentage (which we can directly estimate) and the change in their selection percentage:

(2)

$$S_{i,g,t=T} = \underbrace{S_{i,g,t=0}}_{selection\ in\ base\ year} + \underbrace{\left(S_{i,g,t=T} - S_{i,g,t=0}\right)}_{change\ in\ selection}$$

We can estimate the change in selection for each MA enrollee as the average change in selection percentage calculated for a proxy group of similar enrollees who were enrolled in the FFS program between $t = 0$ and $t = T$. We define $P_{b,d}^{c,T}$ as the set of beneficiaries that serve as the proxy group for any given cohort, c, of MA enrollees in year T (defined by the year they first enrolled in MA) who have the same base year ($t = 0$), selection percentage b, and year of death d relative to the target year ($t = T$). The average change in selection for the proxy group is calculated as

(3)

$$\Delta S_T^p = \sum_{i \in P_{b,d}^{c,T}} \left(S_{i,g,t=T} - S_{i,g,t=0}\right) \times \alpha_i$$

Each individual's weight in the calculation is represented by α_i.[81] The term $S_{i,g,t=0}$ is defined in equation (1), and $S_{i,g,t=T}$ is defined similarly as the ratio of each individual's actual spending in the target year relative to an estimate of their predicted spending in that same year:

(4)

$$S_{i,g,t=T} = \frac{y_{i,g,t=T}}{\overline{y}_{g,t=T} \times r_{i,g,t=T}}$$

Proxy groups are constructed by segmenting the population of beneficiaries who were enrolled in FFS from $t = -1$ through at least one month of $t = T$ into 50 mutually exclusive groups.[82,83] Those FFS enrollees are assigned to groups according to two key characteristics. First, they are assigned to one of three mortality groups based on their mortality in year $t = T$, $t = T + 1$, and $t > T + 1$. Second, they are assigned to a group based on their base-year selection percentage at $t = 0$. Each MA enrollee is matched to the proxy group that has the same mortality status and level of base-year selection, and the enrollee is then attributed the average change in selection for their matched proxy group.

For example, consider the set of MA enrollees in 2022 who were last enrolled in FFS in 2017 (including all of 2016), died in 2023, and had a selection percentage of 92 percent in 2017. The proxy group for those enrollees consists of beneficiaries who were enrolled in FFS in 2017 (including all of 2016) through 2022, died in 2023, and had a selection percentage between 90 percent and 100 percent in 2017.[84] The average change in selection percentage for that proxy group between 2017 and 2022 is used as the estimate for the change in selection percentage for the MA enrollees who match to that proxy group.

Matching on base-year selection percentage is important for capturing the potential for mean reversion because people who begin the period with a large degree of favorable (or unfavorable) selection may be more likely to experience larger changes that bring them closer to the mean. Matching on mortality is important because people closer to death tend to have higher spending on average, both in absolute terms and relative to their predicted spending. The average change in selection for the proxy group also accounts for changes to the Medicare risk-adjustment model, changes in the composition of the FFS population, and secular trends in FFS spending over the period. For example, changes to Medicare's risk-adjustment model are reflected in the calculation through changes in risk scores for the proxy group.

Cohort-level estimates of MA switchers

We construct aggregate selection percentages at the mortality-cohort-group level by aggregating the estimates of individual-level selection effects, weighting by predicted spending and number of months enrolled in MA during year $t = T$.

(5)

$$S_{c,d,T} = \sum_{i \in C^{d,T}} \left(S_{i,g,t=0} + \Delta S_T^p\right) \times w_{i,T}$$

Because the risk scores of MA enrollees at year $t = T$ are influenced by the coding practices of their plans, in constructing the weights for this calculation we estimate what each individual's risk score would have been in year $t = T$ had they been enrolled in FFS.[85] To do this estimate, we take the beneficiary's FFS risk score from the base year before they switched to MA and trend it forward based on the change in risk score for members of their proxy group.

Assigning cohort-level estimates to remaining MA population

About 38 percent of the MA-enrolled population in each year are in our study population and have their selection percentage estimated using the method outlined above. The bulk of the remaining MA population either enrolled in MA upon their initial eligibility for Medicare (33 percent) or had less than two years of prior FFS enrollment (29 percent). For those enrollees, we assign a selection percentage as the estimated selection percentage of switchers who joined MA in the same year and had the same mortality status in the following two years. That is, selection percentages are assigned to MA enrollees outside the study population at the mortality-cohort-group level. (We also assign selection percentages to beneficiaries who enrolled in MA prior to 2008 using the estimated selection percentages for the 2008 cohort of our study population.) The decision to generalize estimates of selection from our study population to those other groups is supported by our own analysis and external studies.

Our analysis suggests that MA enrollees who switched from FFS but had less than two years of prior FFS

coverage had favorable-selection effects that were at least as large as the MA enrollees in our study population with at least two years of prior FFS coverage. In our March 2024 report to the Congress, we used risk scores constructed from concurrent diagnoses to examine the effect of favorable selection for beneficiaries who had only one full year of prior FFS enrollment (before switching to MA). We estimated favorable-selection effects that were consistently larger for these beneficiaries than for our study population of MA switchers (i.e., beneficiaries who had at least two years of FFS enrollment before joining MA) (Medicare Payment Advisory Commission 2024).

For beneficiaries who enroll in MA upon initial Medicare eligibility, the available evidence is also consistent with favorable selection. One study used mortality as a rough proxy for MA favorable selection and found substantially lower mortality rates among enrollees who elected MA during their first year of Medicare eligibility (Newhouse et al. 2019). Further, another group of researchers examined pre-Medicare spending for a sample of about 11,000 beneficiaries who enrolled in MA at age 65 between 2015 and 2019. When comparing the risk-adjusted pre-Medicare spending of these MA enrollees with the pre-Medicare spending of a sample of beneficiaries who elected FFS at age 65, these researchers found about 12 percent to 13 percent lower risk-adjusted spending in the MA sample relative to the sample of FFS beneficiaries (Teigland et al. 2023). That estimate of favorable selection exceeds our estimate of favorable selection for MA switchers throughout the 2015 to 2019 period, which we estimate to be 4 percent to 9 percent using the Commission's simple method, which is most comparable with that study's methods. Our analyses combined with the results of other research suggest that the effect of favorable selection for MA entrants who have less than two years of prior FFS coverage, or none at all, may be even larger than what we observed in our study population.

Final aggregate selection percentage of MA population

The final aggregate selection percentage of the entire MA enrolled population in year t = T is a dollar-weighted average of the individual selection percentages. Each enrollee is weighted by the number of months they were enrolled in MA in year t = T and their projected FFS risk score (using the change in risk score of the proxy group during MA enrollment). This weighting reflects each individual's predicted spending in year t = T as a share of the MA population's predicted spending in year t = T.

Our approach to estimating selection for the MA population in the target year using data from people who were enrolled in MA in that year implicitly accounts for the role of selective attrition out of the MA program. "Selective attrition" refers to the tendency for the beneficiaries who either die or disenroll from the MA program to FFS to have risk scores that underpredict their spending. Analyses by the Commission and other researchers have found evidence of selective attrition, suggesting that the size of favorable selection in the MA population could be higher than estimates using data from all people who initially enrolled in MA. By defining our study population as beneficiaries who are enrolled in MA during the target year, we exclude beneficiaries who disenrolled from MA in earlier years. Those beneficiaries are not relevant for estimating selection in the target year because they are no longer part of the MA population. This approach to accounting for selective attrition implicitly through the construction of the study population remains the same in the current version of the methodology and the methods used in the March 2024 report to the Congress.

Technical changes relative to the methods used for the March 2024 report to the Congress

The methodology outlined above reflects several technical updates to our methods from last year. The Commission's March 2024 report to the Congress used the same analytic framework of using cohorts of people who had previously switched from FFS to MA and were still enrolled in MA in the target year and using the FFS experience of cohorts with the same level of base-year favorable selection to estimate changes in favorable selection during MA enrollment (Medicare Payment Advisory Commission 2024). The analysis described in this chapter continues to use the analytic framework from our March 2024 report but makes several technical improvements to improve the accuracy of the estimated changes in favorable selection during MA enrollment and to improve the ways in which we incorporate decedents and near-decedents into our analysis. We made two sets of changes to address those aims.

First, we now use the broadest population of FFS enrollees possible to construct our proxy groups that are used to estimate changes in selection during MA enrollment (including changes due to mean reversion). Choosing a proxy-group population is challenging because it is unknown how the selection percentage of the actual MA population would have changed if they were enrolled in FFS. Our previous method used the portion of FFS enrollees that were future MA entrants as the proxy-group population, which was motivated by a desire to construct a proxy group that was as similar as possible to the MA-enrolled population. However, there was some concern that using future MA entrants could understate mean reversion if beneficiaries with less mean reversion were more likely to later switch to MA but exhibited a more typical mean reversion tendency once they were enrolled in MA. Although our previous approach may have understated mean reversion, a critique of our new, broader proxy group is that it might overstate mean reversion for the MA-enrolled population (and thus understate selection). As a result, we view our updated proxy group as a more conservative methodological choice. Our additional update to the proxy-group construction to include matching by mortality status (described below) mitigates this concern somewhat by making the FFS proxy populations more similar to the MA population with respect to their mortality.

Second, we made several changes to more thoroughly incorporate decedents and near-decedents into our analysis. Our previous method excluded decedents from the populations used to construct the numerator and the denominator of the selection percentages in many parts of the analysis, for tractability. However, we identified several concerns about the exclusion of decedents, some of which would tend to increase the selection effect and others that would tend to decrease it. Our goal with this set of methodological updates is to more accurately reflect selection and the change in selection for decedents and near-decedents in our estimates.

The first concern was that we were understating the mean reversion for decedents and near-decedents in the MA population (that is, overstating their favorable selection) because decedents were not included in the previous proxy groups used to estimate changes in selection. The second concern arose as we considered the first methodological update to use the broader FFS population for our proxy-group population. Because there are more decedents and near-decedents in the FFS population than the MA population, we were concerned that the broader FFS population might overstate mean reversion for MA enrollees not close to death. (Our analysis shows that, on average, decedents and near-decedents are highly unfavorable and have large changes in their selection percentages.) Third, we were concerned that decedents were not included in the FFS denominator used to construct our base and change in selection percentages, whereas decedents are included in the population that CMS uses to construct MA benchmarks.

We address the first and second concern jointly by including decedents in the new proxy-group population and by matching the proxy-group populations to the MA-enrolled population by mortality status. We address the third concern by including decedents in the populations used to estimate predicted spending in the denominators for the base- and target-year selection percentages. That is, the populations used to estimate the terms $\bar{y}_{g,t=0}$ in equation (1) and $\bar{y}_{g,t=T}$ in equation (4) now includes people who died in $t = 0$ and $t = T$, respectively. Including decedents in the denominators is also a necessary change to make if we want to include decedents in the proxy-group population (which serves as the numerator for the change in selection estimate). Including decedents in both the numerator and the denominator of all relevant steps of the calculations is necessary for consistency and improves the accuracy of our estimates.

We now describe each of the technical updates more thoroughly:

- Changes to the comparison group (denominator) populations for all components of the estimate: We made two changes to the populations used to estimate predicted spending in the denominators of our selection percentages (that is, the populations used to estimate $\bar{y}_{g,t=0}$ in equation (1) and $\bar{y}_{g,t=T}$ in equation (4)). Previously, the populations used for those calculations included FFS enrollees who were both alive for the entire year and did not switch to MA in the following year. The denominator population now includes FFS enrollees who died during the year and enrollees who switched to MA in the following year. Both those changes are consistent with the populations that CMS uses to calculate benchmarks, and

making those changes allows us to better account for differences in mortality between MA and FFS.

- Changes to the proxy-group populations used for the change in selection component of the estimate: Proxy cohorts now consist of all beneficiaries who remained in FFS during the period of MA enrollment, including beneficiaries who died in the target year $t = T$. Previously, we included only the subset of FFS beneficiaries who switched into MA in the year following the target year in our proxy groups. This update to our method allows our estimate to better account for the change in selection percentage for MA enrollees who die within the target year.[86]

- Matching the MA-enrolled population to proxy groups using mortality status: When modeling changes in selection during MA enrollment, we now match MA cohorts and their proxy cohorts by both mortality (using the number of years to death relative to the target year $t = T$) and the initial selection percentage in year $t = 0$. This modification allows our estimate to better account for larger changes in selection for decedents (MA enrollees who died in the target year, year $t = T$) and near-decedents (who died in year $t = T + 1$). Previously, we assumed that decedents and near-decedents had the same change in selection percentage as MA enrollees who were not near death. That earlier approach likely overestimated the level of favorable selection (that is, understated the selection percentage) for MA enrollees who were close to death because decedents and near-decedents disproportionately have high risk-standardized spending.

- Assigning selection percentages to the rest of the MA population using mortality status: We use estimates of favorable selection for MA enrollees in our study population to assign selection percentages to MA enrollees outside of our study population. Under the previous version of our method, we matched MA enrollees who were outside our study group to those in our study group based on their year of entering MA. For example, individuals who entered MA in 2018 but did not have the required number of years in FFS to be in our sample were assigned the average selection percentage of members of our study cohort who entered MA in 2018. Under our updated method, we now also match MA enrollees outside our study population to those in our study population by mortality status (using the number of years to death relative to the target year $t = T$) when assigning them a selection percentage. In addition, we trend forward the initial average risk score of each mortality group in each study population cohort by the increase in risk score of their proxy cohort-mortality group. We apply this trended risk score to the broader MA cohort-mortality group. Thus, each MA enrollee receives a selection percentage and expected risk score based on their MA entry year and mortality status in year $t = T$ and $T + 1$. We previously implicitly assumed that the share of decedents and near-decedents was the same between the MA study population and the rest of MA enrollees outside the study population. However, MA enrollees outside our study population have a smaller share of decedents relative to our study population (who were previous switchers and tend to be older). Thus, this update to our method more accurately accounts for mortality differences between MA enrollees included and not included in our study populations.

We compared the estimates that we published in the March 2024 report to the Congress for the MA population in 2021 to our estimates for the 2021 population under the updated methodology. The updates to our method decreased our overall estimate of favorable selection by about 2 percentage points in 2021, from 12.8 percent to 10.9 percent (Table 11-A1).

During the base year $t = 0$, adding decedent spending in the denominator decreases the selection percentage (thereby increasing the base-year effect of favorable selection) for each MA-entry cohort (in year $t = 0$) by 8 percentage points to 13 percentage points. This result is consistent with the expectation of adding decedent spending to average spending for the entire FFS population with Part A and Part B coverage. We compare average risk-standardized spending with and without decedents. We find that including decedents increased average FFS risk-standardized spending by 10 percent in 2021. Between base year $t = 0$ and target year $t = T$, we find that adding decedent spending to the numerator similarly increases the selection percentage (thereby decreasing the effect of favorable selection) by the target year for each MA-entry cohort

TABLE 11–A1

Estimated favorable selection in 2021 is similar under the previous and updated methodologies

	(Consecutive years in MA) MA entrant year													
MA entrant	***(14)*** **2008**	***(13)*** **2009**	***(12)*** **2010**	***(11)*** **2011**	***(10)*** **2012**	***(9)*** **2013**	***(8)*** **2014**	***(7)*** **2015**	***(6)*** **2016**	***(5)*** **2017**	***(4)*** **2018**	***(3)*** **2019**	***(2)*** **2020**	***(1)*** **2021**
March 2024 method (survivor-based restrictions and a narrow FFS proxy group of future MA entrants)														
Base spending relative to FFS	77%	74%	79%	74%	74%	80%	83%	81%	83%	87%	87%	90%	88%	91%
Change in selection percentage while in MA	10%	13%	9%	14%	14%	8%	6%	8%	6%	2%	3%	0%	2%	–2%
Selection percentage trended forward to 2021	87%	87%	88%	88%	88%	88%	89%	89%	89%	89%	89%	90%	89%	88%
Overall plan spending relative to 2021 average across 14 cohorts (enrollment weighted)														88.6%
Overall impact on MA payments relative to FFS spending (100% / 88.6% – 1)														12.8%
March 2025 method (incorporating decedents and a broad FFS proxy group)														
Base spending relative to FFS	64%	66%	67%	64%	65%	68%	72%	71%	73%	76%	76%	79%	79%	79%
Change in selection percentage while in MA	28%	22%	22%	24%	23%	21%	18%	18%	17%	15%	16%	13%	10%	9%
Selection percentage trended forward to 2021	92%	88%	89%	88%	88%	89%	90%	89%	90%	91%	92%	92%	89%	88%
Overall plan spending relative to 2021 average across 14 cohorts (enrollment, risk, and mortality weighted)														90.2%
Overall impact on MA payments relative to FFS spending (100% / 90.2% – 1)														10.9%

Note: MA (Medicare Advantage), FFS (fee-for-service). "MA entrants" are beneficiaries who switched from FFS to MA and who stayed in MA for at least one month of MA enrollment in 2021. "Spending" reflects the year prior to MA entry and is risk adjusted and trended forward using a FFS population that matched the same enrollment criteria, had the same initial level of favorable selection, and had the same mortality status in 2021. Lower MA-entrant spending relative to FFS spending reflects a greater effect of favorable selection. The analysis excludes MA enrollees without at least two full years of enrollment in FFS Part A and Part B prior to the year of MA entry as well as those who joined a non-MA private plan (e.g., cost plan), had end-stage renal disease, had Medicare as a secondary payer, resided in multiple counties during the year, or resided in Puerto Rico (due to the relatively small number of FFS beneficiaries in that territory). Estimates for 2008 are used for enrollees who entered MA prior to 2008. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment, Medicare claims spending, and risk-adjustment files, 2006–2022.

(in year t = T where T = 2021) by 8 percentage points to 18 percentage points. Thus, on net, the updates to our method do not produce markedly different results for most of the MA cohorts in 2021. Ten of the 14 cohorts that comprise the 2021 estimate of favorable selection have selection percentages that

changed by 1 percentage point or less; 2 of the 14 cohorts have selection percentages that changed by 2 percentage points; 1 of the 14 cohorts has a selection percentage that changed by 3 percentage points; 1 of the 14 cohorts has a selection percentage that changed by 5 percentage points. The 2008 MA-entry cohort experienced the largest increase in selection percentage (5 percentage points). This finding likely results from our applying the selection percentage for 2008 to all MA enrollees who enrolled in MA before 2008, and these enrollees have a larger share of decedents, which we now account for in our analysis. Conversely, the 2021 MA-entry cohort does not experience any change in its estimated selection percentage—even though we now account for the relatively smaller share of decedents among this group.

While it is difficult to separately identify the effect of each of our technical changes on our estimate of favorable selection, we estimate the impact of all our mortality-related changes separately from the impact of constructing proxy groups using a broad population of FFS enrollees (instead of the earlier approach of using a narrower population of FFS enrollees who later enrolled in MA) for our estimate of mean reversion. We compare our prior estimate of favorable selection for 2021 (the most recent estimate reported in the March 2024 report) with our current estimate for 2021.

- First, we estimate the impact from all our mortality-related changes by applying all our technical updates with the exception of using the general FFS population as our proxy-group population for the change in favorable selection during MA enrollment (i.e., mean reversion). Instead, we largely maintain the definition of our previous proxy groups by using the population of FFS beneficiaries who entered MA in the year after target year t = T + 1. (Because there are no decedents among the population of FFS beneficiaries who switch to MA in T + 1, we used the general population of FFS beneficiaries who died in year T when constructing proxy groups for decedents.) We find that applying our mortality-related changes, while largely holding constant the proxy-group population used in the previous version of the method, results in an overall selection percentage of 86.2 percent in 2021, 3 percentage points lower than our previous estimate (meaning greater favorable selection).
- Second, we estimate the impact of using the general FFS population as our proxy-group population (i.e., the group that we use to estimate mean reversion during MA enrollment). Applying all of our mortality adjustments, we compare our favorable selection estimates when using a general FFS proxy group relative to using a narrower proxy group of FFS beneficiaries who switched to MA in T + 1. We find that using a general FFS proxy group results in an overall selection percentage of 90.2 percent in 2021, 4 percentage points higher than the 86.2 percent selection percentage estimated when applying the mortality-related changes alone.

Taken together, our technical updates increased the overall selection percentage by 2 percentage points in 2021 (thereby decreasing the overall estimate of favorable selection by 2 percentage points). The updates have a larger effect on our overall estimates of favorable selection from 2016 to 2020, the other years for which both sets of estimates are available (data not shown). Whereas we had previously estimated that the effect of favorable selection on MA payments increased from 5 percent in 2016 to 13 percent in 2021, we now estimate that the effect of favorable selection was more stable during that period, increasing more slowly from 8 percent in 2016 to 11 percent in 2021. We will continue working to understand the drivers of favorable selection during this period.

Sources of uncertainty in the Commission's estimate of favorable selection

There are four main sources of uncertainty in the Commission's estimate of favorable selection. Below, we discuss those sources. We have tried to make reasonable modeling assumptions where there is uncertainty; however, our estimate of favorable selection could be higher or lower if actual trends differ from those assumptions.

- We have a high degree of confidence in our estimate of favorable selection for beneficiaries in our study population before they enter MA ("base-year selection"). However, there is uncertainty in our estimate of the change in selection while our study population was enrolled in MA because that change cannot be observed directly with available data and must be estimated using a different population of beneficiaries who are enrolled in FFS. We make the best use we can of available data to

estimate the change in selection by matching our study population to FFS "proxy groups" using their base selection before entering MA and mortality status during the year of MA enrollment. Our analysis suggests that this portion of the estimate is conservative because using narrower proxy groups of FFS beneficiaries who later enrolled in MA produces larger selection effects. However, the actual change in selection could be higher or lower than we estimate.

- There is also uncertainty regarding the selection effect for MA enrollees outside our study population. Due to a lack of data, we assign a selection percentage to those beneficiaries using data from MA beneficiaries in our study population. Our analysis, described earlier in the appendix, indicates that assigning selection percentages that we estimate by using our study population to the remaining MA population is appropriate and may be conservative.
- Another source of uncertainty stems from data limitations that require us to exclude beneficiaries who lack a full prior year of FFS enrollment from the FFS comparison population used for the denominators. That method excludes some beneficiaries from the denominator whom studies have demonstrated to have unfavorable (that is, higher) risk-standardized spending—beneficiaries who have recently disenrolled from MA to FFS (Fuglesten Biniek et al. 2024)—which suggests that our estimated selection effects would be larger if those beneficiaries were included. It also excludes FFS beneficiaries who recently became eligible for Medicare. Their risk-standardized spending may be higher or lower than the population of FFS beneficiaries with complete data who are in our comparison group, so omitting those beneficiaries may cause our estimate of favorable selection to be either higher or lower.
- Finally, there is uncertainty in our assignment of a zero selection effect to MA enrollees with ESRD. We assign this effect because plans are paid for those enrollees using a different payment system, so estimating their selection would require a separate method. Payments to MA plans for ESRD enrollees account for about 6 percent of total payments to MA plans in 2025. Therefore, the exclusion of ESRD enrollees is not expected to have a large effect on our overall estimate. We will consider conducting a separate analysis of the degree of selection among the ESRD population in the future. ■

TECHNICAL APPENDIX 11–B

Coding intensity

The Commission's method for estimating MA coding intensity

The Commission's method for estimating coding intensity is based on the demographic estimate of coding intensity (DECI) method, originally developed by Kronick and Chua (2021). The DECI method implicitly assumes that Medicare Advantage (MA) enrollees are no less healthy than fee-for-service (FFS) Medicare beneficiaries with similar demographic characteristics. Therefore, the DECI method attributes higher demographic-adjusted MA risk scores relative to FFS to higher MA coding intensity rather than worse health acuity or complexity among MA enrollees than FFS beneficiaries. Figure 11-B1 (p. 390) shows how the DECI method estimates coding intensity.

National average CMS hierarchical condition category risk scores

We identify monthly MA or FFS enrollment using the plan identifier in the Medicare common enrollment file, and we require all MA and FFS beneficiaries to have both Part A and Part B using the "Medicare enrollment code" data field. Then we use monthly indicators in risk-score data to exclude beneficiary months in which an end-stage renal disease (ESRD) risk score would be applied and to assign "new-enrollee" and institutional risk scores as appropriate. For all remaining months, we assign the appropriate community-model risk score using the monthly Medicare–Medicaid dual status code from the enrollment file to adjust for full, partial, or no Medicaid benefits, and we use the beneficiary's age from risk-score data to determine aged or disabled status. In each year, we use the version of the risk model or blend of versions that was used for payment to MA plans. Finally, we aggregate the monthly risk scores to calculate national average MA and FFS CMS hierarchical condition category (HCC) scores for the four groups identified below.

When developing this method, we benchmarked our estimate of the national average risk score for all FFS beneficiaries in 2019 (including those with Part A only) of 1.0682 against the national average published by CMS of 1.0685. Our estimate of the average risk score for all FFS beneficiaries was similarly close to CMS's published results for 2017 and 2018.

National average demographic risk scores

We calibrate an annual risk model based only on demographic characteristics for FFS beneficiaries with both Part A and Part B (excluding beneficiaries with ESRD) by including age category (CMS–HCC model categories), sex, Medicaid eligibility (full benefits, partial benefits, or no benefits), and institutional status. We use the same enrollment and risk-score indicator variables as in the CMS–HCC risk-score analysis described above.

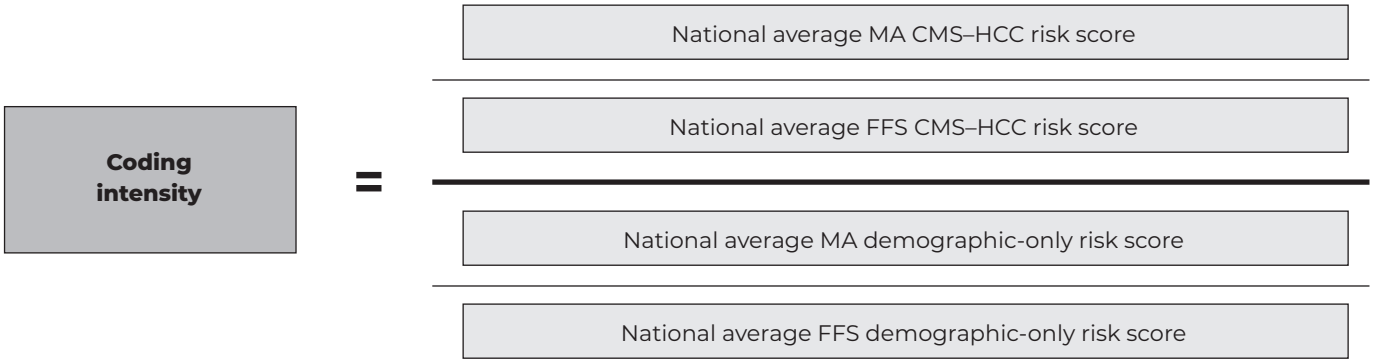
We calculate monthly Medicare spending by summing the annual spending amounts in the Medicare beneficiary summary file (excluding beneficiaries with any hospice use) and dividing by the months of Part A and Part B enrollment in the year. We calculate separate risk models (with dollar-value age and sex coefficients) for beneficiaries with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits, and then divide each model's coefficients by the average spending for that group to convert the dollar coefficients to risk scores. The average risk score in each model is 1.0. Finally, we apply those demographic risk scores to MA and FFS beneficiaries with both Part A and Part B and aggregate them to national averages for each of the four groups identified below.

Calculation of coding intensity that accounts for Medicaid eligibility and institutional status

For MA and FFS, we calculate average CMS–HCC and demographic risk scores separately for continuing (not new-enrollee) beneficiaries with institutional status, full Medicaid benefits, partial Medicaid benefits, and no Medicaid benefits. We then calculate average CMS–HCC and demographic risk scores for continuing enrollees using the share of MA enrollees in each of the four groups as weights for both the MA and FFS averages. Then we calculate a DECI estimate for continuing enrollees using the formula in Figure 11-B1 (p. 390). Finally, we calculate a DECI estimate for all enrollees, adding together the continuing-enrollee DECI estimate multiplied by the risk-score-weighted share of continuing MA enrollees and the new-enrollee DECI estimate multiplied by the risk-score-weighted share of new enrollees in the analysis. This final step constrains risk scores for new enrollees to

FIGURE 11–B1

DECI method estimates coding intensity as the ratio of two ratios



Note: DECI (demographic estimate of coding intensity), MA (Medicare Advantage), CMS–HCC (CMS hierarchical condition category), FFS (fee-for-service).

Source: Kronick and Chua 2021.

have no coding intensity because their risk scores are not based on diagnostic coding. We use a risk-score-weighted new and continuing enrollment share to combine new and continuing enrollee DECI estimates because those weights reflect the share of MA payment associated with each group. Table 11-B1 shows an example of DECI calculation for 2023 which accounts for Medicaid-eligibility and institution-status differences in MA and FFS.

Impact of phasing in the V28 risk-adjustment model

The new risk-adjustment model introduced in 2024 (V28) is expected to reduce MA risk scores, coding intensity, and payments to MA plans. The V28 risk model makes several changes. First, the new model excludes some HCCs with much higher rates of coding in MA relative to FFS Medicare. Second, the new model constrains the coefficients of some HCCs with the same group of related conditions where there are differential rates of MA and FFS coding among the HCCs in the group. Third, the new model implements an entirely new mapping of International Classification of Diseases (ICD)–10 diagnosis codes to HCCs, which had the effect of removing several diagnoses from the HCCs included in the payment model. The prior mapping was developed from a mapping of ICD–9 diagnoses to HCCs and a diagnosis-code mapping from ICD–9 to ICD–10. (CMS switched from requiring the submission of ICD–9 to ICD–10 diagnosis codes in 2015.)

There are three factors to consider when estimating the impact of a new risk model: the direct impact on MA risk scores, the impact on the normalization factor used to scale risk scores for the model, and changes in MA-plan coding practices.

1. Relative to the prior risk model (V24), the V28 model removes many diagnoses that CMS identified as having high rates of coding in MA relative to FFS. The removal of diagnoses with high rates of MA coding—holding coding practices constant—means that fewer HCCs are identified for MA enrollees, which reduces MA risk scores.

2. A normalization factor is designed to keep the average FFS risk score at 1.0 and is specific to each risk model. Generally, the normalization factor for a given risk model starts at 1.0 in the model calibration year and increases in each subsequent year based on the projected cumulative increase

TABLE 11–B1

Calculation of MedPAC's coding-intensity estimate, 2023

Beneficiary group	CMS-HCC risk-score average		Demographic risk-score average		MA share of continuing enrollees
	MA	FFS	MA	FFS	
Continuing enrollees					
No Medicaid	1.063	0.928	0.998	1.006	75.8%
Partial Medicaid	1.373	1.050	1.008	1.003	8.4
Full Medicaid	1.638	1.305	1.044	1.005	14.8
Institutional	2.411	2.136	2.181	2.177	1.0
MA weighted average risk scores	1.187	1.006	1.017	1.017	

Beneficiary group	CMS-HCC MA/FFS risk-score ratio	Demographic MA/FFS risk-score ratio
Continuing enrollees	1.187 / 1.006 = 1.180	1.017 / 1.017 = 1.000

Beneficiary group	DECI estimate	MA share of enrollees	MA average HCC risk score	Group weight
Continuing enrollees	1.180 / 1.000 = 1.181 (18.1%)	91.6%	1.187	95.5%
New enrollees	1.000 (0.0%)	8.4	0.605	4.5
All enrollees	**1.173 (17.3%)**			

Note: CMS–HCC (CMS–hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service), DECI (demographic estimate of coding intensity). Analysis excludes beneficiaries with end-stage renal disease and beneficiaries residing in Puerto Rico. Risk scores reflect the V24 risk model that was used for payment in 2023. The DECI estimate is the ratio of the MA/FFS CMS–HCC risk score ratio and the MA/FFS demographic risk score ratio. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding. For 2023, we use the most recently available (2022) master beneficiary summary file for the FFS spending used to calculate the demographic risk-score models.

Source: MedPAC analysis of 2023 Medicare enrollment and risk score files and 2022 Medicare enrollment and Master Beneficiary Summary Files.

in average FFS risk scores since calibration. MA risk scores are divided by the normalization factor, so larger factors reduce risk scores by more than smaller factors. Because the V28 model is calibrated using more recent data, the cumulative increase in FFS risk scores since model calibration is smaller, and the V28 normalization factor is smaller than the V24 model. Transitioning from the larger V24 factor to the smaller V28 factor increases MA risk scores.

3. Current estimates of the effect of transitioning from V24 to V28 are based on MA risk scores using data from years in which the V24 risk model was used for payment and the V28 risk model had not yet been announced. Many MA organizations and providers contracting with MA plans identify the diagnostic codes that affect payment and adapt their diagnostic-coding processes to maximize risk scores for a specific risk model (these strategies are sometimes called "diagnostic-code capture" or "HCC-gap closure"). Therefore, current estimates of the impact of the V28 model compare optimized V24 risk scores with nonoptimized V28 risk scores. If MA plans adapt their coding practices in response to the incentives created by the new model, initial comparisons of V24 and V28 risk

scores would overestimate the impact of V28 on MA risk scores and payment to MA plans.

In 2024, payments to MA plans were based on a blend of two-thirds V24 and one-third V28 risk scores. In 2025, payments will be based on a blend of one-third V24 and two-thirds V28 risk scores, and for 2026, CMS has proposed that payments will be based entirely on V28 risk scores. The normalization factor applied to risk scores mirrors the blend of V24 and V28 models used for risk scores.

Comparing V24 and V28 risk scores

In the Advance Notice for 2025, CMS reported that between 2024 and 2025 (reflecting one-third of the V28 phase-in) the V28 model will reduce (non-normalized) MA risk scores by an estimated 4.44 percent due to the removal of diagnosis codes and the constraint on certain HCC coefficients. This reduction will be offset by a 1.99 percent increase in MA risk scores due to a smaller normalization factor, for an estimated net reduction of 2.45 percent. Assuming that this annual effect is the same across the three-year phase-in period implies an estimated net effect on MA risk scores of about 7.5 percent due to the V28 model's exclusion of diagnosis codes and constraint on coefficients, and to the normalization factor.[87]

We conducted our own analysis of the impact of V28 using MA encounter data and FFS claims to identify diagnoses that are eligible for risk adjustment and to calculate V24 and V28 risk scores for 2021, 2022, and 2023.[88] We first estimated the effect of V28 on MA risk scores if plan coding practices did not respond to the incentives created by the new model. Across all three years, we found that average MA V28 risk scores were about 13.7 percent lower than average MA V24 risk scores, and average FFS V28 risk scores were about 7.3 percent lower than average FFS V24 risk scores (for FFS beneficiaries with both Part A and Part B). (The effect of the V28 model on FFS risk scores is a proxy for the effect on the normalization factor.) By combining those two effects, we estimated a net reduction of MA risk scores of about 6.5 percent if plan coding practices did not respond to the incentives under the new model.

Estimating the impact of V28 on MA coding intensity

To more directly assess the impact of the V28 risk model on differential MA and FFS coding intensity, we applied MedPAC's DECI method to the V24 and V28 risk scores that we calculated for 2021, 2022, and 2023. Across all three years, we found that the average MA coding-intensity estimate was 7.7 percentage points lower for V28 risk scores than for V24 risk scores. That difference of 7.7 percentage points represents the effect of the V28 risk model on overall MA coding intensity if coding practices were held constant, but it does not reflect MA plans' efforts to optimize coding practices for the V28 model in 2024 and 2025. This coding-intensity estimate incorporates the net effect of the first two factors we consider when estimating the effect of the V28 model: the removal of diagnosis codes and the constraint on certain HCC coefficients in the V28 model, as well as the offsetting effect of the smaller V28 normalization factor. We note that all three ways of estimating the net effect of the first two factors—CMS's analysis of risk-score differences, our analysis of risk-score differences, and our estimates of coding-intensity difference for the two risk models—produce similar results, giving us some confidence in the estimate of the effect of the V28 model from the first two factors.

To estimate the effect of changes in plans' coding behavior (the third factor described above), we began by analyzing how coding changed in the years after CMS transitioned from the V12 risk model to the V22 model in 2014. (We recognize that there are differences between this risk-model transition and the transition from V24 to V28, but this transition is the most recent experience to estimate plans' coding behavior). Similar to the V28 model, the V22 risk model excluded some diagnoses that have much higher rates of coding in MA relative to FFS. Unfortunately, we lack the necessary data to estimate the effect on plans' coding behavior in the first year that the model was introduced. Instead, we estimate how much faster V22 coding intensity grew relative to V12 coding intensity between the first and second years that the V22 model was in effect. To do so, we applied MedPAC's DECI method to the V12 and V22 risk scores for 2014 and 2015 (the only two years of data available during the transition from V12 to V22) to estimate the relative growth in coding intensity between the two models. Coding intensity was lower under the V22 model, but it grew faster between 2014 and 2015 relative to growth under the V12 model, indicating that plans were able to offset some of the reductions in risk scores under the new model by adjusting their coding practices to account for different

incentives under the newer model. We incorporate the faster coding-intensity growth rate from the first and second years of the V22 model into our assessment of coding-intensity growth in the first couple years under the V28 model.

The growth in coding intensity under V28 might be even larger than the growth we estimated during the first two years of the transition from V12 to V22. First, the V22/V12 difference in coding-intensity growth in the first year in which the model was introduced could be larger than the growth in coding intensity we estimated between the first and second years of V22 implementation. Second, compared with 2015 and 2016, when V22 was implemented, we have observed an increased focus on risk adjustment and the potential financial gains from greater diagnostic-coding intensity. There has been a dramatic increase in the number of companies currently selling training programs, diagnostic-coding manuals, and other risk-score-optimization strategies for the transition from V24 to V28.[89]

Incorporating estimates of the V28's impact into MA coding-intensity projections

For 2024 and 2025, we projected under the V24 and V28 models separately and then applied the blend of risk scores that will be used for payment in each year. We started with the 2023 coding-intensity estimates of 17 percent under the V24 model and of about 10 percent under the V28 model (17 percent minus 7.7 percentage points due to lower coding intensity under V28), which reflects no plan response because the V28 model had not yet been used for plan payments.

To calculate the coding-intensity growth rate under V28, we started with the V24 coding-intensity growth rate of 1.6 percentage points annually, which is the average V24 coding-intensity trend from 2019 to 2023. We then applied the V22/V12 coding-intensity growth-rate ratio, adjusting the ratio to account for the greater share of diagnosis codes excluded from the V28 model relative to the V22 model. Based on this analysis, we estimate that coding intensity will grow about 2.4 percentage points annually under the V28 risk model.

We then projected coding intensity under V24 by adding 1.6 percentage points each year and projected coding intensity under V28 by adding 2.4 percentage points each year. After applying the payment-year risk-score blends, we estimate coding intensity to be about 17 percent in 2024, reflecting a blend of two-thirds V24 coding intensity (about 19 percent) and one-third V28 coding intensity (about 12 percent). For 2025, we estimate MA coding intensity to be about 16 percent, reflecting a blend of one-third V24 coding intensity (about 20 percent) and two-thirds V28 coding intensity (about 14 percent). ■

Endnotes

1 CMS includes FFS-claim administrative costs in MA benchmarks, which account for about 0.20 percent of FFS spending (Centers for Medicare & Medicaid Services 2023a, Centers for Medicare & Medicaid Services 2021). Expenses for FFS-claim administration are included in our comparison of FFS spending with MA payments and differ from the expenses found in Medicare's Trustees' reports, which include the administration and oversight of the MA program and the enrollment of all Medicare providers (which is required for contracting with MA plans). The Medicare Trustees reported that administrative expenses (including those for MA enrollees) accounted for 1.04 percent of CMS's total Medicare benefit costs in 2020 (Boards of Trustees 2021).

2 Two plan types enrolling very small numbers of MA enrollees are not described here. Private FFS plans that operate without a network are limited to counties where fewer than two network-based plans are offered (about 3 percent of counties for 2025); by the end of 2024, private FFS plans covered fewer than 32,000 beneficiaries. Medical Savings Account plans combine a high deductible and a Medical Savings Account, and by the end of 2024 they covered about 1,100 beneficiaries.

3 HMOs generally do not pay for care provided by out-of-network (OON) providers. They often require that enrollees select a named primary care provider (PCP), who manages referrals to specialists. PPOs provide more flexibility for enrollees by not requiring a named PCP and by allowing enrollees to see both in- and out-of-network specialists without a referral. However, these plans generally have both higher premiums than HMOs and higher cost sharing for OON providers compared with in-network providers. HMO point-of-service is a subset of the HMO plan type that allows members to seek out-of-network care for certain types of services or in certain cases (such as travel). These plans offer less flexibility to seek care OON than PPOs but more than standard HMOs.

4 Payments described here do not apply to the relatively small number of enrollees with end-stage renal disease (ESRD). How Medicare pays MA plans for enrollees with ESRD is described in Chapter 12 of the Commission's March 2021 report to the Congress (Medicare Payment Advisory Commission 2021b).

5 If a plan bids above the benchmark, the plan's base rate is set at the benchmark and enrollees must pay a premium (in addition to the usual Part B premium) equal to the difference between the bid and the benchmark.

6 Examples of non-Medicare-covered supplemental benefits include dental, vision, and hearing coverage. Plans can offer such benefits on a mandatory or optional basis. Mandatory supplemental benefits are automatically included in the benefit package for all enrollees in a plan. Plans may use rebates to finance mandatory supplemental benefits and may charge enrollees a premium to cover costs not covered by the rebate. Additionally, plans may offer optional supplemental benefits. Plans are not permitted to apply rebate dollars toward optional supplemental benefits; enrollees pay an additional premium to access these benefits. Optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.

7 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only those beneficiaries with both Part A and Part B coverage (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017). This change would make the assumptions about FFS spending in the calculation of MA benchmarks and payments more reflective of the MA-eligible population.

8 An MA plan's benchmark may be as high as 125 percent of CMS's local-area projected FFS spending. The ACA caps any county's benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor, or (2) 100 percent of its estimated FFS spending in the current year. Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark-growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark-growth caps, which limited the benchmarks in many counties (Medicare Payment Advisory Commission 2016c).

9 Before 2022, MA plans also submitted diagnostic information through the Risk Adjustment Processing System (RAPS). The use of RAPS data was phased out from 2016 through 2021, except for contracts in the Program of All-Inclusive Care for the Elderly, which continue to use pooled RAPS and encounter data as the source of diagnostic data for risk scores.

10 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk-adjustment model for several reasons. First, CMS has found that adding diagnoses from these sources does not improve the model's ability to

predict medical expenditures. Second, concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers). Third, a high proportion of reported diagnoses from certain settings (e.g., lab and imaging tests) are used to rule out having a diagnosis (Pope et al. 2004).

11 To date, RADV audits have been initiated for plan years 2018 and earlier and have been completed for only a few years. Information about payment recoveries based on RADV audits has only been made public for 2007. Given the limited nature of RADV audits, we do not yet know whether the more widespread use of audits would affect plans' coding practices.

12 MA enrollees who could potentially have lower cost-sharing liability in FFS would likely have difficulty obtaining a Medigap policy if they switched to FFS, limiting their potential savings. Beneficiaries are only guaranteed access to a Medigap supplemental insurance policy with no underwriting, even if they have a preexisting condition, if they purchase it during the six-month Medigap open enrollment period that begins on the first day a beneficiary is both 65 years old and enrolled in Medicare Part B. Most beneficiaries have only one Medigap open enrollment period during their lifetime. Except in limited circumstances (e.g., a beneficiary moves outside of their MA plan's service area), access to a Medigap policy is not guaranteed in most states after the Medigap open enrollment period ends. Only four states (Connecticut, Massachusetts, Maine, and New York) require guaranteed-issue access to Medigap for aged (65 and over) beneficiaries in FFS Medicare, regardless of medical history, meaning that insurers cannot deny a Medigap policy to applicants based on preexisting conditions (Boccuti et al. 2018). In certain circumstances, beneficiaries who choose to enter MA and who subsequently disenroll to FFS within a 11-month trial period may also have guaranteed access to Medigap coverage with no underwriting (42 U.S.C. Sec. 1395ss).

13 In 2023, 15 percent of MA enrollees and 20 percent of FFS enrollees resided in rural areas.

14 Our measurement of beneficiary access to plans uses 2025 plan bids and July 2024 county-level enrollment for the Medicare population with both Part A and Part B coverage. Plans are included in a county only if they project enrolling at least one beneficiary in that county.

15 All beneficiaries enrolling in Medicare Part B, regardless of their decision to receive benefits through FFS or MA, are required to pay the Medicare Part B premium. Some MA plans use rebate dollars to pay a portion of their members' Part B premium as a supplemental benefit. Beneficiaries enrolling in Part D may pay a separate Part D premium, although MA Prescription Drug plans may use rebate dollars to reduce the amount the beneficiary pays for drug coverage under the plan. Plans bidding above the local benchmark or offering more supplemental benefits than can be financed by the plan rebate charge enrollees an additional plan premium. We refer to plans that do not charge a separate plan premium (including any Part D premium) as "zero-premium" plans. The increasing availability of zero-premium plans in recent years has largely been driven by the availability of zero-premium local PPO plans. Between 2019 and 2023, the availability of zero-premium local PPO plans increased from 69 percent of Medicare beneficiaries to 96 percent, and the availability of zero-premium HMOs increased from 86 percent to 98 percent.

16 We exclude employer group plans because they do not submit bids and so do not receive a rebate in the same manner as bidding plans. Instead, starting in 2019, CMS began paying employer group plans based on the bidding behavior of nonemployer plans in the prior year: The employer group plans receive a base payment rate that is based on the average bid-to-benchmark ratio of nonemployer plans (by quartile of FFS spending and plan type), plus a share of the difference between the base payment rate and a county-specific benchmark.

17 In 2025, conventional plans project that 11 percent of the rebate dollars used to reduce cost sharing will be allocated for plan administrative costs and profit. Among dual-eligible SNPs, 14 percent of the plan-projected rebate dollars used to reduce cost sharing is projected to be allocated for plan administrative costs and profit.

18 The plan liability for the MOOP cap is generally not comparable with FFS spending because most beneficiaries in FFS Medicare have supplemental insurance and are unlikely to have cost-sharing expenses that exceed the OOP cap for MA enrollees. In addition, MA enrollees are prohibited from purchasing Medigap coverage because MA plans are expected to provide supplemental benefits in lieu of Medigap coverage.

19 While MA plans have enrolled a growing number of beneficiaries with end-stage renal disease, MA plans' projected MOOP liability remained at 1 percent of projected payments annually from 2023 to 2025. The MOOP liability reported in plan bids is less than half of the 2.8 percent MOOP value estimated by Wakely in a report commissioned by AHIP, which used FFS claims data to estimate the MOOP value (Wakely 2024). The Wakely estimate did not account for the lower MOOP liability accrued by MA plans because of out-of-network care, claims denials, plan switching during the year, and cost-sharing reductions that are financed through plan rebates. In addition, the Wakely estimate did not consider cost-sharing reductions for FFS beneficiaries with supplemental coverage that would have reduced the

MOOP liability in FFS. Further, Wakely did not adjust for Medicare Part A and Part B services that were financed by FFS on behalf of MA enrollees (e.g., Medicare services during hospice election). Wakely counted these services toward their MOOP estimate even though these types of services were not financed by MA plans.

20 Beneficiaries eligible for special enrollment periods include (but are not limited to) those who move outside of their plan's service area, move to a new county with additional plan options, live in or move out of a nursing home or rehabilitation hospital, are eligible for Medicaid coverage, or lose Medicaid coverage.

21 In 2025, conventional MA plans (that is, excluding employer plans and SNPs) project that 12 percent of the $53 used for non-Medicare-covered supplemental benefits will be allocated for plan administrative costs and profit. Among D–SNPs, 14 percent of the $234 used for non-Medicare-covered supplemental benefits is projected to be allocated for plan administrative costs and profit.

22 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional and psychological impact of injuries or health conditions, and reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general-use purposes or to address social determinants of health. The amount of projected spending for new types of supplemental benefits is not available in plan bid data.

23 MA plans do not allocate administrative expenses or margins for Part D premium buydowns or Part D supplemental benefits when submitting Part C bids.

24 In 2025, changes to the structure of the Part D direct-subsidy amount may have resulted in plans overestimating the amount of Part C rebates needed for their target Part D premium. Part D premium targets are initially calculated before plans know how much rebate funding they need to cover their target Part D premium (which is only known after Part D plans submit bids and CMS calculates the national average bid amount). After plans know how much they will need in rebates to cover their target Part D premium, plans reallocate their rebate to ensure that plan enrollees receive the full value of the rebate. However, CMS restricts changes in projected Part C margins that result from rebate allocations to an average of $1 per member per month (https://www.cms.gov/files/document/cy2025-rebate-reallocation-training-handout.pdf). If an MA plan overestimated the amount of Part C rebates needed for their Part D premium, they would likely need to reallocate rebate funding from the Part D premium buydown to the Part B premium buydown, the only rebate-funded benefit for which plans do not receive a margin.

25 Federal regulations require MA plans to submit encounter records for all items and services provided to enrollees (42 CFR Sec. 422.310(b)), including items and services provided through supplemental benefits; however, CMS's Encounter Data Submission and Processing guidance limits that requirement to supplemental services for which the plan has sufficient data to populate an encounter record. In addition, CMS systems are able to accept "professional" and "institutional" claim formats, which allow for the collection of some supplemental services, but CMS was not equipped to accept dental claims prior to 2024. Further, reimbursement for many supplemental benefits does not use any claim format (e.g., fitness, meals, transportation, pest control), meaning there is no standard way for plans to submit information about the use of such benefits. Beginning in 2024, CMS required MA organizations to submit plan-level information (not through beneficiary-level encounter records) for a wide range of supplemental-benefit categories, including data on the number of enrollees who are eligible for each benefit, the number of enrollees who used each benefit, total and median instances of use among eligible enrollees, the net spending amount incurred by the plan to offer each benefit, the type of payment arrangement, how the plan accounts for the cost of the benefit (including administrative expenses), and the total out-of-pocket cost per utilization for enrollees (Centers for Medicare & Medicaid Services 2024b).

26 The Commission is examining MA rebates and supplemental benefits in greater depth in other reports and presentations during this analytic cycle; the results of that analysis will be presented separately.

27 We estimate total MA payments by using CMS's projected enrollment and incurred payments per enrollee (Boards of Trustees 2024).

28 Our estimate of MA payments relative to FFS spending does not account for other potential factors that are more difficult to measure with certainty, including how benchmark quartiles and plan bids and payments would have changed if calculating FFS spending using only beneficiaries with both Part A and Part B. In addition, our analysis does not include secondary effects that can be measured with far less certainty, such as the potential spillover of provider behavior that can occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of MA and FFS improper payments found retrospectively.

29 We note that our 2025 estimate of spending on MA relative to the amount Medicare would have spent for comparable FFS beneficiaries (120 percent) reflects some changes from the method used in the Commission's 2024 comparison (reported to be 122 percent in our March 2024 report) (Medicare Payment Advisory Commission 2024). First, in 2024 we conservatively projected that the effects of favorable selection would be similar to prepandemic levels (about 9 percentage points). For 2025, we used estimates of favorable selection from 2021 and 2022 to project the effect of favorable selection in 2023 to 2025. We also made technical updates to refine our methodology for estimating favorable selection; those updates increased our estimates of favorable selection from 2017 to 2020 and decreased our estimate of favorable selection for 2021. We now project that favorable selection accounts for 11 percentage points of the difference in spending. Second, we revised our method of estimating coding intensity to exclude beneficiaries in Puerto Rico because they lack complete data and to weight new enrollees by the share of payments associated with new and continuing enrollees. Also, we revised our estimated effect of phasing in the V28 model when we projected the effects of coding intensity from the most recent analytic year (2023) to subsequent payment years. For 2024 and 2025, we projected coding intensity based on the annual trend from 2019 through 2023, an increase of 1.6 percentage points per year. Then we reduced the annual trend by our estimate of the effect of the V28 phase-in, which is –2.3 percentage points in 2024 and –1.8 percentage points in 2025. See Technical Appendix 11-B, "Impact of phasing in the V28 risk-adjustment model" (p. 390), for more details. The net effect of all of those factors accounts for the –2 percentage point difference in our 2025 and 2024 estimates of MA spending relative to comparable FFS beneficiaries.

30 Our projected $84 billion in MA payments above FFS spending in 2025 does not include spending for beneficiaries with ESRD. MA plans receive separate base payments for these beneficiaries, and MA payments are risk adjusted using a separate risk model. In future years, we will consider how to compare MA payments and FFS spending for ESRD beneficiaries, including the effects of favorable selection and coding intensity.

31 We also exclude beneficiaries for whom Medicare is a secondary payer and beneficiaries with ESRD in our comparisons using historical data.

32 Our estimates of the base-spending comparison for the years prior to 2016 continue to rely on CMS's projections of FFS spending (including adjustments that eliminate the effect of the sustainable growth rate) because those were the data we used under an older version of our methodology when those estimates were first published in earlier reports. We have not updated those estimates because our analysis indicates that results would be similar under our updated methodology that uses historical data. A more detailed description of the change in methodology for the base payment comparison can be found in the Commission's March 2023 report to the Congress, where it is described as a change from the prospective method to the retrospective method (Medicare Payment Advisory Commission 2023b).

33 The Commission's March 2023 report details our methodology for comparing our estimates using CMS's projections with historical spending for MA-eligible beneficiaries (Medicare Payment Advisory Commission 2023b). That report describes several adjustments that should be made when making this comparison. A 2024 analysis by Wakely that was commissioned by AHIP estimated the raw average spending difference between all Medicare beneficiaries and the subset of Medicare beneficiaries with both Part A and Part B coverage (Wakely 2024). This method is inadequate for comparisons of MA payment differences because CMS's payment methodology accounts for (among other things) Medicare as a secondary payer, the geographic differences in risk-standardized FFS spending, the geographic distribution of MA enrollees, and nonclaims FFS spending. The Commission's comparisons adjust for these differences, including the use of county-level FFS-spending data and risk scores, MA enrollment, MA risk scores, and MA payment rates.

34 We also report estimates from a simpler, more suggestive method that focuses on the selection percentage of MA entrants who recently switched from FFS compared with beneficiaries who remained in FFS. The advantages of that simpler method are that it can more easily be compared with estimates from the literature that use similar methods, and we can compute it for more years of data (going back to 2007). We use that simpler method for the selection estimates from 2007 to 2015 in Figures 11-3 and 11-4 and use our current, more comprehensive method for the estimates reported starting in 2016.

35 Our estimates account for the incentives that beneficiaries have to switch from FFS to MA because of the MOOP limit. However, MOOP limits do not appear to be an important factor in MA plan selection. For example, one study found that more generous OOP maximums did not result in enrollment gains in 2022 (Cates et al. 2022). Instead, the study found that lower premiums and a higher prevalence of supplemental benefits were associated with plans that experienced enrollment growth. This finding is consistent with prior research that found premiums were a driving factor in beneficiary plan selection (Jacobson et al. 2016, Jacobson et al. 2014, Medicare Payment Advisory Commission 2015, Meyers et al. 2019, Skopec et al. 2019).

36 Using the study from Teigland and colleagues, we identified the pre-Medicare spending and risk scores of the MA and FFS populations. We standardized the pre-period spending by the risk scores and converted the risk-standardized spending differences to payments above FFS spending.

37 Categories of risk scores were based on the distribution of MA entrants such that we determined a sufficient number of enrollees were in each risk-score category.

38 The Commission recognizes that social risk factors are associated with differences in health status and health care use and that switching between MA and FFS may lead to changes in a beneficiary's use of health services and in their Medicaid eligibility. Limited evidence suggests that MA plans do not provide greater access to services overall relative to FFS (Agarwal et al. 2022, Commonwealth Fund 2021, Fuglesten Biniek et al. 2021). In addition, MA plans have a financial incentive to ensure that beneficiaries who are eligible but not enrolled in Medicaid receive those benefits while in MA. These additional Medicaid benefits would potentially reduce the cost-sharing liability for both beneficiaries and MA plans. Further, enrolling beneficiaries in Medicaid who were Medicaid eligible but previously unenrolled also increases beneficiary risk scores because their predicted costs in MA would be under a Medicaid segment in CMS's risk model (rather than a non-Medicaid segment). To the extent that such beneficiaries would have remain unenrolled in Medicaid if still in FFS Medicare, this phenomenon would increase favorable selection in MA. Given our reliance on a beneficiary's FFS experience when estimating favorable selection, we cannot account for these additional changes in a beneficiary's social risk while enrolled in MA.

39 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied to a beneficiary and factors that affect a plan's base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan's base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have ESRD. A plan's base rate varies according to the plan's bid and the local area's benchmark.

40 International Classification of Diseases, 10th Revision, Clinical Modification guidelines for 2022.

41 In the V28 CMS–HCC risk model, introduced in 2024, these three HCCs have been constrained to have the same coefficient due to within-hierarchy coding intensity compared with FFS Medicare.

42 CMS has modified the risk-adjustment model to better align FFS and MA risk scores. Between 2014 and 2016, CMS phased in a new risk-adjustment model that had a coding-intensity estimate that was about 2.5 percentage points less than under the previous model because the new model removed some diagnoses that were found to be coded more frequently in MA. In 2017, CMS began accounting for Medicaid-benefit eligibility more accurately (full-, partial-, or no-benefits status by month), which reduced the gap in MA and FFS risk scores by about 1 percentage point, eliminating the amount by which MA risk scores were unduly higher than FFS due to differing shares of beneficiaries by Medicaid eligibility status. In 2024, CMS began phasing in a new risk model that, similar to the model introduced in 2014, is expected to reduce the gap in coding intensity relative to FFS by removing or constraining the coefficient of some diagnoses that were found to be coded more aggressively in MA.

43 The monthly Medicaid-status indicator that we use to identify eligibility for full, partial, or no Medicaid benefits incorrectly lists the vast majority of beneficiaries in Puerto Rico as not being eligible for Medicaid benefits.

44 In some counties, the full 5 percent or 10 percent quality-bonus increase to a plan's benchmark is limited by the ACA benchmark caps.

45 This organization-level analysis, like our national estimate of coding differences, uses the same method of estimating coding intensity as described in Chapter 13 of MedPAC's March 2024 report to the Congress, except that the MA risk scores are calculated separately for each MA organization.

46 Based on MedPAC's interviews with physicians and reporting from *Stat News* (Bannow et al. 2024).

47 Recent reporting shows that agents and brokers are often paid by plans to conduct health risk assessments of new enrollees, but such assessments are not allowable for risk adjustment because agents and brokers are not clinicians.

48 The general steps we followed were to identify physician and hospital encounter records allowable for risk adjustment; identify each record as a health risk assessment (using procedure codes for annual wellness visit or initial preventive physical exam, or an evaluation and management visit provided in the home), chart review (using a chart-review indicator), or other service; map diagnoses from those records to HCCs; apply HCC hierarchies; compare the HCCs we identified from encounter records with the HCCs in CMS's risk-score file and exclude HCCs not identified in both sources; apply HCC coefficients for the appropriate risk model; and apply Part A and Part B payment rates specific to each plan. We then identified the number of HCCs and associated dollar amounts that were supported through a health risk assessment, chart review, or both.

49 The six HCCs that each generated more than $900 million in payments from health risk assessments and the percentage of the time that a health risk assessment was the only source of the HCC were vascular disease, 45 percent; major depressive, bipolar, and paranoid disorders, 44 percent; disorders of immunity, 64 percent; diabetes with chronic complications, 15 percent; chronic obstructive pulmonary disorder, 26 percent; morbid obesity, 37 percent. We note that diabetes with chronic complications has a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients.

50 The legal complaints cited in this section support this statement. One complaint includes exhibits of plan documents that detail the financial performance of the plan's chart-review program (United States of America v. Anthem Inc. 2020).

51 The eight HCCs that each generated more than $1 billion in payments from chart reviews and the percentage of the time that a chart review was the only source of the HCC were vascular disease, 32 percent; chronic obstructive pulmonary disorder, 26 percent; diabetes with chronic complications, 17 percent; major depressive, bipolar, and paranoid disorders, 32 percent; congestive heart failure, 23 percent; disorders of immunity, 40 percent; morbid obesity, 33 percent; and rheumatoid arthritis and inflammatory connective tissue disease, 31 percent. We note that diabetes with chronic complications and congestive heart failure are among the HCCs that have a constrained coefficient in the V28 risk model, meaning that differences in the level of severity (e.g., diabetes without complications, with chronic complications, or with acute complications) for these conditions are not reflected in the V28 risk-adjustment model coefficients.

52 About $5.2 billion in payments to MA plans was from HCCs identified on a health risk assessment and a chart review but not during any record of a physician or hospital encounter during the same calendar year.

53 For RADV audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.

54 Audit-eligible enrollees were also required to have Part B enrollment for the full data-collection year, continuous enrollment in the contract for the full data-collection year and January of the payment year, and no end-stage renal disease or hospice status.

55 Other factors may also influence insurers' decisions to enter new markets. Examples include state and federal regulatory and financial requirements (including licensure requirements), the size of the market, the local MA penetration rate, the number of competitors, benchmark payment rates for the market relative to the health care needs of the population, availability and quality of providers, and the estimated likelihood of achieving a sustainable risk profile after accounting for CMS's coding-intensity adjustment (Buzby et al. 2022, Killian and Swenson 2016).

56 Counties in Connecticut are excluded due to changes over time in how the state's counties are tabulated. Employer plans are excluded because employer plans do not compete directly with nonemployer plans.

57 The study assessed only whether the parent organization listed for a particular MA contract changed; it did not assess whether the company acquired one or all of the acquired insurer's MA contracts or acquired the other insurer altogether.

58 The top three organizations nationally also had the highest share of enrollees in both urban and rural areas in 2024. In urban areas, the top three organizations covered 58 percent of MA enrollees (up from 57 percent in 2023). In rural areas, the top three organizations accounted for 67 percent of the MA enrollees (up from 66 percent in 2023).

59 In 2024, 18 percent of MA enrollees were eligible for Medicaid and enrolled in dual-eligible SNPs (D–SNPs). The national D–SNP enrollment is more concentrated than overall MA enrollment (the three largest D–SNPs had 61 percent of enrollment). Enrollment in D–SNPs has been getting more concentrated nationally: The three largest organizations nationally had 60 percent of total enrollment in D–SNPs in 2024, an increase from 57 percent in 2023.

60 The HHI is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size; the index reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Under Department of Justice and Federal Trade Commission guidelines, markets with an index above 1,800 are considered highly concentrated (Department of Justice and Federal Trade Commission 2023).

61 A "related party" is defined as any entity that "has a different tax identification number than that of the MAO but is associated with the MAO by any form of common, privately held ownership, control, or investment, including any

arrangement in which the MAO does business with a related party through one or more unrelated parties" (Centers for Medicare & Medicaid Services 2023b).

62 Some parent organizations that are neither provider owned nor among the top five largest nationally report high rates of payments to related parties (shown under the "All other organizations" category in Figure 11-17, p. 369). Most of these organizations are recent entrants to the MA market with venture capital financing. We did not find evidence that these companies were owners of health care provider organizations, and the high rates being reported may reflect the structure of the business venture rather than the degree of vertical integration with providers.

63 Star rating is a framework that CMS uses across MA and FFS. On its Care Compare website, CMS publishes star ratings on different types of Medicare providers (like physicians, hospitals, nursing homes, and others) so that beneficiaries can see how providers perform for FFS beneficiaries in their local area. However, there is no single quality evaluation for FFS Medicare in its entirety; star ratings of providers in FFS reflect their individual performance. The performance of a set of providers in a local area is not directly comparable with an MA star rating, which reflects the joint performance of an MAO and its network of contracted providers, at the contract level.

64 This count includes measures for Medicare Advantage Prescription Drug plan (MA–PD) contracts. MA-only contracts and PDPs are measured on different subsets of measures.

65 Measures are assigned unique weights, and the overall score is a weighted average. The other roughly 60 measures that Medicare collects are display measures that CMS publicly reports on the Medicare.gov website (not the Medicare Plan Finder website). Some display measures were previously incorporated into the star ratings but have been transitioned out. Others may be new measures that are being tested before inclusion in the star ratings or that are otherwise reported for informational purposes only.

66 Currently, quality results for MA are reported on a contract-wide basis, and those results are used to determine the star rating for all plans under the contract's offerings.

67 The 2025 star-rating values have been updated with data from CMS's December 2, 2024, release of the 2025 Star Ratings Data Tables.

68 We also include FFS–CAHPS results in Chapter 4 (on physician and other health professionals).

69 Using the beneficiary survey responses, CMS calculates national case-mix-adjusted FFS–CAHPS and MA–CAHPS scores. Scores are adjusted for education, self-reported general health status, self-reported mental health status, proxy completion or assistance with survey completion, dual eligibility or low-income-subsidy eligibility, age, and completion of the survey in an Asian language, all of which have been demonstrated to be associated with patient-experience scores (https://www.ma-pdpcahps.org/globalassets/ma-pdp/quality-assurance/2025/ma-pdp-cahps-qapts-v15.0.pdf#page=86). The FFS– and MA–CAHPS survey items and case-mix adjustment are largely the same, which can allow comparison between FFS and MA measure scores.

70 Because MA contracts do not represent uniform geographic units, sampling at the contract level generates an average that is not necessarily geographically representative of the MA population nor geographically comparable with the FFS sample.

71 The Commission discussed this literature at the March 2024 public meeting, https://www.medpac.gov/wp-content/uploads/2023/10/MA-quality-presentation-FINAL.pdf.

72 One study found that additional benefits and limits on out-of-pocket spending were the two leading reasons that MA enrollees chose an MA plan (Leonard et al. 2022).

73 Part B spending represents about 60 percent of all FFS Medicare spending (which is assumed to be the same share of spending on Part B services by MA plans). Twenty-five percent of Part B spending is financed through premiums paid by all Medicare Part B enrollees. The estimate does not account for the reduction in Part B premiums that is offered by some MA plans as a supplemental benefit.

74 The share of non-ESRD MA enrollees with at least two years of prior enrollment in FFS is based on enrollment months in 2021.

75 We exclude beneficiaries with Medicare as a secondary payer. CMS's payment rates to MA plans are adjusted with the goal of removing the effects of having Medicare as a secondary payer.

76 CMS sets MA payment rates using a non-ESRD population. MA plans are separately paid a state-based ESRD rate for MA enrollees.

77 MA enrollees who use hospice continue receiving supplemental benefits through their MA plan, but MA plans are immediately no longer paid the base payment for Part A and Part B services for that enrollee. Thus, we remove MA months while a beneficiary uses hospice, but we count the share of the month prior to hospice enrollment as MA

enrollment. Medicare spending while an MA enrollee is in hospice is excluded from our analysis entirely and is not included in our FFS denominator.

78 In 2022, about half of MA entrants (51 percent of enrollment months) met these criteria; for the remaining entrants, 8 percent had between one and two years of prior FFS enrollment, 12 percent had less than one year of prior FFS enrollment, and 30 percent had no prior FFS enrollment (meaning they enrolled directly in MA when they first became eligible for Medicare).

79 The population of FFS enrollees in each county used in the denominator includes all beneficiaries with at least one month of FFS enrollment in time $t = 0$ who were enrolled in FFS for the entire prior year ($t = -1$). It includes people who switched to MA in the following year. That construction is designed to closely align with the population that CMS uses to construct predicted spending while also ensuring that risk scores were constructed using CMS's HCC model. We also require the population of FFS enrollees in the denominator to be enrolled in both Part A and Part B to enhance similarity with the MA population. Average spending in the county is weighted by enrollment months and standardized to a 1.0 risk score (calculated as $\bar{y}_{g,t=0} = \frac{\sum_i y_{i,g,t=0}}{\sum_i r_{i,g,t=0}}$).

80 Mean reversion can occur in two directions. When an individual's spending is initially below their predicted spending, mean reversion can occur if their growth in spending exceeds their growth in risk score. Conversely, when an individual's spending is initially above their predicted spending, mean reversion can occur if their growth in spending is lower than their growth in risk score.

81 The weights represent each individual's share of the total predicted spending in the proxy group. Thus, the individual weight is defined as $\alpha_i = \frac{\bar{y}_{g,t=0} \times r_{i,g,t=0}}{\sum_i \bar{y}_{g,t=0} \times r_{i,g,t=0}}$.

82 Each cohort of MA enrollees and their proxy cohort of FFS beneficiaries were placed into 50 mutually exclusive groups and matched on those groups (an increase from 45 groups in our March 2024 report to the Congress). Beneficiaries were first placed into one of three mortality groups based on the year of death: year $t = T$, $t = T + 1$, and $t > T + 1$. Decedents (death in $t = T$) and near-decedents (death in $t = T + 1$) were assigned to 1 of 10 categories within their respective mortality group based on initial selection percentage in year $t = 0$. Nondecedents (death in $t > T + 1$) were assigned to 1 of 30 categories based on initial selection percentage in year $t = 0$. Categories of initial selection percentage were developed based on the distribution of spending and enrollment, with the goal of having meaningful differences between the categories while sustaining a reliable sample of enrollees within each category.

83 Although there is an insufficient number of observations to match MA enrollees to proxy groups by county of residence, we required beneficiaries in the proxy group to reside in counties with at least one MA enrollee in MA cohort c.

84 Beneficiaries in the proxy group are also required to be enrolled in FFS in the year prior to the base year (2016 in this example) in order to have a populated HCC risk score for 2017.

85 The weights are constructed to reflect each individual's predicted spending in year $t = T$ as a share of the mortality-cohort group's predicted spending in year $t = T$: $w_{i,T} = \frac{\bar{y}_{g,t=T} \times r_{i,t=T} \times m_{i,T}}{\sum_{i \in C^{d,T}} \bar{y}_{g,t=T} \times r_{i,t=T} \times m_{i,T}}$, where $m_{i,T}$ indicates months of enrollment.

86 The denominators for the comparison groups exclude beneficiaries who used hospice in the prior year but include beneficiaries who had hospice during the year of spending.

87 CMS's published normalization-factor data also show that the V28 normalization factor will increase MA risk scores by about 2 percent per year, or about 6 percent in total. The normalization factor applied to MA risk scores in 2023 was 1.127 (V24 only) and was reduced to 1.103 in 2024 (reflecting a two-thirds V24 factor of 1.146 and a one-third V28 factor of 1.015); it will be further reduced to 1.081 in 2025 (reflecting a one-third V24 factor of 1.153 and a two-thirds V28 factor of 1.045).

88 We used CMS's V24 and V28 risk-model software published for 2024 (https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors/2024-model-software/icd-10-mappings).

89 Some examples of companies offering services to optimize coding for V28 include Advantmed, AGS Health, Alix Partners, Apixio, Athena Health, CareJourney (by Arcadia), Centauri Health Solutions, Change Healthcare, CodingIntel, Cotiviti (Verscend Technologies Inc.), Credo Health, Creyos, Datavant (formerly Ciox), DoctusTech, Edifecs, Episource, ForeSee Medical, Health Endeavors, Health Information Associates, Healthmine, IKS Health, IMO Health, Inovalon, IQVIA, Lightbeam Health Solutions, Matrix Medical Network, McKinsey & Company, Navina AI, Optum, Pareto Intelligence, Peoples Health (a UnitedHealthcare company), Persivia, PwC, R1 RCM, RAAPID Inc., Reveleer, Signify Health (CVS Health), UST HealthProof (Advantasure), Vatica Health, Vee Healthtek, Veradigm, and Wolters Kluwer.

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Measles Outbreak – June 17, 2025

NEWS UPDATES **June 17, 2025**

The Texas Department of State Health Services is reporting an outbreak of measles primarily in West Texas.

- At this time, 750 cases have been confirmed since late January. This is an increase of 6 since the June 10 update.
- Less than one percent, or fewer than 10 of the confirmed cases, are estimated to be actively infectious since their rash onset date was less than a week ago.

- Individuals are infectious four days prior to and four days after rash onset.

Ninety-seven of the patients have been hospitalized. This number is the total number of people hospitalized over the course of the outbreak. It is not the current number of people in the hospital.

There have been two fatalities in school-aged children who lived in the outbreak area. The children were not vaccinated and had no known underlying conditions.

Based on the most recent data, DSHS has identified designated outbreak counties with ongoing measles transmission: Gaines, Lamar, and Lubbock.

DSHS is working with local health departments to investigate the outbreak.

We will post weekly measles updates on Tuesdays.

2025 Texas Measles Outbr

6/17/2025

All data provisional and subject to cha

Figure 1

Outbreak Cases by County

Home County	Confirmed	% of Total
Andrews	3	0.4%
Atascosa	1	0.1%
Bailey	2	0.3%
Borden	1	0.1%
Brewster	1	0.1%
Brown	1	0.1%
Carson	1	0.1%
Cochran	14	1.9%
Collin	1	0.1%
Dallam	7	0.9%
Dawson	26	3.5%
Eastland	2	0.3%
Ector	12	1.6%
El Paso	58	7.7%
Erath	1	0.1%
Gaines	413	55.1%
Garza	2	0.3%
Hale	5	0.7%
Hardeman	1	0.1%
Hockley	6	0.8%
Lamar	23	3.1%
Lamb	1	0.1%
Lubbock	53	7.1%
Lynn	2	0.3%
Martin	3	0.4%
McLennan	9	1.2%
Midland	6	0.8%
Parmer	5	0.7%
Potter	1	0.1%
Randall	1	0.1%
Reeves	2	0.3%
Rockwall	1	0.1%
Terry	60	8.0%
Upshur	5	0.7%
Yoakum	20	2.7%
Total	**750**	**100.0%**

Figure 2

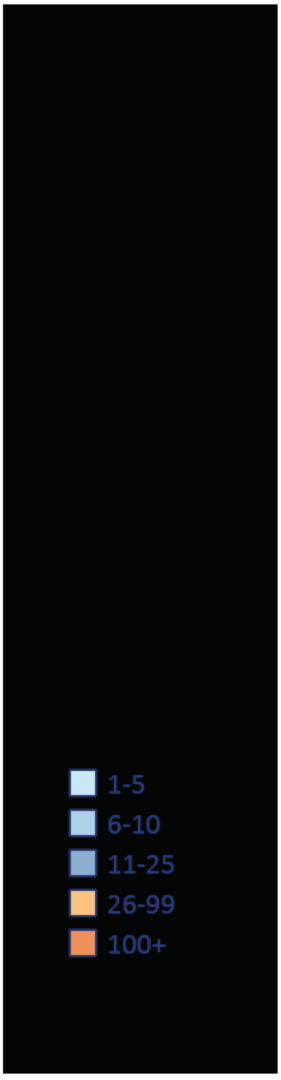


Figure 3

Outbreak Cases by Age

Age Group	Confirmed
0-4 Yrs	219
5-17 Yrs	284
18+ Yrs	243
Pending	4

Figure 4

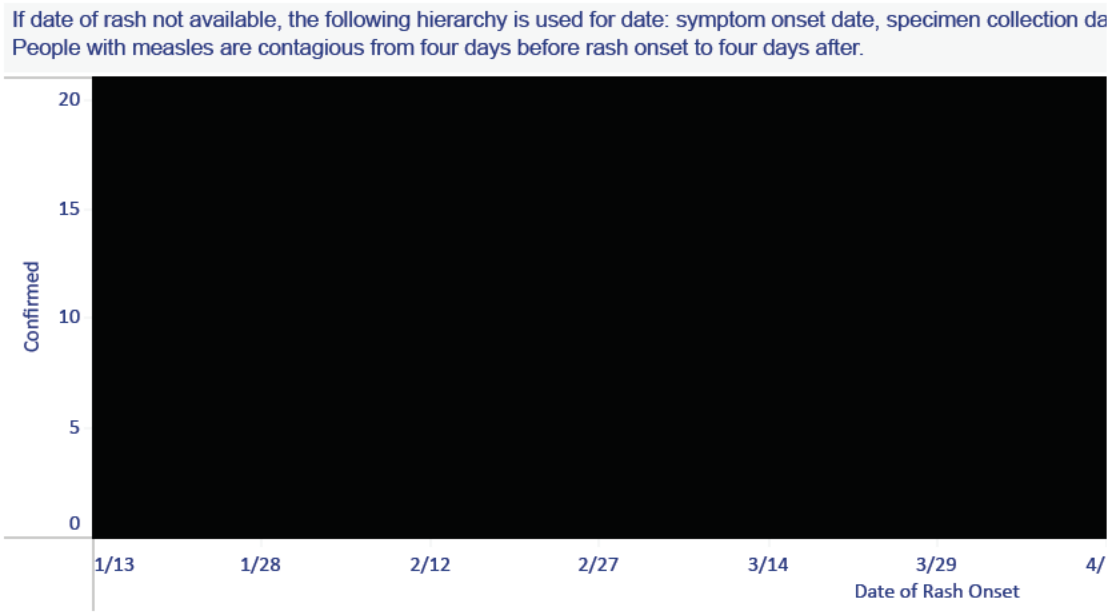
Outb

Vaccination Status
Unknown/Unvaccinate
Vaccinated: 1 dose
Vaccinated: 2+ doses

*The unvaccinated/unknown
more than 14 days before sy

Figure 5

Outbreak Cases by Date of Rash Onset



Measles Prevention

The best way to prevent getting sick is to be immunized with two doses of a vaccine against measles, which is primarily administered as the combination measles-mumps-rubella vaccine. Two doses of the MMR vaccine are highly effective at preventing measles.

People who live in or visit the counties in the outbreak counties listed above should follow the outbreak vaccination recommendations (/sites/default/files/Admin-Meales/doc/measles-infographic.pdf) .

To get vaccinated, people can go to their health care provider or a pharmacy. Vaccines are also available through the Texas Vaccines for Children and Adult Safety Net Providers. Use the maps located on the measles outbreak page (/measles) to locate a TVFC or ASN provider. Pharmacies can vaccinate people 14 and older without a prescription. Children under 14 need a prescription to get the MMR vaccine at a pharmacy.

Additional information for the public and health care providers is available at the links below:

Measles Outbreak page (/measles)

Measles FAQ page (/measles/measles-frequently-asked-questions)

DSHS News Release – Jan. 30 Announcing Cases in Gaines County (/news-alerts/state-health-officials-urge-vigilance-additional-measles-cases-are-identified)

DSHS News Release – Feb. 25 Outbreak Update (/news-alerts/dshs-provides-update-measles-outbreak)

DSHS News Release – Feb. 26 Texas Announces First Death in Measles Outbreak (/news-alerts/texas-announces-first-death-measles-outbreak)

DSHS News Release – April 6 Texas Announces Second Death in Measles Outbreak (/news-alerts/texas-announces-second-death-measles-outbreak)

DSHS Health Alert – Feb. 5 Gaines County Outbreak (/news-alerts/measles-outbreak-gaines-county-texas)

DSHS Health Alert – Feb. 24 Measles Exposures in South & Central Texas (/news-alerts/measles-exposures-central-south-central-texas)

DSHS Health Alert – March 6 Measles Outbreak Case Definition (/news-alerts/measles-outbreak-case-definition)

DSHS Health Alert – April 7 Texas 2025 Measles Outbreak – Expanded Outbreak Counties (/news-alerts/health-alert-texas-2025-measles-outbreak-expanded-outbreak-counties)

Data

School Coverage (https://www.dshs.texas.gov/immunizations/data/school/coverage)

Conscientious Exemptions (https://www.dshs.texas.gov/immunizations/data/school/conscientious-exemptions)

Measles (Rubeola) Data | Texas DSHS (https://www.dshs.texas.gov/vaccine-preventable-diseases/vaccine-preventable-disease-conditions/measles-rubeola/measles-rubeola/measles-rubeola-data)

Other 2025 Texas Measles Cases

2025 Texas Measles Cases Not Associated with the Outbreak in West Texas

County	**Cases**
Bell	1
Brazoria	1
Collin	3

County	Cases
Denton	2
El Paso	2
Fort Bend	1
Harris	3
Harrison	1
Hays	1
Randall	2
Rockwall	1
Scurry	1

County	Cases
Shackelford	1
Tarrant	4
Travis	2
Williamson	6
Total	**32**

Cases on this table may be moved to the West Texas outbreak dashboard if further investigation indicates a connection to the outbreak.

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Georgetown University
McCourt School of Public Policy
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Work Reporting Requirements – Even with Exemptions – Will Have Significant Consequences for People with Substance Use Disorders

April 29, 2025 Guest

As highlighted on **Say Ahhh!** earlier this month, Congress continues to consider imposing work reporting requirements on people who get their health coverage through Medicaid. As a practical matter, one thing is clear: the only purpose of this proposal is to terminate Medicaid coverage for the most vulnerable Americans. Work reporting requirements in public benefit programs have **never** led to more people working, but rather to widespread loss of coverage. This is the only way budget "savings" could be realized, especially as states would be forced to spend funds to develop or enhance administrative systems to comply with new restrictions and avoid cutting off coverage who meet the requirements or area exempt. (Revisit the chaos that ensued during the **Medicaid unwinding** to see what could go wrong for people who remain eligible.)

Despite claims from policymakers that they have learned lessons from failed experiments in other programs, there is simply no way that all individuals who are truly exempt from work reporting requirements would not lose their coverage. One population at the greatest risk for loss of coverage is people with substance use disorders. Approximately **2 in 5** nonelderly adult Medicaid enrollees have a substance use disorder or mental health condition, and **Medicaid** provides a wide array of prevention, treatment, and supports for people with these conditions that save lives, with a significant **return on investment**.

A number of existing and pending public benefit work reporting requirement policies attempt to exempt people who are actively participating in a drug or alcohol addiction treatment program, such as the **Supplemental Nutrition Assistance Program (SNAP)**[1] and the pending 1115 demonstration waivers in **Ohio** and **Arizona**. The federal SNAP exemption is limited to individuals who are participating in private, non-profit treatment facilities and community mental health centers, which make up **less than half** of the substance use disorder treatment facilities in the U.S., and are not equally distributed across the country. States have interpreted this requirement in dramatically different ways, where some only include acute full-time treatment while others have no minimum hour requirements.

In addition to the limited number of substance use disorder treatment programs that meet the statutory definition to permit a work reporting requirement exemption, the reality is that the **vast majority of people with substance use disorders do not receive treatment**. Even with a concurrent work reporting requirement exemption for people with substance use disorders who are "unfit to work," there would still be a need for people to see a provider to get proof of this "unfit" status. As Joan Alker **noted**, these types of exemptions could require significant paperwork burdens on clinicians, and force these providers to make decisions about their patients that could have life-or-death consequences.

Importantly though, this perverse incentive is not limited to clinicians. Average spending for Medicaid members with a substance use disorder diagnosis is more than **twice as high** as spending on those without this diagnosis. As states try to control costs in Medicaid, particularly **with other proposed cuts** to Medicaid such as a reduced federal match for the expansion population, they may be incentivized to make it harder for people to access substance use disorder treatment if that means people with these conditions would lose their coverage and state Medicaid programs would no longer incur costs for this or other treatment (although individual medical debt and uncompensated hospital costs would increase). States or Medicaid managed care organizations could lower reimbursement rates for providers, limit the number of providers who can participate in their networks, or deny medically necessary care to make it harder for people with substance use disorders to access the treatment they need. While any of these strategies would be illegal under the Mental Health Parity and Addiction Equity Act, the U.S. Department of Health & Human Services Office of Inspector General found that there has been **widespread noncompliance** with this law across

states. Essentially, rather than protecting people with substance use disorders, this type of exemption could lead to more discrimination.

At the same time, people who need substance use disorder treatment would face even more barriers to treatment than they already do. Individuals who do not meet the work reporting requirement because of their substance use would not be able to go to a provider to get that diagnosis or a referral to an appropriate treatment facility. They may need other treatment first, before they can address their substance use, which they may not be able to pursue if they cannot meet the work reporting requirement and get Medicaid coverage. Many people with substance use disorders have co-occurring mental health conditions or other physical health conditions that may have been exacerbated by their substance use, but they would not be able to access those other treatment programs if only addiction treatment programs are exempted from the work reporting requirements.

And what happens once a Medicaid member completes their addiction treatment program? Due to widespread stigma and discrimination against people with substance use disorders, or even a history of the condition, they still face significant barriers to finding and maintaining a job, and then they would lose access to all of their other health care services and supports that are available through Medicaid.

A "health institute" led by a former Trump appointee **claims** that Medicaid is not the appropriate source of funding to address the overdose epidemic, and that grant funding should be used instead (despite the Administration's simultaneous **efforts** to cut this funding and reduce the federal workforce that facilitates these grants). Grant funding serves an important role for addiction and recovery supports, largely because they have been so woefully underfunded for far too long. However, federal grants accounted for only about $4 billion in spending on substance use disorders in 2023, compared to **Medicaid's $29 billion**. Ultimately, grants are not a long-term sustainable solution to ensuring broad access to prevention and treatment for a health condition. Health insurance is. And this stigma-based argument ignores the reality that substance use disorders are health conditions, and should be treated as no less.

Ultimately, even with the best of intentions, work reporting requirements won't work for people with substance use disorders. The U.S. is finally seeing a decrease in **overdose deaths**, but we are still losing

close to 100,000 lives every year. Now is not the time to impose barriers to affordable health care for the most vulnerable Americans.

1. Notably, the federal SNAP requirements also allow states to receive place-based waivers to exclude regions from the work reporting requirements when there is a high unemployment rate or an insufficient job market, which **every state and DC** has received at some point in the last two decades. ↩

— ***Deborah Steinberg**, Senior Health Policy Attorney at Legal Action Center*



Guest

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

of the

U.S. House of Representatives

"Full Committee Markup of Budget Reconciliation Text"

May 13, 2025

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share comments on Budget Reconciliation Text that is to be considered by the Energy and Commerce Committee.

Medicaid is the largest single source of coverage in the United States, providing health care to more than 72 million Americans. These include children and babies, people with disabilities, the elderly and nursing home patients. In addition, it is a program upon which so many hard-working people depend.

The following comments are specific to Subtitle D of the Committee Print providing for reconciliation pursuant to H. Con. Res. 14, the Concurrent Resolution on the Budget for Fiscal Year 2025.

Section 44132. Moratorium on new or increased provider taxes.

States can finance the non-federal share of the Medicaid program by applying health care-related taxes, often referred to as provider taxes, fees or other assessments. States can implement these taxes through various approaches, including determining which providers to tax (e.g., hospitals and health systems, nursing facilities, managed

care organizations) and on what basis to apply the tax (e.g., per admission or bed, share of net revenue, flat taxes). Forty-nine states and the District of Columbia imposed at least one health care-related tax in fiscal year 2024. Provider taxes currently must be below the threshold of 6% or less of net patient revenues. States and providers rely on provider taxes to fund essential services and provide care for Medicaid beneficiaries. States use these funds to support Medicaid coverage, such as children's behavioral health services, maternal care and rehabilitative services, as well as to offset low Medicaid payment rates.

This section freezes, at current rates and amount, states' provider taxes in effect as of the date of enactment of this legislation and prohibits states from establishing new provider taxes. No federal matching funds would be allowed for state provider taxes imposed after the date of enactment, or any provider taxes that were increased (in amount or rate) after the date of enactment. The legislation also includes a provision that prohibits states from increasing the tax base by expanding items or services, or expanding the tax base to include providers that were previously not included. Our understanding is this would effectively cap provider taxes at the dollar amount in place on the date of enactment.

AHA Position:

The AHA is greatly concerned about the significant disruption this policy change will have on states' ability to fund their Medicaid programs. We believe the proposed restrictions on provider taxes fail to recognize the critical role they play in closing significant gaps in the cost of care for essential services. By freezing the taxes, the proposal ignores circumstances that drive increased health care costs including inflation, increased labor and drug costs, increased utilization and increased population demand for services. The Committee's proposal, based on our reading of the text, does not simply freeze provider percentage tax rates — it also appears to lock in the amount of dollars raised as of enactment of the law into perpetuity. Over time, the restrictions on this legitimate, vital funding tool will lead to diminished critical resources to support Medicaid beneficiaries.

There are significant variations among the Medicaid programs, and this policy change will impact each state differently. We also are concerned that the Committee does not include any alternate funding mechanisms to replace the loss of federal support in the states due to the proposed restrictions placed on provider taxes.

It is our belief that most states would be unable to close this financing gap created by further limiting their ability to tax providers; and as a result, they may need to make significant cuts to their Medicaid programs, including reducing eligibility, eliminating or limiting benefits and further reducing the chronic Medicaid underpayment rates for providers. In addition, states could address financial losses by limiting or eliminating non-mandatory benefits for all Medicaid beneficiaries, such as prescription drug coverage, clinic services, certain behavioral health services, home and community-based services (HCBS), and physical and occupational therapy. We are committed to

preserving hospital and health systems ability to care for Medicaid beneficiaries. We urge the committee to consider the long-term impact of this policy that will pull resources away from essential services upon which everyone in the community relies, including emergency, trauma, maternal and behavioral health care services.

Section 44133. Revising the payment limit for certain state directed payments (SDPs).

States may direct managed care plans to make additional payments to providers to pursue a state's overall Medicaid program and quality goals. The 2024 Medicaid managed care final rule established new requirements for SDPs, including defining the requirements for SDP evaluation plans and setting the average commercial rate (ACR) as the upper payment limit for SDPs for inpatient and outpatient hospital services.

This section directs the Department of Health and Human Services (HHS) to revise current regulations to limit SDPs for services furnished on or after the enactment of this legislation from exceeding the total published Medicare payment rate. This limit applies to SDP programs that were not in place on the date of enactment but does allow for SDP preprints that are in process with HHS to qualify at higher levels. Approved SDPs that are in place on the date of enactment are not subject to the limit, but states could not increase the SDP, and states would be required to submit a preprint for new or modified SDPs, and program renewals, for approval by the Centers for Medicare & Medicaid Services (CMS).

AHA Position:

Supplemental payments are a longstanding, vital tool that states can use to mitigate the chronic underpayments caused by low base rates for services provided to Medicaid patients. SDPs are used to support essential hospital services in our communities, including behavioral health and obstetrical services, and to create incentives to improve quality and health outcomes. They are particularly important in rural areas, where hospitals are sometimes the sole source of care in a community.

Setting limits on the amount that can be paid for SDPs into perpetuity will impact the delivery of care for both Medicaid beneficiaries as well as the larger communities served by our hospitals and health systems. Under this policy, funding for essential Medicaid supplemental payments will be frozen in time and will not keep up with year-over-year increases in health care costs. It is important to note that even when supplemental payments are included, Medicaid still pays less than the cost of providing care to Medicaid patients. For example, excluding supplemental payments, Medicaid fee for service payments paid less than 58 cents for every dollar hospitals spent caring for Medicaid patients in 2023, and Medicaid MCOs paid less than 65 cents over the same period. The Medicaid shortfall in hospital payments was $27.5 billion in 2023.

OTHER KEY PROVISIONS

PART 1—MEDICAID

Subpart A—Reducing Fraud and Improving Enrollment Processes

Section 44101. Moratorium on implementation of rule relating to eligibility and enrollment in Medicare Savings Programs (MSPs).

This section would rollback requirements in the "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" final rule, including those that: 1.) automatically enroll certain Supplemental Security Income (SSI) recipients in the Qualified Medicare Beneficiary (QMB) eligibility group of the MSP program; 2.) use data from the low-income subsidy program as an application for MSPs and align the family size definitions between the MSP and LIS programs; and 3.) accept self-attestation for certain types of income and resources.

AHA Position:

While the rule has not taken effect, the AHA is concerned about the potential loss of coverage and increase in uncompensated care that may result from delaying implementation.

Section 44102. Moratorium on implementation of rule relating to eligibility and enrollment for Medicaid, CHIP, and the Basic Health Program.

The legislation delays until Jan. 1, 2035, the implementation of the final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes." The final rule addressed several key barriers to accessing and maintaining coverage for eligible individuals, including individuals who are Aged (65+), Blind, or Disabled (ABD), dually eligible individuals, the medically needy, people receiving Long-Term Services and Supports (LTSS) or Home and Community Based Services (HCBS) and children with disabilities. Provisions of the rule included streamlining verification processes, limiting renewals to no more frequently than every 12 months for high-risk individuals (non-MAGI populations), and establishes minimum timelines for applicants to provide needed information. States must be in full compliance with the provisions of the rule by June 2027, and, therefore, several key provisions have not yet been implemented.

This section prohibits HHS from implementing the rule for 10 years.

AHA Position:

While the rule has not taken effect, the AHA is concerned about the potential loss of coverage and increases in uncompensated care that may result from delaying implementation.

Section 44108. Increasing frequency of eligibility redeterminations for certain individuals.

This section requires states to conduct eligibility determinations for expansion population adults every six months. Current law currently requires such determinations to occur every 12 months.

AHA Position:

The AHA is concerned about the cost and additional administrative burden to the health care system, as well the potential loss of legitimate coverage, that may result from the policy change.

Section 44110. Prohibiting federal financial participation (FFP) under Medicaid and CHIP for individuals without verified citizenship, nationality, or satisfactory immigration status.

This section prohibits federal financial participation for Medicaid and CHIP enrollees in a reasonable opportunity period unless the individual successfully verifies their citizenship or immigration status. It is optional for states to provide coverage during the verification period.

AHA Position:

The AHA supports verification of citizenship and immigration status to qualify for Medicaid benefits, but we are concerned about the potential for a delay in coverage and care for individuals who would otherwise be eligible for the program.

Section 44111. Reducing expansion FMAP for certain states providing payments for health care furnished to certain individuals.

Federal funds for care provided to undocumented individuals is available in limited circumstances only. States can cover refugees and asylum seekers upon entering the U.S. (and being designated as such) for up to seven years. Additionally, states can reimburse hospitals for emergency care provided to individuals who meet other Medicaid eligibility requirements, but who do not have eligible immigration status.

This section reduces by 10% the Federal Medical Assistance Percentage (FMAP) for Medicaid expansion states that use their Medicaid infrastructure or another state-based program to provide health care coverage to those who are not qualified aliens otherwise lawfully residing in the U.S. (i.e., undocumented immigrants), reducing the 90% match for a state's expansion population to 80%.

AHA Position:
The AHA is concerned that lower FMAP for expansion states covering undocumented immigrants — with their own state funds — would have a substantial impact on

hospitals, as it would lead to more uncompensated care and potentially lower provider payments in the affected states. It is important to note that hospitals are required to treat patients regardless of immigration status under EMTALA.

Subpart B—Preventing Wasteful Spending

Section 44121. Moratorium on implementation of rule relating to staffing standards for long-term care facilities under the Medicare and Medicaid programs.

The "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" final rule established minimum nurse staffing requirements for long-term care facilities (LTCFs) of at least 3.48 hours of nursing care a day, including at least 0.55 hours of care from a registered nurse and 2.45 hours of care from a nurse aide, as well as the availability of a registered nurse onsite at a facility 24 hours a day, seven days a week. The rule goes into effect for urban facilities in 2027 and for rural nursing homes in 2029.

On April 7, the U.S. District Court for the Northern District of Texas vacated the 2024 CMS minimum staffing standards for long-term care facilities.

This section prohibits HHS from implementing the rule for 10 years.

AHA Position:

The AHA supports the rescission of this rule as it does not consider existing workforce shortages and could lead to additional challenges for hospitals to discharge patients to LTCFs. The AHA filed a friend-of-the-court brief in the case and last year urged CMS not to finalize the mandate but instead develop more patient- and workforce-centered approaches focused on ensuring a continual process of safe staffing in nursing facilities.

Section 44122. Modifying retroactive coverage under the Medicaid and CHIP programs.

Current statute requires that states cover Medicaid state plan services at least three months (90 days) prior to the month that the eligible individual applies for Medicaid coverage. Individuals must have been determined eligible for Medicaid at the time that they received the services within the retroactive coverage period. States can reduce or eliminate the retroactive coverage period through the Section 1115 demonstration waiver. This section limits retroactive coverage in Medicaid to one month prior to an individual's application date.

AHA Position: Limiting the scope of retroactive coverage would impact both patients and providers. We are reviewing this policy to better understand what implications it may have for patients' access to care.

Subpart C—Stopping Abusive Financing Practices

Section 44131. Sunsetting eligibility for increased FMAP for new expansion states.

The American Rescue Plan Act (ARPA) provided an opportunity for states to receive an additional five percentage point increase for their traditional FMAP if they choose to expand. The additional match would be in effect for two years after the state expanded. There was no set expiration for the FMAP increase. At the time ARPA was enacted, 12 states had not expanded Medicaid. Since then, two states, Missouri and Oklahoma, expanded Medicaid and received the full eight quarters of the FMAP increase, and two states are currently receiving the FMAP increase — North Carolina and South Dakota. There are 10 states that have not yet expanded their Medicaid program. This section sunsets the temporary 5% enhanced FMAP but would apply the policy prospectively, to not impact states currently receiving an enhanced federal match under this authority.

AHA Position:

The AHA has supported incentives for states to expand their Medicaid programs. It is unclear whether additional states will be using this incentive in the short term.

Section 44134. Requirements regarding waiver of uniform tax requirement for Medicaid provider tax.

This section modifies the requirements regarding uniformity of provider taxes and, specifically, whether a state's tax is considered "generally redistributive." Under the draft legislation, a tax is not considered generally redistributive if:

- Within a permissible class, lower Medicaid volume health care entities are taxed at a lower rate than higher Medicaid volume health care entities.
- Within a permissible class, high Medicaid volume health care entities are taxed more heavily than non-Medicaid health care entities.
- The tax excludes or imposes a lower tax rate on health care entities based upon Medicaid participation status, whether the term "Medicaid" is mentioned.

AHA Position:

We are concerned this policy change will undermine state Medicaid financing arrangements and could have implications for coverage disruption.

Subpart D—Increasing Personal Accountability

Section 44141. Requirement for states to establish Medicaid community engagement requirements for certain individuals.

Under the prior Trump administration, many states sought to require some populations to demonstrate that they are working as a condition of eligibility for Medicaid. As of April 2025, Georgia is the only state to implement community engagement requirements as approved by CMS, although three states (Arizona, Arkansas, and Ohio) have waivers pending with the agency.

This section establishes community engagement requirements for certain Medicaid beneficiaries. Beginning Jan. 1, 2029, states are required to establish community engagement requirements for non-exempt expansion adults aged 19-64. Individuals must work or engage in qualifying activities (e.g., community service, educational programs, job training) for not less than 80 hours/month. Mandatory exceptions include specified excluded individuals (e.g., caretakers, disabled veterans, medically frail individuals), individuals under the age of 19, pregnant or post-partum women, individuals enrolled in Medicare part A or part B, and institutionalized individuals. Optional exceptions for short-term hardship events include individuals receiving inpatient hospital services, nursing facility services, or inpatient psychiatric services; individuals in disaster zones; and individuals in areas with high unemployment. Compliance is verified during the initial eligibility determination, as well as part of subsequent eligibility redetermination, or more frequently as determined by the state. States may use data sources like payroll data to verify compliance. If the state is unable to verify that the individual has met the community engagement requirements, the individual will have 30 days to demonstrate compliance before they are disenrolled. States must determine whether an individual would qualify for Medicaid under other eligibility pathways before disenrolling. If an individual is eligible for Medicaid but is disenrolled due to not meeting community engagement requirements, that individual is not eligible for premium tax subsidies in the health care marketplace. The legislation provides $100 million in grants in fiscal year 2026 for system development.

AHA Position:

We appreciate that the Committee provided thoughtful criteria regarding those who should be subject to this provision.

We are, however, concerned about the implementation challenges of reporting requirements and the option for states to conduct more frequent compliance checks than during the redetermination period. We would encourage more opportunities for beneficiaries to come into compliance before termination. In addition, we are concerned about the provision that those who are disenrolled due to failure to meet community engagement requirements would not be eligible for premium tax credits and, therefore, would not be able to afford coverage through their state's marketplace.

Some analysis indicates that community engagement requirements as a condition of coverage for the Medicaid population could result in loss of coverage. This also could result in additional uncompensated care for hospitals.

Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.

Currently, states have the option to set cost-sharing requirements for certain enrollees above 100% of the federal poverty level (FPL). The maximum allowable deductible and copayment amounts are set by CMS, and can be applied to institutional care, non-institutional care, non-emergency use of the emergency department and prescription drugs services and supplies. For inpatient hospital care, for example, the maximum allowable copayment is $75 at 100% FPL, 10% of the cost the agency pays for 100-150% FPL and 20% of the cost the agency pays for those who are above150% FPL. No out-of-pocket costs may be imposed for emergency services, family planning services, preventive services for children and pregnancy services. Out-of-pocket costs are capped at 5% of family income.

This section requires states to impose cost sharing requirements at an amount greater than $0 and not exceeding $35 on Medicaid expansion enrollees. Total cost sharing may not exceed 5% of family income. States may allow providers to require payment as a condition of providing services, though providers may waive cost-sharing requirements on a case-by-case basis. The legislation would not permit cost-sharing on primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room).

AHA Position:

The AHA is concerned about the challenges providers face in collecting cost-sharing from low-income patients. We also are concerned that cost sharing requirements are both a burden on low-income patients and can be a significant barrier to coverage, particularly when consequences, such as potential loss of health care services, are applied for failure to pay.

PART 2—AFFORDABLE CARE ACT

Section 44201. Addressing waste, fraud, and abuse in the ACA exchanges.

This section codifies most of the proposed policies in the 2025 Marketplace Integrity rule, including: shortening the Health Insurance Marketplace open enrollment period, removing the low-income special enrollment period, changing the premium adjustment percentage methodology, allowing insurers to require that enrollees pay past-due premiums before renewing coverage, implementing more stringent eligibility verification processes, disallowing DACA recipients to receive premium tax credits or cost-sharing reductions and prohibiting gender-affirming care as an essential health benefit. The draft legislation does not include the proposal that would improve transparency of agency, broker, and web-broker behavior, and varies in its language regarding the de minimus range, which impacts the value of coverage within each metal tier. The provisions within this section would take effect for plan years beginning on or after Jan. 1, 2026.

AHA Position:

The AHA is concerned that this section would codify parts of the rule that could impact coverage, including shortening the Health Insurance Marketplace open enrollment period, removing the low-income special enrollment period, changing the premium adjustment percentage methodology, allowing insurers to require that enrollees pay past-due premiums before renewing coverage and implementing more stringent eligibility verification processes. Coverage loss associated with these policies, combined with additional changes to the Medicaid program resulting in coverage loss, would have substantial consequences for patient access to care as well as the financial stability of hospitals, health systems and other providers.

PART 3—IMPROVING AMERICANS' ACCESS TO CARE

Section 44302. 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 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.

AHA Position:

The AHA supports efforts to improve access to care for Medicaid and CHIP beneficiaries.

Section 44303. Delaying DSH reductions.
This section delays the Medicaid Disproportionate Share Hospital (DSH) reductions, currently $8 billion reductions per year that are set to take effect for fiscal years 2026 through 2028, to instead take effect for fiscal years 2029 through 2031. This section also extends funding for Tennessee's DSH program, which is set to expire at the end of this fiscal year, through fiscal year 2028.

AHA Position:

The AHA supports a delay in the start of the remaining DSH cuts.

Section 44304. Modifying update to the conversion factor under the physician fee schedule under the Medicare program.

This section applies a new single conversion factor for Physician Fee Schedule services under the Medicare program starting in 2026 (as opposed to the two distinct ones scheduled for implementation under current law: one for physicians participating in alternative payment models and another for those who are not). For 2026, the update to

the single conversion factor would be 75% of the percentage increase in the Medicare Economic Index (MEI), for 2027 it would be 10% of the percentage increase in the MEI. This provision would not be retroactive.

AHA Position:

The AHA supports the Committee's efforts to address payments for our nation's physicians.

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Steve Davis
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Steve Davis has left his role at the top of DOGE, the White House said Thursday.

His departure comes on the heels of Elon Musk's announcement that he is stepping back from government worland returning to his companies.

Davis had been a key leader at the Department of Government Efficiency, handling the day-to-day operations such as hirings and firings, current and former DOGE staffers said. He took cues from Musk and helped guide the work of the DOGE team of engineers that had been deployed to various agencies.

NAMI Statement on Devastating Medicaid, SNAP Cuts Passed by U.S. House

NAMI HELPLINE

sted on May 22, 2025

ington, VA – Earlier today, the U.S. House of Representatives passed a budget bill that will ·iously hurt people with mental illness by massively cutting critical programs like Medicaid d SNAP, which provide lifesaving support to millions of Americans. NAMI is deeply alarmed d saddened by the passage of this bill in the House and released the following statement m CEO Daniel H. Gillison, Jr.:

"Millions of people will lose their health care coverage under the House of Representatives' budget reconciliation bill, including many with mental health conditions. Medicaid is the backbone of our country's mental health system, paying for roughly one quarter of the country's mental health and substance use care and covering one in three people with a mental illness. Cutting hundreds of billions of

> dollars from Medicaid will undoubtedly hurt millions of Americans and keep far too many from getting the mental health services they need and deserve."

The *One, Big, Beautiful Bill Act* makes deep cuts to Medicaid, which will result in fewer people having health care coverage, fewer health care services available, more expensive care, and a weaker overall U.S. mental health system. The bill makes significant cuts to the Supplemental Nutrition Assistance Program (SNAP, or food stamps) that will impact millions of working Americans who rely on food assistance to feed their families.

The bill will now move to the Senate. Congressional leaders have indicated that they hope to have a final bill on President Trump's desk by the July 4th holiday. NAMI's Chief Advocacy Officer Hannah Wesolowski said:

> "We are deeply concerned that half of the House would back a bill that so clearly harms people with mental illness—including many in their own districts. There is nothing beautiful about cutting off millions of Americans from life-saving health care coverage and food assistance. We fervently hope that the Senate will reject these cuts and protect access to these life-saving programs. NAMI will keep fighting to protect Medicaid and protect mental health care."

NAMI launched the **"Protect Medicaid. Protect Mental Health."** campaign earlier this year to raise awareness of the impact of Medicaid on mental health care. Through this campaign, NAMI advocates have sent more than 120,000 emails and made more than 6,000 phone calls to Congress to protect Medicaid.

To learn more about NAMI and our advocacy work, visit **nami.org/Medicaid**.

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National Alliance on Mental Illness

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SCIENCEINSIDER SCIENCE AND POLICY

NIH director faces pointed questions at first staff town hall

Jay Bhattacharya says he disagrees with firings, supports minority health studies

20 MAY 2025 • 9:15 AM ET • BY JOCELYN KAISER



Jay Bhattacharya's early days as director of the National Institutes of Health have been marked by controversy. BEN CURTIS/AP

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At his first staff town hall, National Institutes of Health (NIH) Director Jayanta "Jay" Bhattacharya yesterday faced a packed auditorium and fielded challenging questions on topics from transparency about

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decisions by President Donald Trump's administration to gender research. He also tried to make the case that he shares his employees' concerns about crippling layoffs and is working to get NIH operations back on track.

"My goal is to make this place better," said Bhattacharya, who started at the agency on 1 April.

The event on NIH's main campus in Bethesda, Maryland, drew 1200 questions in advance, nearly 500 attendees in person, and many more online. The turnout—and the skeptical reactions some expressed online or privately to *Science*—reflected the recent upheaval at the agency. Since Trump took office in January, NIH has lost about 2500 of its 20,000-person staff to layoffs and hundreds more to retirement and other departures.

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Bhattacharya said he didn't decide who was terminated or offered reassignment. "I actually don't have any transparency in how those decisions were made, and actually I'm quite upset about that. It would be nice to have had some say," Bhattacharya said. (*Science* obtained a recording of the town hall.)

A health economist who left Stanford University for the NIH job, Bhattacharya joked that his hair has turned grayer since he became director. He said he is adjusting to working for the federal government and has sometimes mistakenly left his ID in his computer—a common practice among many NIH employees but one that, a few weeks ago, led the White House's Department of Government Efficiency to threaten the jobs of some agency staffers.

Bhattacharya's staff had canceled a previously scheduled town hall, a move that some speculated reflected concerns that the union representing NIH's trainees, which includes college graduates through postdocs, planned a walkout. Indeed, a group of several dozen people did walk out a few minutes into Bhattacharya's remarks, prompting some applause. "It's nice to have free speech," he responded.

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Bhattacharya, whose opposition to public health measures such as vaccine mandates and school closures during COVID-19 won him fans among conservatives and others, ticked through a list of his now familiar priorities. They include prioritizing research on chronic disease, supporting reproducibility, backing "edge science," and encouraging scientific freedom.

He wants to stop NIH-funded risky virus research known as gain-of-function (GOF) studies because "it's possible" that the agency backed studies in Wuhan, China, that caused the COVID-19 pandemic: "I believe it," he said. But he didn't expand on ambiguities in a recent White House executive order that appears to restrict GOF research except to say such studies are "a tiny, tiny portion of our portfolio."

The new director discussed a new NIH policy for grantees and in-house scientists that he had signed off on. It aims to reduce the use of lab animals, he says, because "what we want is research that improves the health of people, not just the health of mice." Many lab researchers worry about the policy's implications for research.

Tackling another controversial policy decision made since he started, Bhattacharya insisted a new NIH requirement that foreign scientists apply directly for agency grants instead of receiving subawards from their U.S. partners won't stop vital work. "Foreign collaborations will continue," he said.

He answered several questions gleaned from the 1200 submissions and from audience members, including one asking how he squares his opposition to diversity, equity, and inclusion (DEI), which he calls "political ideology," with research on health disparities, some of which he has himself done. Bhattacharya said NIH remains committed to studying the health of women and minority health populations in order "to advance the health and well-being of every single American."

He said researching the health effects of redlining, in which people of certain races or ethnicities are denied services such as mortgages based on where on a map they live, is a "completely legitimate kind of study" that NIH could fund because "you can remove the policy" and



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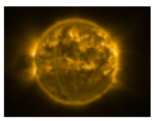
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study its effects. Yet he said structural racism cannot be studied because it's "not a scientific hypothesis." One audience member pointed out that redlining is a form of structural racism.

Another asked about how his support for scientific dissent fits with a Trump policy declaring that there are only two biological sexes, male and female, and rejecting the use of gender in research. Bhattacharya took a hard line: "Sex is a very cleanly defined variable. If you're using gender, you have to have a scientific reason for using gender" and cannot make it "a routine question in order to make an ideological point."

He was asked about concerns that patients might be afraid to come to NIH for experimental treatments because they are not citizens and fear arrest by immigration authorities. The NIH Clinical Center is a "sacred place" obligated to treating patients "regardless of what their status is," he declared.

Bhattacharya also addressed more practical matters, saying teleworking was probably gone forever and promising to help get needed lab supplies. "No gloves?" he said. "We'll get that fixed" by bringing back fired staff in procurement offices, he vowed.

Some watching the town hall gave the new director grudging praise for being willing to go off script. But others were skeptical of his seemingly contradictory views on studies involving DEI. And several in-house NIH scientists told *Science* they felt he only paid lip service to their concerns. "Denying problems," said one senior researcher, pointing to ongoing issues such as an exodus of clinical researchers.

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MEDICAL RESEARCH

Impact of NIH Grant Terminations

AAMC

Training and Career Development Grants

Analysis release date: June 10, 2025

Background

This year's terminations of biomedical research grants funded by the National Institutes of Health (NIH) is unprecedented in the history of the agency. One key area that has been impacted is NIH-funded research training and career development grants, which play a vital role in building the next generation of the biomedical research workforce. This brief focuses on research training and career development grants and analyzes available data, as of June 4, 2025, from a dynamic database that tracks grant terminations.

Summary of Terminated Funding

As of June 4, 2025, 2,282 NIH grants awarded to U.S. institutions have been terminated and not reinstated, representing nearly $3.8 billion of lost funding (total unliquidated funding) (Table 1). The majority (52%) of terminated grants (n = 1,183) were awarded to U.S. medical schools and hospitals, representing nearly $2 billion of all lost funding. Nearly two-thirds (61%) of all terminated grants were research and development grants, and 38% were research training and career development grants, the focus of this data brief.

Table 1. Overview of the Impact of Grant Terminations on U.S. Institutions

	U.S. Medical Schools and Hospitals	All Institutions
Count of Terminated Grants	**1,183**	**2,282**
Research and Development	727 (61%)	1,384 (61%)
Research Training and Career Development	452 (38%)	862 (38%)
Other*	4 (0.3%)	36 (2%)
Total Funding Lost	**$1,969,690,939**	**$3,790,259,187**
Research and Development	$1,653,260,115	$3,269,020,123
Research Training and Career Development	$314,544,432	$512,043,624
Other*	$1,886,392	$9,195,440

* "Other" grants include NIH funding for construction and modernization, small businesses, and transactions other than grants, contracts, and cooperative agreements. Note: Percentages may not sum to 100 due to rounding.

Terminated Training and Career Development Grants

Of the 862 research training and career development grants that have been terminated, the most prevalent type was F31 grants (n = 269) — grants awarded to graduate students to provide mentored research support — totaling nearly $4.7 million in lost funding (Figure 1). Additionally, 161 R25 grants — grants that support programs to promote interest and training in biomedical research — were terminated, totaling $153 million. Moreover, 122 T32 grants and 61 T34 grants — grants that enable institutions to recruit and support undergraduates, graduate students, and postdoctoral scholars for health-related research careers — were terminated, totaling $246 million in lost funding. Fifty-six K99 grants — career transition grants supporting postdoctoral scholars in their transition to faculty positions — were terminated, totaling $3.8 million in lost funding.

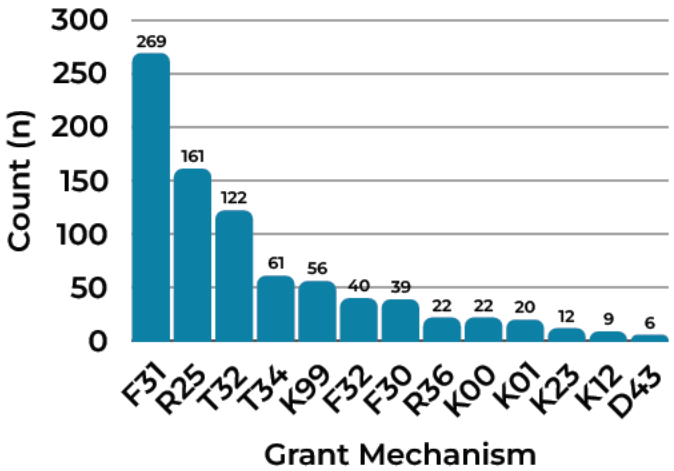


Figure 1. NIH research training and career development grant mechanisms with five or more terminated grants.

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MEDICAL RESEARCH

Impact of NIH Grant Terminations

AAMC

Training and Career Development Grants

State-level Impacts of Terminations

The top 10 states impacted by terminations of NIH research training and career development grants represent all five major geographic regions, including the Northeast (Massachusetts, New York, and Pennsylvania), Southeast (Georgia, North Carolina, and Virginia), Midwest (Illinois), Southwest (New Mexico and Texas), and West (California) (Table 2). Across the United States, institutions lost a combined $512 million in research training and career development grants. This loss of critical funding for graduate students and postdoctoral scholars has had an immediate and harmful impact on the biomedical research workforce and the ability of academic medicine to attract and retain the best and brightest scientists.

Table 2. The Financial Impact of Terminated Research Training and Career Development Grants and All NIH Grants on U.S. States and Territories

State or Territory	Lost Funding From Research Training and Career Development Grants	Total Lost Funding From All NIH Grants	State or Territory	Lost Funding From Research Training and Career Development Grants	Total Lost Funding From All NIH Grants
Alabama	$7,535,526	$19,873,668	Montana	$516,168	$921,984
Alaska	$432,838	$1,131,784	Nebraska	$446,323	$2,706,261
Arizona	$2,364,196	$17,300,756	Nevada	$684,731	$6,126,145
Arkansas	$844,512	$4,128,598	New Hampshire	$521,639	$521,639
California	$39,504,890	$295,779,796	New Jersey	$1,640,576	$14,620,415
Colorado	$1,755,200	$16,018,140	New Mexico	$17,630,935	$24,943,744
Connecticut	$853,727	$45,772,415	New York	$135,115,246	$590,674,412
Delaware	$1,215,067	$7,871,520	North Carolina	$8,946,037	$471,070,875
Florida	$2,027,364	$72,065,676	North Dakota	$195,699	$195,699
Georgia	$10,805,513	$114,408,263	Ohio	$3,148,236	$24,631,914
Hawaii	$5,726,529	$33,346,749	Oklahoma	$599,148	$9,005,974
Idaho	$243,448	$243,448	Oregon	$1,227,411	$5,669,735
Illinois	$9,077,951	$85,176,315	Pennsylvania	$10,813,075	$81,302,148
Indiana	$2,974,566	$5,942,595	Puerto Rico	$2,687,746	$3,032,150
Iowa	$162,263	$5,264,538	Rhode Island	$1,227,709	$8,115,519
Kansas	$0	$1,400,998	South Carolina	$8,915,266	$16,986,055
Kentucky	$113,938	$10,085,068	South Dakota	$106,327	$1,125,374
Louisiana	$1,219,327	$9,318,716	Tennessee	$1,687,467	$40,917,967
Maine	$566,051	$22,524,444	Texas	$14,118,116	$107,790,842
Maryland	$6,354,088	$59,616,686	U.S. Virgin Islands	$16,247	$16,247
Massachusetts	$168,107,248	$1,285,173,571	Utah	$1,064,738	$2,511,034
Michigan	$5,542,742	$31,862,710	Virginia	$9,821,456	$44,275,887
Minnesota	$4,213,784	$46,896,897	Washington	$2,501,510	$94,448,666
Mississippi	$100,957	$1,771,798	Washington, D.C.	$3,742,983	$11,149,060
Missouri	$8,547,582	$20,698,218	Wisconsin	$4,379,532	$13,826,075

Note: No terminated grants are currently reported in Vermont, West Virginia, or Wyoming.

Data Sources and Methods:

- Ross N, Delaney S, Barente A, Mairson E. NIH grant terminations in 2025. Grant Tracker. Accessed June 4, 2025. https://grant-watch.us/nih-data.html
- Methodology for this analysis: https://www.aamc.org/media/83991/download

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MEDICAL RESEARCH

Impact of NIH Grant Terminations

May 6, 2025

Background

This year's terminations of biomedical research grants funded by the National Institutes of Health (NIH) is unprecedented in the history of the agency. This brief summarizes the current state and impact of NIH grant terminations on U.S. institutions, with a focus on medical schools and hospitals, drawing from a dynamic database that tracks grant terminations.

Summary of terminated funding

As of May 5, 2025, 777 NIH grants awarded to U.S. institutions have been terminated, representing $1.9 billion of lost funding (total unliquidated funding). About 45% of these grants (n = 346) were awarded to U.S. medical schools and hospitals, representing $1 billion (54%) of all lost funding. Roughly 61% of all terminated grants were research and development grants, and 29% were research training and career development grants (Table 1).

Table 1. Overview of the Impact of Grant Terminations on U.S. Institutions

	US Medical Schools and Hospitals (%)	All Institutions (%)
Count of Terminated Grants	**346 (100)**	**777 (100)**
Research and Development	201 (58)	473 (61)
Research Training and Career Development	106 (31)	222 (29)
Other*	39 (11)	82 (11)
Total Funding Lost	**$1,014,395,451**	**$1,874,241,088**
Research and Development	$547,359,962	$1,262,244,857
Research Training and Career Development	$137,931,918	$182,252,938
Other*	$329,103,571	$429,743,293

* "Other" grants include NIH funding for construction and modernization, small businesses, and transactions other than grants, contracts, and cooperative agreements.

Impact by grant mechanism

Of the 777 terminated grants, 32% (n = 245) were R01 grants, which support independent research projects, representing nearly $250 million in lost funding. An additional 8% (n = 63) were F31 grants — research training and career development grants awarded to graduate students to provide mentored research support — totaling $1.2 million in lost funding. Six UM1 grants, which support large-scale research activities like clinical networks and research programs, were also terminated, representing a loss of $452 million and 24% of all lost funding (Figure 1).

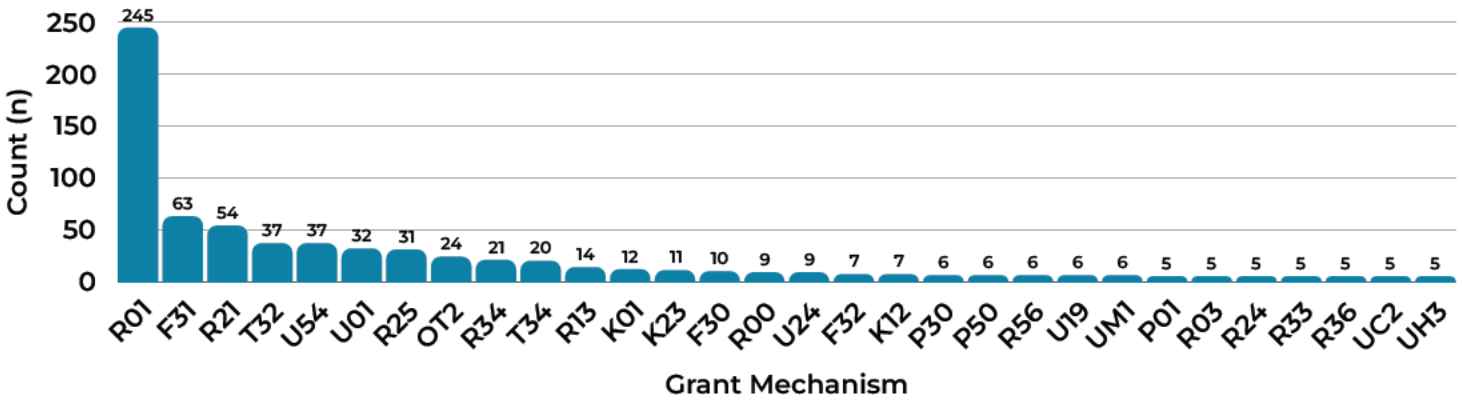


Figure 1. NIH Grant Mechanisms with Five or More Terminated Grants

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Impact of NIH Grant Terminations

Impact on clinical trials

Ninety-one of the terminated grants (12%) were associated with 113 active clinical trials and represented 34% of lost NIH funding ($643 million). Of these terminated grants, 51 (56%) investigated topics related to HIV or AIDS, 36 (40%) focused on mental or behavioral health, 16 (18%) focused on cancer, and 15 (16%) focused on COVID-19 (Figure 2). Fifty-five grants (60%) funding active clinical trials mentioned LGBTQ+ populations, 52 (57%) mentioned racial or ethnic subpopulations, 32 (35%) mentioned women, and 20 (22%) mentioned low-income populations.

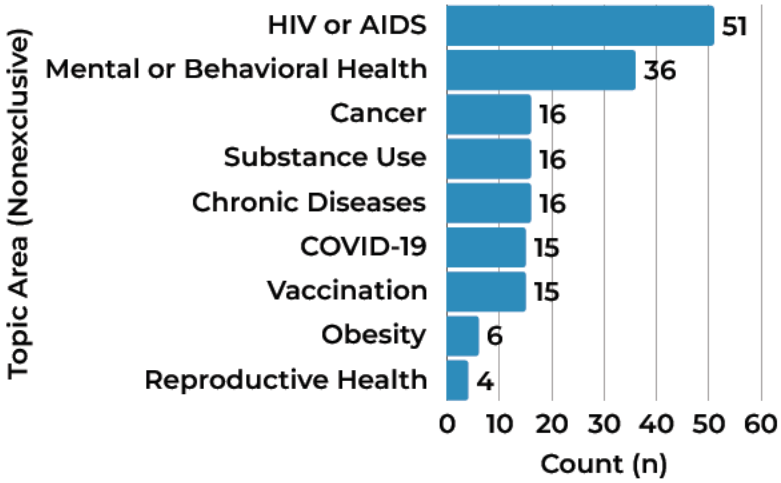


Figure 2. Topic Areas of Terminated Grants with Active Clinical Trials

Impact on states

The top 10 states impacted by the NIH grant terminations represent all five major geographic regions, including the Northeast (Massachusetts and New York), Southeast (Florida, Georgia, Maryland, North Carolina, and Tennessee), Midwest (Illinois), Southwest (Texas), and West (California). Altogether, these 10 states account for $1.6 billion in lost funding (Table 2). The NIH IDeA program, which strengthens the research infrastructure and capacity of historically underfunded states and Puerto Rico, lost a combined $75.4 million across 59 terminated grants.

Table 2. The Financial Impact of Terminated NIH Grants on U.S. States

#	State	Lost funding	#	State	Lost funding	#	State	Lost funding
1	New York	$575,614,031	16	New Mexico	$ 18,709,599	31	Missouri	$3,448,467
2	North Carolina	$566,096,741	17	Michigan	$ 18,519,832	32	Oregon	$2,990,228
3	California	$98,579,246	18	Ohio	$ 12,524,989	33	Hawaii	$2,205,051
4	Texas	$71,809,080	19	Connecticut	$ 12,367,269	34	Utah	$1,682,811
5	Florida	$62,943,080	20	Wisconsin	$ 11,713,633	35	Mississippi	$1,226,197
6	Massachusetts	$54,342,417	21	Alabama	$ 11,143,098	36	Nevada	$1,170,756
7	Maryland	$51,883,438	22	Washington, D.C.	$ 7,935,384	37	Arkansas	$1,056,357
8	Illinois	$46,757,256	23	South Carolina	$ 7,138,004	38	Nebraska	$1,044,308
9	Georgia	$40,871,810	24	Arizona	$ 5,284,577	39	Montana	$814,453
10	Tennessee	$34,358,919	25	Vermont	$ 5,130,709	40	Alaska	$791,503
11	Virginia	$29,676,109	26	Oklahoma	$ 5,106,864	41	Kentucky	$773,937
12	Minnesota	$28,154,391	27	Rhode Island	$ 4,565,242	42	Iowa	$667,894
13	Maine	$21,567,108	28	New Jersey	$ 4,262,316	43	Indiana	$571,401
14	Washington	$21,264,991	29	Colorado	$ 3,606,529	44	Puerto Rico	$363,997
15	Pennsylvania	$19,752,301	30	Louisiana	$ 3,473,432	45	Idaho	$281,335

Note: No terminated grants have been reported in Delaware, North Dakota, South Dakota, Wyoming, Kansas, West Virginia, or New Hampshire.

Data Sources and Methods:

- Ross N, Delaney S, Barente A, Mairson E. NIH grant terminations in 2025. Grant Tracker. Accessed May 5, 2025. https://grant-watch.us/nih-data.html
- U.S. Dept of Health and Human Services, NIH, National Library of Medicine, National Center for Biotechnology Information. ClinicalTrials.gov. Accessed May 5, 2025. https://clinicaltrials.gov/
- Methodology for this analysis: https://www.aamc.org/media/83351/download

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‘Have we no shame?’ Federal judge declares hundreds of NIH grant terminations ‘void and illegal.’

Judge William Young ordered the NIH to restore funds for research related to racial minorities and LGBTQ+ people.

By **Chris Serres** Globe Staff, Updated June 16, 2025, 7:33 p.m.



Left to right, Ariel Beccia, an instructor at the LGBTQ Health Center of Excellence at the Harvard T.H. Chan School of Public Health, Julia Marcus, associate professor at Harvard Medical School and with the LGBTQ Health Center of Excellence, and Brittany Charlton, associate professor and founding director of the LGBTQ Health Center of Excellence at the Harvard T.H. Chan School of Public Health, all had their NIH funding terminated. SUZANNE KREITER/GLOBE STAFF

In a harshly worded ruling Monday, a federal judge in Boston accused the Trump administration of discrimination against minorities and LGBTQ+ individuals and ordered the world's largest funder of biomedical research to reinstate hundreds of research grants that were terminated by the National Institutes of Health, declaring the grant terminations "illegal and void."

The decision, which came in a two-hour hearing over two lawsuits against the Trump administration, is a major victory for scientists across the country who are reeling from billions of dollars in funding cuts by the National Institutes of Health.

While judges have previously intervened to temporarily block the Trump administration's cuts, Monday's ruling marks a pivotal step in efforts to halt, or at least slow, the assault on scientific research. It marks the first time a judge has ordered the NIH to restore canceled funding, legal experts said. It also marks the first time a federal judge has explicitly argued that the Trump administration's cuts to NIH research grants are rooted in prejudice, not policy.

"I've sat on this bench now for 40 years. I've never seen government racial discrimination like this," said US District Court Judge William G. Young, who was appointed to the federal bench by former President Ronald Reagan. "Is it true of our society as a whole? Have we fallen so low? Have we no shame?"

Ruling from the bench, Young decreed that the grant terminations are illegal because they are "arbitrary and capricious" — a legal term referring to a decision that is made without a rational basis or sufficient consideration. The judge formally reversed the grant terminations at issue in the case, stating that the government must immediately make the funds available.

The decision applies to more than 800 individual grants identified in two lawsuits against the Trump administration and the NIH, attorneys for the plaintiffs said. The grants at issue focus on racial disparities, health equity, vaccine hesitancy and maternal

health in minority communities, banned through a series of executive orders, deeming them unworthy of federal funding.

The Trump administration is "exploring all legal options" including asking the judge to stay the ruling or appealing, said Andrew Nixon, a spokesman for NIH's parent agency, the Department of Health and Human Services. "HHS stands by its decision to end funding for research that prioritized ideological agendas over scientific rigor and meaningful outcomes for the American people," he said in an email to the Globe.

"It is appalling that a federal judge would use court proceedings to express his political views and preferences," White House spokesman Kush Desai said in a statement to Politico. "How is a judge going to deliver an impartial decision when he explicitly stated his biased opinion that the Administration's retraction of illegal DEI funding is racist and anti-LGBTQ?"

Attorneys for the Trump administration have consistently argued in court that the funding cuts are based on sound policy decisions and that research into gender identity is often "unscientific" and does not advance the health of Americans.

A group of public health experts, labor unions and the American Public Health Association filed a lawsuit in April challenging those grant cuts over what they call an "ongoing ideological purge" of scientific research. The lawsuits allege that the NIH broke from its usual science-based review process and launched a "reckless and illegal purge" to stamp out research on topics and populations that it no longer favored. It alleges that the Trump administration disregarded congressional mandates to fund health disparities research, and violated federal administrative process law by failing to provide scientific reasoning behind the cuts.

A second lawsuit was filed by a group of 16 states.

Since February, the NIH has revoked a total of 2,282 grants that add up to almost $3.8 billion of lost funding, according to a new analysis by the Association of American

Medical Colleges. With its large concentration of universities, hospitals, and research institutions, Massachusetts has been hardest hit by the NIH funding cuts, losing $1.28 billion in research funding, the analysis found.

"While today's ruling is reassuring, President Trump's cuts to NIH funding have already caused significant damage," said Governor Maura Healey in a statement Monday afternoon. "He halted lifesaving research into cures for cancer and Alzheimer's – diseases that we are all impacted by. We can't get that time back. He forced our research universities to lay off staff and rescind PhD offers. And he handed China and other foreign countries the opportunity to recruit away our researchers, scientists and entrepreneurs. President Trump's NIH funding cuts made America weaker and less competitive – and Judge Young made the right decision by striking them down."

Researchers who brought the lawsuits against the federal government also hailed the ruling.

"Today's decision is an important step in protecting public health and allowing critical research to continue. Research that helps us understand and treat serious diseases should be based on science, not politics," said Brittany Charlton, an associate professor at Harvard Medical School and a plaintiff in the case. "This ruling rightly allows important studies that were unfairly stopped to move forward again."

It is unclear how Monday's ruling will affect researchers at Harvard University - the focal point of the Trump administration's relentless attacks on scientific research and higher education. At Harvard Medical School alone, more than 350 federal grants have been terminated. Those that were identified in the lawsuit may have their funding reinstated, though they're a fraction of what has been canceled.

At several points in Monday's hearing, Young expressed confusion and frustration over the criteria the government was using to terminate grants. He pointed to a series of Trump administration directives that made claims that, he argued, did not appear

adequately explained or supported by facts. Young said the language in the directives was sometimes so vague that he couldn't determine whether they were based on science.

"This court finds and rules that the explanations [from the Trump administration for the grant terminations] are bereft of reasoning virtually in their entirety," Young said. "These edicts are nothing more than conclusory, unsupported by factual development."

Young also took issue with Trump administration statements asserting that funding of DEI-related research projects support "unlawful discrimination."

"Where's the support for that? Any support? Any rational explanation?" Young asked the attorney for the Department of Justice. "I see no evidence of that. Point me to ... any particular grant or group of grants being used to support unlawful discrimination on the basis of race. From what I can see, it's the reverse."

The plaintiffs did not accuse the NIH of racial discrimination in their lawsuits, but Young repeatedly raised the issue during Monday's two-hour hearing.

"I am hesitant to draw this conclusion — but I have an unflinching obligation to draw it — that this represents racial discrimination and discrimination against America's LGBTQ community," Young said. "That's what this is. I would be blind not to call it out. My duty is to call it out."

Still, it remains to be seen whether the Trump administration will comply with the order and reinstate funding for the terminated grants.

In March, a federal judge granted a preliminary injunction blocking enforcement of a Trump executive order banning federal funds from being used to promote so-called "gender ideology." Yet the administration has continued to cancel the grants anyway, say researchers tracking grant terminations.

On Monday, Young repeatedly pressed the attorney for the Trump administration, Thomas Ports, Jr., to explicitly state whether the director of the National Institutes of

Health would obey his decision.

"Are they going to obey, promptly?" Young asked.

"Your honor, I would expect defendants to comply," Ports said in response.

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The Influential Adviser Helping Shape Kennedy's Policies

Calley Means, a health care entrepreneur, coordinated a presidential commission report on chronic diseases in children.

Listen to this article · 4:39 min Learn more



By Dani Blum

May 22, 2025

Calley Means says he knows firsthand that America's food and pharmaceutical industries are corrupt. As a former lobbyist, he argues, he once helped corrupt them.

Mr. Means, 39, has emerged as a key figure in the Make America Healthy Again movement. He is a top adviser to Health Secretary Robert F. Kennedy Jr. and coordinated a presidential commission report that will be published Thursday on the causes of chronic disease among children. That report is expected to touch on some of the movement's top priorities, including environmental toxins, ultraprocessed foods and corporate influences over our health.

Corporate influence has long been a talking point for Mr. Means, who has rapidly risen from an obscure health care entrepreneur to an influential figure shaping the White House's health priorities. (It was Mr. Means who suggested to Mr. Kennedy that he consider joining forces with President Trump last summer.) He is a fixture on Fox News and on popular podcasts, where he often discusses rising rates of issues such as infertility, depression, diabetes and obesity.

He is the co-founder of Truemed, a startup that helps people funnel their flexible savings account dollars toward products like weights, saunas and supplements. Mr. Means has said making it easier for people to purchase these types of products could help prevent disease.

Mr. Means, who does not have any formal medical training, has used his experience consulting for companies like Coca-Cola and the pharmaceutical industry to call out what he sees as insidious tactics that harm American children. For example, he has said that he worked to ensure sugar taxes failed, on behalf of soda companies.

He argues that the health care industry profits from sick children and frequently describes the American public as being on a pharmaceutical "treadmill," arguing that the health care system pushes the public toward prescription medications rather than prioritizing diet and exercise.

While many scientists and doctors agree with the movement's focus on the health of American children, some have bristled at what they see as an overly simplified picture of complex causes of chronic disease.

At times, Mr. Means has also flouted conventional medical guidance, posting on Instagram that children should drink "more raw milk and less juice" (the Food and Drug Administration has warned against raw milk) and writing on X that Covid vaccine mandates are a "war crime, particularly for kids." He has also called water fluoridation "an attack on lower income kids," citing research linking high levels of fluoride with lower childhood IQ. The science around the potential cognitive effects of fluoride at levels found in American drinking water is still unsettled.

Mr. Means declined to comment for this article.

Mr. Trump recently said he would name Mr. Means's sister, Dr. Casey Means, as his nominee for surgeon general. Dr. Means also co-founded Levels, a wearable glucose monitor company.

The siblings co-wrote the book "Good Energy: The Surprising Connection Between Metabolism and Limitless Health," which blames ultraprocessed foods, pesticides, sedentary lifestyles and other issues for a range of chronic diseases. The book also focuses on their mother, who died just 13 days after she was diagnosed with advanced pancreatic cancer in 2021. The pair write that their mother's doctors suggested treatments that would have kept her away from her family in her final days, given pandemic precautions.

"Good Energy" became a best seller. The Means siblings took ideas once closely aligned with the left — such as reducing environmental toxins — and framed them in a way that resonated with conservatives who were already skeptical of the health care system. The siblings' appearance on Tucker Carlson's podcast last August became Apple's most-shared episode of 2024. Soon after, the siblings appeared on the "The Joe Rogan Experience" podcast to talk about their book, the food industry and corporate corruption.

Lately, Mr. Means has found a new platform: a government news conference. Onstage at a recent F.D.A. event announcing a federal push to phase out common food dyes, Mr. Means reflected on the MAHA movement's progress: "These are things that a year or two years ago would have been absolutely out of the question."

Dani Blum is a health reporter for The Times.

A version of this article appears in print on , Section A, Page 14 of the New York edition with the headline: The Influential Adviser Helping Shape Kennedy's Policies

Will Dr. Oz Push Medicare Advantage Plans Now That He's Confirmed?

As original Medicare faces funding shortfalls, Dr. Oz might shift to private insurance providers through Medicare Advantage. Here's what we know so far.



BY MAURIE BACKMAN LAST UPDATED APRIL 4, 2025 | CONTRIBUTIONS FROM ELLEN B. KENNEDY IN NEWS

There are changes afoot in how government agencies will oversee health care for retirees and older adults. President Donald Trump tapped physician and TV personality Dr. Mehmet Oz to lead the Centers for Medicare & Medicaid Services (CMS), and on April 3, he was confirmed on a party-line vote of 53 to 45.

Oz has already proposed a vision for Medicare that would increase private-sector involvement.

Like his boss — head of the Department of Health and Human Services Robert F. Kennedy Jr. — Oz is a controversial pick. The two have been criticized for sometimes supporting unproven remedies rather than scientific evidence.

For example, Oz has a history of promoting questionable supplements and unproven weight loss strategies, and prominent doctors have criticized Oz for his "disdain for science and for evidence-based medicine."

Although there remains some question about how RFK Jr. might change Medicare and your retirement, Oz has been much more vocal about how to lead the CMS. This is particularly important given that the trust that funds Medicare could be depleted by 2036. Oz will likely try to steer retirees and older Americans toward one specific type of Medicare coverage.

Medicare Advantage plans

Medicare enrollees must choose between original Medicare (Parts A and B plus a Part D drug plan) and Medicare Advantage (MA). Advantage plans are those offered by private insurers and must provide at least the same level of coverage as original Medicare. Many seniors are drawn to Medicare Advantage plans because they commonly offer supplemental benefits beyond what original Medicare covers.

In 2024, an estimated 99% of Medicare Advantage plans offered eye exams and/or glasses as a supplemental benefit, reports the Kaiser Family Foundation, while 98% offered dental care and 96% offered hearing exams and/or aids. These are services that original Medicare will not pay for, which commonly leaves enrollees with substantial out-of-pocket costs unless they enroll in a Medigap plan.

While the costs associated with Medicare Advantage vary by plan, in 2024, 75% of enrollees paid no added premium besides the mandatory fee for Part B.

As of 2024, roughly 32.8 million people were enrolled in a Medicare Advantage plan. That accounts for 54% of the Medicare-eligible population. Now that he's confirmed, Oz will likely try to increase these numbers.

Oz's support for MA plans

Oz has long been a staunch supporter of Medicare Advantage plans. In a 2020 *Forbes* article he co-authored, Oz said that Medicare Advantage enrollees get superior care thanks to competing plans. As the article stated, Medicare Advantage offers "much better benefits, care coordination, quality controls, levels of performance accountability and cash-flow models for implementing and delivering continuously improving models of care."

The article went further, though, proposing a new "Medicare Advantage for All" program that would provide coverage to every American who is not eligible for Medicaid.

Oz proposed funding such a program with "an affordable 20% payroll tax" to be split evenly among employees and their employers, similar to how Federal Insurance Contributions Act (FICA) taxes are paid today. He also argued that a shift toward Medicare Advantage for All would save taxpayers money.

Whether the program would realize those savings is not settled. A 2023 report by the Physicians for a National Health Program found that Medicare Advantage overcharges taxpayers by anywhere from $88 billion to $140 billion per year.

Even if Medicare Advantage for All doesn't take off, it's likely Oz will, at the very least, try to expand Medicare Advantage enrollment. Whether that includes improvements to these plans, however, is yet to be determined.

Medicare Advantage plans have their flaws

Many consumers like their Medicare Advantage plans, but problems have been mounting.

Prior authorization. Most Medicare Advantage plans subject enrollees to prior authorization requirements that commonly lead to delays in care and, in some cases, denials of care.

As of 2024, 99% of Medicare Advantage enrollees participated in plans with prior authorization requirements. These requirements can apply to expensive diagnostic tests, durable medical equipment and inpatient hospital stays. By contrast, original Medicare

rarely requires prior authorization, eliminating bottlenecks and giving seniors quicker access to care.

Limited provider choice. Medicare Advantage plans also commonly limit participants to narrow provider networks, whereas enrollees in original Medicare can see any provider in the country where Medicare is accepted.

Hospital systems are increasingly cutting ties with some Medicare Advantage plans due to factors such as slow reimbursements and excessive prior-authorization requirements. As of early 2025, 22 health systems have dropped Medicare Advantage plans, according to Becker's Hospital Review.

Higher costs for Advantage plans .... sometimes. There are also conflicting reports as to whether patients face higher out-of-pocket costs under original Medicare vs Medicare Advantage.

Estimated monthly out-of-pocket costs were 18% to 24% lower in Medicare Advantage than original Medicare for a typical enrollee from 2014 to 2019, according to a November 2024 Health Affairs study. However, in some cases, original Medicare plus a Medigap supplement could result in lower costs.

Medicare Plans K and L, for example, cap out-of-pocket spending for 2025 at $7,220 and $3,610, respectively. The out-of-pocket maximum for Medicare Advantage plans is $9,350 for in-network services and $14,000 for both in and out-of-network costs in 2025, but some plans set lower limits.

The issue, too, is that as people age, their health care needs tend to increase, and as Medicare Advantage enrollees get sicker, they tend to experience higher levels of coverage denials. The rate of older adults in the final year of their lives leaving Medicare Advantage and switching to original Medicare doubled from 2016 to 2022, per *The Wall Street Journal* (paywall), netting Medicare Advantage insurers more than $6 billion and sticking taxpayers with the bill.

The Medigap trap. Many people signing up for Medicare Advantage plans don't realize that if they decide to go back to original Medicare, they might not be able to get a Medigap plan for supplemental coverage. That's because Medigap plans are typically only available in most states in the first six months after you become eligible for Medicare.

Conflicts of interest

New appointees under Trump might have conflicts of interest with the Medicare Advantage insurance industry in several ways.

Trump has appointed Don Dempsey as associate director of the Office of Management and Budget's health programs. This position grants Dempsey control over the CMS, and thus Medicare, purse.

Dempsey most recently served as the vice president of policy and research at the Better Medicare Alliance, a lobbying organization for the Medicare Advantage industry. According to the *Financial Times* (paywall) and *Newsbreak*, the organization is funded by Humana and UnitedHealth, the two largest Medicare Advantage companies in the U.S.

There's also the question of Oz's ties to health care companies and investments that have helped him amass his personal fortune — ties that present as a conflict of interest for anyone tasked with heading up the CMS. *The New York Times* puts the value of his business and family ventures at $90 million to $335 million.

In a recent ethics filing, Oz disclosed investments in a broad swath of health-related companies and products. He has said that he would sell his positions in dozens of companies to avoid a conflict of interest. Those include as much as $600,000 in stock in UnitedHealth Group, the nation's largest provider of the Medicare Advantage plans, which Oz has been known to tout

Oz also pledged to resign from paid advisory positions.

But Oz's financial entanglements leave questions about the nature of certain business relationships.

"I can't even tell from his disclosures what direct or indirect arrangements he has," Kathleen Clark, a law professor at Washington University in St. Louis who specializes in government ethics, told *The New York Times*. Even if Oz divests from companies that present a conflict of interest, he would also need to extricate himself from years of endorsements.

Christopher Krepich, a spokesman for Oz, said that Oz was cooperating with the Office of Government Ethics and would comply with its rules.

How Medicare might change

As head of the CMS, Oz will likely favor Medicare Advantage plans over Medicare. Project 2025, a controversial Heritage Foundation plan for overhauling the government that now has Trump's support, has proposed making Medicare Advantage the default choice.

Under Oz's lead, the hope is that he'll also work to improve Medicare Advantage. For example, limiting the number of services subject to prior authorization could help streamline care for older Americans and potentially lead to better outcomes.

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West Wing Playbook: Remaking Government

Your guide to Donald Trump's unprecedented overhaul of the federal government.



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Mass firings hit speed bump at HHS

By **SOPHIA CAI**, **ADAM CANCRYN**, **LAUREN GARDNER**, **BEN JOHANSEN** and **IRIE SENTNER** | 03/31/2025 06:14 PM EDT

Welcome to POLITICO's West Wing Playbook: Remaking Government*, your guide to Donald Trump's unprecedented overhaul of the federal government — the key decisions, the critical characters and the power dynamics that are upending Washington and beyond.*

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A sweeping layoff plan affecting more than 10,000 employees at the Department of Health and Human Services was abruptly delayed Friday over growing backlash with how the process was being orchestrated by **BRAD SMITH**, the DOGE lead at HHS, two officials tell POLITICO.

At the center of the controversy is Smith's secretive approach and his attempts to shield one HHS agency he has ties to from the reduction in force process, according to the two officials as well as two others, all granted anonymity to describe the sensitive conversations. The fallout has laid bare internal tensions within DOGE and raised questions about transparency in one of the most consequential restructuring efforts of the federal workforce.

Critics say Smith, who led the Center for Medicare and Medicaid Innovation during President **DONALD TRUMP**'s first administration, is maneuvering to spare the Centers for Medicare & Medicaid Services, which houses CMMI, from the brunt of the layoffs, leading to a rare internal revolt within DOGE.

Smith and his top aide, **RACHEL RILEY**, "keep everything close to their chest. The playbook isn't clear, whereas everywhere else, the playbook is very clear," said one HHS official granted anonymity to speak candidly. They "are isolationists."

Riley has drawn further scrutiny for her role in controlling access to the master plan that outlines in granular detail where cuts will fall across HHS. Riley, according to the HHS official, did not share the data files with many of the very people responsible for executing the layoffs — career staff and department heads — thus creating bottlenecks and confusion.

The backlash reached a boiling point at the end of last week, when department heads and senior leadership were learning about expected layoffs from news reports, according to the two people with direct knowledge of the matter. That prompted HHS chief of staff **HEATHER FLICK** and other department senior leadership to temporarily delay the RIF rollout.

An HHS spokesperson said that RIF notices did not go out on Friday so that all the data could be triple checked over the weekend, and that the restructuring process has been collaborative between the DOGE and HHS teams.

Each division built a plan to cut their personnel to 90 percent of Fiscal Year 2019 levels, the spokesperson said, and no division was exempted from that process. However, some parts of HHS had grown more than others over that time period.

Neither Smith nor Riley returned requests for comment. A DOGE spokesperson did not respond to a request for comment.

Smith co-founded a telehealth startup called CareBridge in 2019 before in 2021 founding Russell Street Ventures, a Nashville-based health care incubator, and later Main Street Health, a rural-focused provider network. Smith has since sold CareBridge, but he remains tied to Main Street Health, which is subject to regulation by CMS.

Smith worked closely with senior CMS officials in crafting the RIF plan, ultimately incorporating suggestions that reduced the overall impact on the agency — a contrast from other HHS agencies where he played a smaller role, according to one of the people familiar with the matter.

A revised timeline for the firings has not yet been announced, but those working on the HHS plan worked throughout the weekend to get the process back on track.

Today, CMS abruptly canceled a previously scheduled all-staff meeting with no explanation, said three people familiar with the matter granted anonymity to describe internal dynamics. But elsewhere in HHS, other employees received notices that RIFs might go out as soon as this evening, according to two others familiar with the matter and a document obtained by POLITICO. Still, the recipients acknowledged that it was only a best guess, and the timing could still change.

David Lim contributed to this report.

MESSAGE US — West Wing Playbook is obsessively covering the Trump administration's reshaping of the federal government. Are you a federal worker? A DOGE staffer? Have you picked up on any upcoming DOGE moves? We want to hear from *you* on how this is playing out. **Email us at westwingtips@politico.com.**

Did someone forward this email to you? Subscribe!

POTUS PUZZLER

What was the "White House Gang" of the early 1900s?

(Answer at bottom.)

MUSK RADAR

NEW BOSS AT USIP: A 28-year-old DOGE official has been tapped as the acting president of the U.S. Institute of Peace, the embattled organization where employees faced mass firings over the weekend.

According to a federal court filing today, **NATE CAVANAUGH**, a tech entrepreneur who the New York Times reported has been interviewing people at the General Services Administration for DOGE, will be tasked with transfering the institute's property to GSA, which manages the government's leases, according to the filing. In the filing, lawyers for USIP are requesting that the court blocks the transfer of USIP property to GSA.

Earlier this month, DOGE staff surreptitiously gained access to USIP's headquarters after some of the institute's employees blocked DOGE members from entering.

WHO'S GOT ACCESS: New government disclosures released over the weekend show the broad access members of DOGE have gained to sensitive government systems, our **KYLE CHENEY** and **JOSH GERSTEIN** report.

Discovery No. 1: **MARKO ELEZ**, who was fired from the Treasury Department last month after the discovery of his racist social media posts, has been working for weeks on sensitive systems at HHS. Elez is also part of DOGE's core White House staff and has been detailed to at least four other government agencies, according to the documents.

Other revelations:

- DOGE's **LUKE FARRITOR** has access to 12 sensitive systems, including those that handle Medicare and Medicaid payments, contracts and acquisitions; National Institutes of Health grants and general HHS grants.
- One employee detailed to the GSA, **KYLE SCHUTT**, has access to a database of "Unaccompanied Alien Children."
- DOGE acting administrator **AMY GLEASON** has been working on efforts to modernize Medicare and Medicaid payment systems.

ELON THE CHEESEHEAD: Musk was in Wisconsin on Sunday to lay out why he supports the Republican candidate in Tuesday's high-profile state Supreme Court race, our **SHIA KAPOS** reports, and to explain why he awarded million-dollar checks to two Wisconsin residents who signed an America PAC petition opposing "partisan" judges.

"It's to call attention" to the race, he told a crowd of about 2,000. The giveaways have sparked criticism for potentially violating election laws that bar giveaways in order to persuade voters.

The race will determine the balance of the court and serve as a litmus test for how voters are feeling nine weeks into the second Trump administration.

MAKING THEIR WAY IN: Over the weekend, DOGE gained access to a payroll system that processes salaries for about 276,000 federal workers across dozens of agencies, NYT's **CORAL DAVENPORT** reports. That was despite objections from senior IT staff who feared the DOGE access could compromise highly sensitive government personnel information, including the possibility of making it more vulnerable to terrorist cyberattacks.

DOGE now has visibility into sensitive employee information, including Social Security numbers, and the ability to more easily hire and fire workers.

IN THE COURTS

HOW THE TURNTABLES: Trump and his allies have in recent weeks called for the impeachment of at least five federal judges who have issued injunctions against administration actions, including DOGE moves to gut the federal government. But in past years, especially under **JOE BIDEN**'s administration, those same Trump allies celebrated judicial injunctions.

Two years ago, Trump praised a federal judge's ruling which blocked the Biden administration from communicating with social media companies. "Just last week in a historic ruling, a brilliant federal judge ordered the Biden administration to cease and desist from their illegal and unconstitutional censorship and collusion with social media," he said at a Turning Point Action summit.

In December, Trump applauded when a federal judge blocked the Biden administration from disposing of materials used for Trump's promised Southern border wall before his inauguration. And in 2021, **STEPHEN MILLER**'s America First Legal Foundation asked for injunctions against the Biden administration, including one on the federal employee Covid-19 vaccine mandate.

AGENDA SETTING

IMPACT FELT: A 7.7-magnitude earthquake struck Myanmar on Friday. But as WaPo's **REBECCA TAN** reports, Trump and DOGE's cuts to USAID have stifled American response to the cleanup. Hours after the earthquake, the American officials charged with responding to the disaster received their termination letters. Most of the personnel who would have made up the U.S. response team, including security and sanitation efforts, were already on indefinite leave.

The programs that would have provided life-saving materials, including fuel and medical kits, were axed weeks ago. Trump pledged that America would provide $2 million in aid. But USAID officials say distributing the relief will be more difficult than ever, because the U.S. has severed valuable ties with local organizations and fired staff who would have restored those relationships.

GOT TWO MONTHS, BUDDY: The SEC and Musk agreed to give the president's billionaire adviser another nine weeks to respond to the SEC's lawsuit tied to his purchase of Twitter stock in 2022, our **DECLAN HARTY** reports. Musk will now have until June 6 to respond to the lawsuit, which revolves around the issue of when Musk first publicly disclosed his purchases of Twitter stock.

NOT CONVINCED: Trump has yet to win over Republicans with his push to transfer the Education Department's $1.6 trillion student loan operation to another agency slated for deep staff cuts, our **REBECCA CARBALLO** reports. Trump initially was expected to transfer the portfolio to the Treasury, but instead, he plans to fold it into the Small Business Administration, surprising many lawmakers and conservatives.

Republicans are concerned about the size of the debt and the staffing needed to manage the system of servicers, borrowers and loan applications. "A lot of us were thinking it would go to the Treasury. We're talking about the huge nature of student loans," House Education and Workforce Chair **TIM WALBERG** (R-Mich.) said in an interview.

KNIVES OUT

ELEPHANT(S) IN THE ROOM: A special election in Florida's deep-red 6th Congressional District has enthused Democrats enough to bring out DNC Chair **KEN MARTIN** to canvas the area over the weekend. Half way through

a 25-minute interview with our **KIMBERLY LEONARD**, Martin didn't once bring up the Republican candidate, **RANDY FINE**. Instead, Trump and Musk were on his mind.

"I haven't heard much about him at the doors, to be honest with you," Martin said of Fine. "And so I think this race is about Donald Trump and Elon Musk and people's deep dissatisfaction with what's happening."

WHAT WE'RE READING

She Devoted Her Life to Serving the U.S. Then DOGE Targeted Her. (NYT's Eli Saslow)

Two Republican senators wrestle with how to handle DOGE cuts (WaPo's Theodoric Meyer)

The Great Grovel: How Trump forced elite institutions to bend to his will (POLITICO's John F. Harris and POLITICO Staff)

Steven Cheung Is The Voice of Trump (The Atlantic's Elaine Godfrey)

POTUS PUZZLER ANSWER

The White House Gang was a group of rambunctious children led by **QUENTIN ROOSEVELT**, the youngest of former President **THEODORE ROOSEVELT**'s children. The other members were **ARCHIE ROOSEVELT**, **CHARLIE TAFT**, the son of then-Secretary of War **WILLIAM HOWARD TAFT**, and a few other boys who went to school with Quentin. According to the Theodore Roosevelt Center, the members conducted their "official business" meetings in the attic of the executive residence.

The boys' antics would from time to time upset the president. "In 1908, [President Roosevelt] caught the boys decorating Andrew Jackson's official portrait with well-placed spitballs," the center wrote. "Eager to teach them a lesson about respecting the property of others, the president conducted a hastily arranged 'trial.'

"After finding the conspirators guilty, TR banished the gang members from the White House for one week. 'Portraits,' recalled one gang member, 'were henceforth taboo,'" according to the center.

A CALL OUT! Do you think you have a harder trivia question? Send us your best one about the presidents, with a citation or sourcing, and we may feature it!

Edited by Noah Bierman, Jennifer Haberkorn, and Kaitlyn Locke.

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POLITICO

EXCLUSIVE

Wellness CEO files ethics complaint against top RFK Jr. adviser

An internal MAHA battle is breaking out between an HHS employee who co-founded a health care payments company and a CEO of a rival company.



American entrepreneur and special government employee for Health and Human Services Calley Means speaks during a news conference at the Health and Human Services Department on April 22, 2025, in Washington. | Andrew Harnik/Getty Images

By DANIEL BARNES
05/12/2025 08:14 PM EDT

An internal battle has emerged inside the 'Make America Healthy Again' movement, with the CEO of a supplements company and a top adviser to Health and Human Services Secretary Robert F. Kennedy Jr. leveling accusations against each other that include making threats of retribution, conflicts of interest and leaking false information to far-right activist Laura Loomer.

At the center of the fight are Peter Gillooly, CEO of The Wellness Company, and Calley Means, who in addition to serving as an adviser to RFK Jr. is the co-founder of a health care payments company and the brother of Casey Means, who was recently nominated to be the next surgeon general by President Donald Trump.

In a formal complaint to the Office of the Special Counsel and other agencies filed Saturday and obtained by POLITICO, Gillooly accuses Calley Means of abusing his position at HHS and violating the law prohibiting conflict of interest in government services by threatening to involve Kennedy and National Institutes of Health Director Jay Bhattacharya in the dispute.

“If one more thing happens, I’m going to go to Jay Bhattacharya and Bobby and tell him that you and your cadre of Peter McCullough and Kelly Victory are spreading lies and trying to fuck with him and hurt his administration,” Means said, naming two members of the company’s medical board, in a recording of a Saturday morning call between him and Gillooly obtained by POLITICO. (The transcript of the call is quoted in the complaint.)

During the call, Means accused The Wellness Company, a supplement vendor led by a medical board of vaccine opponents that is regularly promoted on conservative media, of leaking false information about his own company, Truemed, to Loomer. Truemed provides customers with doctors’ letters that allow them to use pre-tax dollars to purchase health and wellness products via their health insurance plans.

“I am going to sue the shit out of you and escalate this if it continues,” said Means, who is currently serving as a special government employee. In that role, Means is allowed to serve in a temporary capacity without having to step away from his personal business.

The dispute puts on display the competing interests within Kennedy’s MAHA movement which has swiftly gained power and influence during Trump’s second term. The MAHA coalition has reshaped the federal government’s approach to health care as Kennedy has ousted roughly 25 percent of HHS staff and empowered vaccine opponents, wellness entrepreneurs and alternative medicine advocates with little to no government experience.

“I received information that the Wellness Company was actively spreading provably false information about Truemed,” Means said in a statement to POLITICO. “I called the CEO of the Wellness Company and threatened legal action if he continued to spread this provably false information. I noted I would prefer they stop spreading provably untrue information before I was forced to take legal action.”

A lawyer for Truemed sent a cease and desist letter to Gillooly and The Wellness Company founder Foster Coulson on Monday, stating they have reason to believe the company

spread false information about Truemed with Loomer for the purposes of embarrassing a competitor, according to a copy of the letter obtained by POLITICO.

Coulson denies sharing information with Loomer. “I have never spoken to Laura Loomer in my entire life,” Coulson told POLITICO. “Using the government to essentially weaponize them against a private company is extremely concerning and is a tremendous threat.”

The confrontation appears to have been prompted by a Friday post on X from Loomer accusing Means and Truemed of committing tax fraud by auto-generating doctors’ letters without authentic medical review.

Reached by POLITICO, Loomer denied being sent any information about Means and said she did not know Coulson. “I look up stuff on my own,” Loomer said.

Means accused Coulson of sharing “incorrect information” about Truemed with people like Loomer, possibly as part of an effort to cut in on Truemed’s business. Following Truemed’s business model could save The Wellness Company’s customers 30-40 percent on their supplements, Means told Gillooly during the call. “Now, that should be something that you guys partner with us on but since you guys have a telehealth platform and if you guys wanted to do that and compete that would be maybe even a good idea,” Means said.

“He clearly states that if I do not accept his accusation and comply — which I am not guilty of in the first place — he will sue myself and my business,” Gillooly wrote in the complaint. “Additionally, Means threatens to blackmail my private corporation with HHS executive leadership if we do not comply with his demands, and extort my business into transacting with Truemed.”

“I think there needs to be a thorough investigation because this sort of behavior has no place in the federal government,” Gillooly told POLITICO.

The complaint was submitted Saturday to the Office of Special Counsel, HHS Office of Civil Rights, HHS Office of Inspector General and the Federal Trade Commission.

“In order to protect the integrity of our investigative process, HHS is unable to confirm any specific investigations or inquiries that may be taking place within the office,” an HHS spokesperson said in a statement. “The Office of Civil Rights thoroughly reviews each complaint and determines if it has the legal authority to review and investigate the complaint.”

The Office of Special Counsel, which handles complaints of government employee wrongdoing, and the HHS inspector general declined to comment. The FTC did not respond to a request for comment.

Learn more about LSEG

White House names Kennedy ally Means as health adviser, source says

By **Reuters**

March 18, 2025 6:33 PM EDT · Updated 3 months ago

March 18 (Reuters) - The White House has appointed Calley Means, an ally of U.S. Health and Human Services Secretary Robert F. Kennedy Jr., as a White House adviser working on Make America Healthy Again issues, a source familiar with the situation said on Tuesday.

Means' role will be focused on food policy and addressing the influence of corporations on health and food policy, according to Bloomberg, which first reported the news.

Feedback

> The Reuters Tariff Watch newsletter is your daily guide to the latest global trade and tariff news. Sign up here.

Means, an entrepreneur and author, will assist the Make America Healthy Again Commission that President Donald Trump created via an executive order last month.

Reporting by Sneha S K and Michael Erman; Editing by Alan Barona, Caroline Humer and Sandra Maler

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RFK Jr. and Trump are torpedoing Alzheimer's research

Boston Sunday Globe · 2 Mar 2025 · By Katherine O'Malley

Robert f. Kennedy Jr., newly confirmed as secretary of Health and Human services, is famous for critiquing what many consider settled science and promoting conspiracy theories.



He could soon make himself known for something new: becoming the first HHs secretary to torpedo Alzheimer's research.

Kennedy and the trump administration are turning the clock back on decades of Alzheimer's research by eliminating diversity in clinical trials, slashing funding for cutting-edge projects, and firing employees who conduct some of the most rigorous research in the world.

At his January confirmation hearing before the Us senate finance Committee, Kennedy attacked the national institutes of Health's research record on Alzheimer's disease, rarely a hot-button topic in Congress. Kennedy accused the niH of funding fraudulent Alzheimer's research in the early 2000s and wasting two decades of time and money.

Like much of what RfK Jr. says, there is a kernel of truth to that, enmeshed in an otherwise misinformed hot take.

During his confirmation hearing, he referenced a 2006 nature article investigating the accumulation of a protein in the brain, amyloid-beta 56, and memory impairment in mice. Kennedy is right — that particular paper was fraudulent. We later learned that the lead author of this paper doctored images to fit his hypothesis. the paper was retracted in 2024, and the scientist resigned from his position at the University of minnesota in february.

this conduct has no place in research and can diminish public trust in science and the institutions that fund it.

but Kennedy's statement is misleading. He conflates this isolated instance of fraud with an assertion that investigating amyloid in Alzheimer's writ large has been a waste of time. An abandonment of amyloid in Alzheimer's research at the niH would be incredibly dangerous. Contrary to his claims, mountains of rigorous research support amyloid's central role in developing Alzheimer's and other types of dementia.

Conceived in 1992 by John A. Hardy and gerald A. Higgins, the "amyloid cascade hypothesis" asserts that an abnormal accumulation of amyloid in the brain leads to the buildup of another protein, tau, resulting in the death of brain cells. Ultimately, this cascade leads to cognitive impairment and dementia.

this hypothesis, and the overwhelming presence of abnormal amyloid plaques in patients' brains, led to a wave of therapies targeting amyloid.

three therapies have hit the market in just the last four years: Aduhelm, Leqembi, and Kisunla (Aduhelm was pulled in 2024 after a lackluster launch). Leqembi and Kisunla are not cures for Alzheimer's, but they have demonstrated statistically significant slowing of cognitive decline in patients with earlystage Alzheimer's disease in clinical trials.

these therapies are the first to attack the disease's pathology and not just alleviate its symptoms. for nearly 7 million Americans living with Alzheimer's and their caregivers, this is good news. to them, this is 20 years of research that has produced something tangible.

but the field has also evolved since the amyloid cascade hypothesis was conceived. We now believe that amyloid is one piece of a very complex puzzle.

to that end, Kennedy is wrong to suggest that the niH has killed off any other stream of research that doesn't concern amyloid. on the contrary, the niH funds 495 active clinical trials for Alzheimer's and related dementia. sixty-eight of these trials focus on drug development. only 12 investigate amyloid. the niH also funds 157 trials on non-pharmaceutical approaches to preventing Alzheimer's, including exercise (41), sleep (17), and diet (five). this surely fits into RfK Jr.'s "make America Healthy Again" agenda.

it's time for Kennedy and the trump administration to refocus their efforts on truly making America healthy. When it comes to Alzheimer's research, there are immediate actions that could effect change.

for starters, the trump administration should reinstate and support elements of diversity, equity, and inclusion in public health agencies, including the niH.

DEi in research means that all populations, regardless of race, ethnicity, or gender, are included in rigorous science to find the best treatments and cures possible.

two-thirds of Americans with Alzheimer's are women. older black and Hispanic Americans are at greater risk of developing the disease than their white counterparts. We cannot investigate Alzheimer's disease without considering DEi.

in addition, the administration must maintain Alzheimer's research funding. Doing anything less would be a threat to decades of progress.

the trump administration has already moved to cut niH funding, and RfK Jr. has called for an eightyear "pause" on research into drug development.

instead of allowing the Alzheimer's research budget to be dictated by the executive branch, we should let niH scientists tell Congress what they need. As required by the national Alzheimer's Project Act, niH scientists use a rigorous, evidencebased process to create an "niH Professional Judgment budget," presented annually to the president and Congress, identifying exactly how much funding is required for Alzheimer's research.

in 2024, Congress reached a bipartisan deal to fund an additional $100 million for Alzheimer's research at the niH, bringing the total funding to about $3.8 billion, the biggest investment ever in the disease. that deal was informed and supported by the niH Professional Judgment budget, and it should stay that way, as required by law.

the future of Alzheimer's research, treatment, and finding a cure could be devastated by RfK Jr. and the trump administration. Yet the 7 million Americans already living with the disease — as well as the millions more expected to contract the disease in the coming decades — don't have time to waste.

Katherine O'Malley is a policy analyst at the Partnered EvidenceBased Policy Resource Center with the Boston University School of Public Health.



Q: On June 9, RFK Jr. fired all 17 members of the Centers for Disease Control and Prevention's (CDC) Advisory Committee for Immunization Practices (ACIP), the panel that helps guide the CDC's vaccine decisions. Two days later, he named eight new members to the panel, including several vaccine critics, according to news reports. What is your reaction to these changes?

A: ACIP has long been a trusted and valued source of guidance on vaccines and vaccination policy. The stature of ACIP is conferred by the people who have been on it, who have been vetted and who are experts in infectious diseases, in vaccines, in clinical trials, and by their rigorous and transparent evaluation of scientific and clinical data. The new members of ACIP are hand-picked by RFK Jr. and most have no evident expertise in vaccines, clinical trials, or infectious diseases. Many of them have been critical of vaccines.

This wholesale replacement is consistent with RFK Jr.'s vocal opposition to vaccines and means that we can anticipate that policy emerging from this new ACIP will be shaped by an anti-vaccine attitude. Take, for example, the change in guidance from HHS—issued without going through the formal review process and before the replacement of the ACIP members—to no longer recommend COVID-19 vaccines for children and during pregnancy. We should expect more of the same.

There are implications for insurance coverage, as insurers are required to fully cover ACIP-recommended vaccines. Pulling back on vaccine recommendations could then result in only those who can afford vaccines getting immunized, a situation that would exacerbate health disparities.

What happens when the inevitable conflicts arise between this new ACIP and medical societies—many of which have already objected to the HHS decision not to recommend COVID-19 vaccination in pregnancy? Where do people go for trustworthy information? Will private insurance companies, Medicare, and Medicaid cover vaccine costs even if the vaccines are not recommended by ACIP?

It's not clear how this will play out, but we should be concerned that reductions in vaccination rates will result in illness and suffering that could have been prevented.

Q: In explaining his firing of the former ACIP members, RFK Jr. wrote in a Wall Street Journal commentary that the committee "has been plagued with persistent conflicts of interest." Is there validity to this claim?

A: The former ACIP members are well-respected experts who were rigorously vetted, who disclosed their conflicts of interest—existing and potential—as part of the evaluation process, and who are subject to stringent rules around conflicts while serving on ACIP. It seems that RFK Jr. was deliberately misleading about the extent of conflicts and implied nefarious hidden motivations to justify firing all of the ACIP members and undermining the legitimacy of their recommendations.

Q: RFK Jr. has made other recent moves having to do with vaccines, including launching a government study on autism led by someone who has previously promoted debunked links between vaccines and autism; changing recommendations for COVID vaccines; and pulling back on vaccine research and development, such as canceling a contract with drug company Moderna to develop a new flu vaccine using mRNA technology, which was used to make COVID vaccines. Can you comment on the impact of these moves?

A: These moves are in keeping with an agenda to undermine confidence in vaccines and in science. Take the autism example. There is already extensive evidence showing that

vaccines do not cause autism—why do we need another study, unless those doing it want a different answer? It's hard not to think that this new study has a predetermined conclusion.

The changes in recommendations for COVID vaccines are of a piece with the overall anti-vaccine agenda. As laid out in the statement from many medical organizations objecting to the changes, there's strong data laying out both the severe consequences of COVID-19 and the safety and effectiveness of COVID-19 vaccination during pregnancy.

The termination of the contracts for vaccine research is alarming and particularly insidious. These moves prevent advances in knowledge that could have led to new ways of reducing illness and suffering.

I have a similar concern about the reduction in funding for biomedical research in this country and the efforts to prevent the best students in the world from coming to the U.S. to do their work and contribute to science. While it's hard to quantify the gains we won't see—the advances in new treatments for a wide range of conditions that are now stymied—you can look at all the recent new treatments for cancer, obesity, heart disease, and other advancements and know that the engine that has led to all that innovation is going to slow and sputter.

Q: More than 1,000 cases of measles have been confirmed in the U.S. so far this year, making it one of the worst outbreaks of the disease since 2000. That year, measles was declared eliminated due to the success of vaccination efforts, according to the CDC. What are your thoughts about what is driving this current outbreak and about the government's response?

A: As of June 13, the CDC reported 1,197 confirmed cases of measles in the U.S.—certainly an underestimate of the total number of cases—and three deaths.

A critical point here is that measles is preventable. The vaccine works exceptionally well. Two doses of the vaccine are 97% effective at preventing measles and a single dose is 93% effective. We're having these big outbreaks because measles—which is highly contagious—is spreading among populations of unvaccinated individuals.

The government's response should be to heavily promote vaccination with the MMR [measles-mumps-rubella] vaccine. Instead, we've seen the HHS secretary incorrectly state that there are—in his words—"many, many good ways to treat measles." There aren't. There is no cure for measles, and it is irresponsible to promote, as he has done, clarithromycin [an antibiotic] and budesonide [a corticosteroid] as cures.

Bloomberg Government

RFK Jr. Commits to Divesting Interests in HPV Vaccine Litigation

Jan. 31, 2025, 6:55 PM EST

- **Kennedy says he will reassign stake in litigation to son**
- **Change in course follows intense lawmaker scrutiny**

Robert F. Kennedy Jr. pledged to divest his financial stakes in lawsuits against Merck, the producer of HPV vaccine Gardasil, according to written responses provided to lawmakers on the Senate Finance Committee.

Kennedy, who has been tapped by President Donald Trump to lead the Health and Human Services Department, wrote he would amend his ethics agreement to the Office of Government Ethics to reassign his financial claims “via an assignment to my non-dependent, adult son.”

The change in course from Kennedy comes as Democrats lambasted the nominee during confirmation hearings this week for profiting off of lawsuits against vaccines. ...

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The latest "Podnosis": A bold bet on sharing real-time patient data

REGULATORY

RFK Jr. says HHS will reinstate 20% of reduced workforce after DOGE errors

By **Noah Tong, Dave Muoio, Emma Beavins** · Apr 4, 2025 9:09am

Robert F. Kennedy Jr. | Department of Hea th and Human Serv ces (HHS) | Dona d Trump | ayoffs



The cuts are the cu m nat on of months of p ann ng by the Trump adm n strat on. (Getty mages/Kev n D etsch)

Editor s Note: *This is a developing story. If you are a dismissed or active federal worker with information to share, please reach out at ntong@questex.com* (https://mailto:ntong@questex.com/)

Updated: April 4 *at 9:54 a.m. ET*

Secretary Robert F. Kennedy Jr. told reporters April 3 the Department of Health and Human Services (HHS) estimated 2,000, or 20%, of the recent job cuts at the department were done in error, adding reinstatements were always part of the plan.

As part of an effort by the Department of Government Efficiency (DOGE) and Kennedy, the health divisions cut their workforce by 10,000 people this week. The cuts only further the agency s downsizing efforts, as seen by previous early retirement, buyout and probationary firings at HHS and across the federal government.

Personnel that should not have been cut, were cut, Kennedy told CBS News during a stop in Virginia. We re reinstating them. And that was always the plan. Part of the DOGE, we talked about this from the beginning, is we re going to do 80% cuts, but 20% of those are going to have to be reinstated, because we ll make mistakes.

Kennedy said during the stop the Centers for Disease Control and Prevention s Lead Poisoning and Prevention and Surveillance Branch was slashed in error. HHS did not respond to a request for comment.

The layoff plans had been unveiled on March 27, though HHS workers didn t begin receiving termination notices until early Tuesday morning.

The wide-reaching job cuts affected employees at the Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration, the CDC and more. While the full extent of the cuts are still developing, early indications suggest entire offices are now shuttered.

A notice of intent written by the HHS and sent to employees—later passed on to union leaders and obtained by Fierce Healthcare—stresses the valuable contributions made by the impacted workers, but reiterated the importance of the department s broader strategy.

Another document obtained by union officials show impacted employees were encouraged to contact Anita Pinder, former director at the Office of Equal Opportunity and Civil Rights at the CMS, who died in November.

At the FDA, the Office of Management is one of the causalities, according to one individual with knowledge of the situation who agreed to share anonymously with Fierce Healthcare under fear of retribution. This office provides services and resources to the Center for Drug Evaluation and Research, a government page explains (https://www.fda.gov/about-fda/cder-offices-and-divisions/office-management). Many FDA employees were locked out of the headquarters April 1.

There were also huge cuts at the National Center on Birth Defects and Developmental Disabilities and the National Institute of Occupational Safety and Health (NIOSH). Within NIOSH is the National Personal Protective Technology Laboratory, which approves N95 respirators and other protective equipment. Closing this office in Pittsburgh, Pennsylvania, as reported, will directly strengthen rival countries to the U.S., said Eric Axel, the executive director of the American Medical Manufacturers Association.

This decision effectively rewards foreign manufacturers who have not made the same investments in quality and safety while punishing American companies that have built their reputations on producing reliable, high-quality protective equipment that meets a global standard, said Axel.

Elsewhere, the entire Freedom of Information Act office, which helps the public understand the innerworkings of a government agency, was eliminated (https://www.cbsnews.com/news/rfk-jr-purges-cdc-fda-records-transparency-teams/) at the CDC and slashed dramatically at the FDA, reported media outlets. Another team focused on infertility was laid off, reported (https://www.huffpost.com/entry/trump-presidency-live-updates_n_67e55ccce4b0d5fb5f3d85c1) The Huffington Post, and communications offices throughout HHS faced heavy reductions (https://www.cbsnews.com/news/rfk-jr-purges-cdc-fda-records-transparency-teams/). The Substance Abuse and Mental Health Services Administration was similarly affected (https://www.govexec.com/workforce/2025/04/cancer-researchers-opioid-abuse-analysts-infectious-disease-experts-layoffs-hhs-begin-take-shape/404 Other top officials at the National Institute of Allergy and Infectious Diseases, the CDC and FDA were offered a transfer (https://www.statnews.com/2025/04/01/hhs-leaders-offered-transfers-to-indian-health-service/?utm_campaign daily_recap&utm_medium email&_hs to the Indian Health Services. And the Administration for Community Living, which handles aging and disability policy and handles Meals on Wheels, faced cuts of at least 40% (https://www.npr.org/sections/shots-health-news/2025/04/01/g-s1-57716/hhs-layoffs-seniors-disabled-liheap-acl).

The cuts don t stop there. Also eliminated is the HHS Office of Infectious Disease and HIV Policy under a reorganization of HHS.

The expertise of the staff, along with their decades of leadership, has now been destroyed and cannot be replaced, said Carl Schmid, executive director of the HIV Hepatitis Policy Institute. We will feel the impacts of these decisions for years to come and it will certainly, sadly, translate into an increase in new HIV infections and higher medical costs.

And in the CDC, the deletion of a tobacco control program spells great trouble in tracking tobacco use and running prevention programs, which are not duplicative roles to tobacco product regulation at the FDA, said former CDC Director Tom Frieden in a LinkedIn post (https://www.linkedin.com/posts/tom-frieden_were-still-learning-about-the-steep-cuts-activity-7312940581448466432-YVLa/?utm_source share&utn

Eliminating CDC's tobacco prevention program would mean less data to inform physicians and parents, weaker state programs, fewer evidence-based strategies, and more people—especially kids—addicted to tobacco, he explained.

Within the Health Resources and Services Administration (HRSA), a fired worker told Fierce Healthcare that the Provider Relief Bureau (https://www.fiercehealthcare.com/regulatory/providers-owe-1b-federal-government-misused-covid-19-emergency-funds-doge-just-cut)—which oversees the integrity of the multi-billion-dollar Provider Relief Fund set up during the pandemic and works to recoup fraudulent payments—has been cut.

A source with ties to HHS said that CMS was largely spared from the April 1 cuts beyond the 300 individuals the department had announced would be cut in the original restructuring announcement on Thursday. The Administration for Children and Families faced deeper cuts, the source said. In a Monday report, insiders

told Politico reporters (https://www.politico.com/newsletters/west-wing-playbook-remaking-government/2025/03/31/mass-firings-hit-speedbump-at-hhs-00261614) that CMS had dodged much of the cuts through the intervention of a DOGE lead whose personal interests are tied to the CMS Innovation Center.

Still, former Deputy Director for the Center for Medicaid and CHIP at CMS Karen Shields posted on LinkedIn that she s heard (https://www.linkedin.com/posts/karen-shields-healthservices_in-the-wee-hours-of-the-morning-today-the-activity-7312804537667338243-LqcY/?utr the entire CMS Office of Equal Opportunity and Civil Rights was eliminated.

Another former agency head, Robert Califf, M.D., who twice served as director of the FDA, said Tuesday morning (https://www.linkedin.com/posts/activity-7312807429178572800-_nD6/?utm_source share&utm_medium member_desktop&rcm ACoAAAACQCYBAjg he was overwhelmed by messages he d received on the firings at his old agency.

The FDA as we ve known it is finished, with most of the leaders with institutional knowledge and a deep understanding of product development and safety no longer employed, he wrote on LinkedIn. I believe that history will see this a huge mistake. I will be glad if I m proven wrong, but even then there is no good reason to treat people this way.

News (https://www.nytimes.com/2025/04/01/us/politics/trump-federal-layoffs-health-food.html) reports (https://www.statnews.com/2025/04/01/hhs-layoffs-start-under-rfk-jr-trump-administration/?utm_campaign rss) have also outlined a slew of high-ranking officials who were let go, placed on administrative leave, pressured to leave the government or decided to do so upon being offered a diminished role at a separate office.

Among these names were Peter Stein, director of the FDAs Office of New Drugs; Brian King, director of the FDAs Center for Tobacco Products; Jeanne Marrazzo, M.D., director of the National Institute of Allergy and Infectious Diseases; Kayla Laserson, director of the CDC s Global Health Center; Julie Tierney, deputy director at the FDAs Center for Biologics Evaluation and Research; and Diana Bianchi, M.D., director of the NIH s National Institute of Child Health and Human Development.

They add to other high-profile departures from the federal health agencies in recent days, chief among which was FDA Center for Biologics Evaluation and Research Director Peter Marks, M.D. (https://www.fiercepharma.com/pharma/cber-chief-peter-marks-telegraphs-exit-fda-industry-watchers-eye-vaccine-cell-gene-hits)

On Tuesday afternoon, Senator Bill Cassidy, R-Louisiana, scheduled a hearing on April 10 for RFK Jr. to explain the cuts. Kennedy promised Cassidy he would appear quarterly before the Senate HELP Committee in exchange for Cassidy s crucial vote to confirm hearing.

The news coverage on the HHS reorg is being set by anonymous sources and opponents are setting the perceptions, he said in a statement. In the confirmation process, RFK committed to coming before the committee on a quarterly basis. This will be a good opportunity for him to set the record straight and speak to the goals, structure and benefits of the proposed reorganization.

The cuts are flatly opposed by numerous groups, including the National Health Council and the Robert Wood Johnson Foundation. RWJF CEO Richard Besser, M.D., called the cuts are reckless and will represent an abdication of the department's essential responsibility to promote and protect health. This will impact many communities, including those with low-income, individuals in rural areas, older adults and people with disabilities, he said in a statement.

Executive order ends collective bargaining at CDC, FDA, others

While these cuts occur, the government is attempting to give itself more leverage to conduct mass layoffs.

President Donald Trump signed an executive order March 27 giving himself authority to end collective bargaining across federal unions, just hours after HHS Secretary Robert F. Kennedy Jr. announced the department could expect 10,000 job cuts in upcoming days.

The executive order said unions with national security missions would be impacted. The order applies to workers at the CDC, FDA, the Department of Veterans Affairs, the National Science Foundation, the HHS Office of General Counsel, the National Institute of Allergy and Infectious Disease, the Administration for Strategic Preparedness and Response (ASPR) and more. Trump s executive order claims current collective bargaining agreements (CBA) allows hostile unions to block a department s agenda.

A memo (https://chcoc.gov/sites/default/files/OPM%20Guidance%20Memo%20on%20Exclusions%20from%20Labor%20Management%20Programs%203-27-202 (PDF) from the Office of Personnel Management was published before the executive order. It said these departments are no longer required to collectively bargain with federal unions. Government agencies were told to limit the required duration of performance improvement plans, makes it easier to fire VA workers with a lower burden of proof, ignore CBA requirements surrounding reductions in force and disregard union protections against return-to-office policy.

On March 31, the 150,000-member National Treasury Employees Union filed a lawsuit against the order, which it said applied to more than 100,000 of its members and would damage the union s ability to collect dues.

One of the largest government labor unions, the American Federation of Government Employees (AFGE), also describe the announcement is a clear threat to its members and all Americans and affirmed plans to block the order in court (https://www.afge.org/article/afge-will-challenge-trumps-illegal-directive-outlawing-federal-unions/).

AFGE is preparing immediate legal action and will fight relentlessly to protect our rights, our members and all working Americans from these unprecedented attacks, said AFGE President Everett Kelley in a statement.

A host of government agencies sued (https://storage.courtlistener.com/recap/gov.uscourts.txwd.1172831290/gov.uscourts.txwd.1172831290.1.0.pdf) (PDF) the AFGE, arguing the current CBAs significantly constrain the executive branch.

The National Treasury Employers Union sued the HHS and other agencies March 3, saying (https://storage.courtlistener.com/recap/gov.uscourts.dcd.279006/gov.uscourts.dcd.279006.1.0.pdf) (PDF) the executive order is unlawful and the CBAs should be respected.

Kennedy details full scope of HHS reorganization

The HHS is set to slash 10,000 full-time jobs and further remake the agency in the Trump administration's vision.

These cuts—in line with the Department of Government Efficiency s (DOGE s) workforce optimization efforts—will save the agency $1.8 billion per year, HHS said in a March 27 morning news release. After factoring in early retirement and the "fork in the road" offering from earlier this year, the agency's total headcount will decrease by 20,000 members.

In an announcement posted online, Secretary Robert F. Kennedy Jr. said good-natured, intelligent employees are bogged down by bureaucracy, with a budget that grew by 38% during the Biden administration.

Approximately 300 cuts will hit the Centers for Medicare and Medicaid Services (CMS). These layoffs will prioritize "reducing minor duplication," but promising the reorganization will not impact Medicare and Medicaid services.

At the FDA, (https://www.fiercebiotech.com/biotech/nearly-5000-fda-and-nih-staffers-laid-hhs-eliminates-entire-alphabet-soup-departments)3,500 workers will be let go. HHS said the cuts will not affect drug, medical device or food reviewers. Inspectors will also not be impacted.

The CDC will fire 2,400 employees, while the National Institutes of Health will slash its workforce by 1,200 workers and "centralize procurement, human resources and communications" across 27 institutes and centers, a fact sheet explains.

During the firing (https://www.fiercehealthcare.com/regulatory/mass-layoffs-hhs-cdc-cuts-1300-probationary-workers-reports-say) of probationary employees earlier this year, in tandem with the Department of Government Efficiency spearheaded by Tesla CEO Elon Musk, employees in these roles were fired and promptly asked to return. These terminations are working through the court system and are currently halted, with many on administrative leave (https://www.fiercehealthcare.com/regulatory/hhs-probationary-firings-reversed-judge-threat-more-terminations-loom) as they wait for more clarification from supervisors and judges. A recent court filing said HHS sent out 3,248 termination notices to probationary employees.

HHS said they do not anticipate cuts beyond these, but the department will seek additional opportunities to "streamlines its operations and agencies."

This will be a painful period for HHS as we downsize from 82,000 employees to 62,000, but we are keenly focused on paring away excess administrators while increasing the number of scientists and frontline health providers so we can do a better job for the American people, Kennedy said.

Senator Ron Wyden, D-Oregon, and former HHS Secretary Xavier Becerra condemned the cuts in statements released the same morning.

American families are going to be hurt by layoffs and closures of this magnitude, full stop," Wyden warned. "These offices work closely with communities to make sure child care, hospitals and nursing homes are safe, strengthen rural health care, and much more. The chaos that is coming will guarantee that kids and seniors fall through the cracks with deadly consequences."

It s hard to make sense of the HHS cuts announced this morning, said Becerra. This has the makings of a manmade disaster.

Offices to be consolidated

The department said there are 28 redundant offices that will be consolidated into 15 new divisions, and 10 regional offices will become five. Kennedy claimed there are more than 100 communications offices, more than 40 IT offices, a dozen procurement offices and nine human resource departments—all operating in silos without communicating together.

“Some of these little fiefdoms, for example, are so insulated and territorial that they actually hoard our patient medical data and sell it for profit to each other,” Kennedy said, adding some public health divisions are “neglecting” public health and are only interested in helping the industries they are supposed to regulate.

Kennedy accused some health divisions of not working in the best interest of Americans, a characterization that is sure to be criticized by Democratic lawmakers and current government employees.

Tammy Baldwin, a Democratic Senator from Wisconsin, decried the administration s plans. The Trump Administration is endangering your family s health to make more room in the budget for their billionaire tax breaks and rig the system for themselves, she wrote in a statement.

As part of the change, HHS will now house an Administration for a Healthy America, or AHA, which will be focused on human resources, information technology, procurement, external affairs and policy.

AHA will combine the Office of the Assistant Secretary for Health, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Toxic Substances and Disease Registry and NIOSH.

“This centralization will improve coordination of health resources for low-income Americans and will focus on areas including, primary care, maternal and child health, mental health, environmental health, HIV/AIDS, and workforce development,” said HHS.

Local AFGE unions argued April 1 moving NIOSH out of the CDC will sever crucial ties between occupational and public health.

“Communicable diseases like tuberculosis, hepatitis, and influenza are occupational illnesses that disproportionately affect healthcare workers and other frontline employees,” said Brendan Demich, chief steward of AFGE Local 1916 from Pennsylvania and Washington, in a statement to Fierce Healthcare. “NIOSH’s work has been critical in ensuring that workers have the proper protection through research on things such as respirators and ventilation controls.

The CDC will assume control of the ASPR, an agency formerly tasked with natural disasters and other public health threats.

A new Assistant Secretary for Enforcement will oversee the Departmental Appeals Board, Office of Medicare Hearings and Appeals and the Office for Civil Rights. This person will be tasked with rooting out waste, fraud and abuse.

Long-rumored to be on the chopping block, the Agency for Healthcare Research and Quality will merge with the Assistant Secretary for Planning and Evaluation (ASPE). This new combination will become the Office of Strategy, to “enhance research that informs the Secretary’s policies and improves the effectiveness of federal health programs.”

The Administration for Community Living (ACL) will be dispersed between the Administration for Children and Families, the ASPE and the CMS. Some stakeholders worry the ACLs functions may be in danger under this reorganization.

Just as you cannot slash billions from Medicaid or close Social Security field offices without harming older adults and people with disabilities, you cannot curtail CMS capacity, dismantle the ACL—the only federal agency charged with maximizing the independence, well-being, and health of older adults, people with disabilities, their families, and their caregivers—or otherwise weaken critical HHS programs, services and functions without causing irreparable damage, said Fred Riccardi, president of the nonprofit Medicare Rights Center, in a statement.

Any realignment of the agency or its functions must preserve the essential work the government has long done to improve the lives of older adults and ensure alignment with Medicare and Medicaid to improve and expand delivery of the services on which Americans rely, said Sarita Mohanty, M.D., president and CEO of The SCAN Foundation.

Secretary of Education Linda McMahon, who is helping oversee the elimination her department, said last week HHS will assume control of special education programs traditionally under her domain, but no further timeline or information has yet been provided by HHS.

A core tenet of the Make America Healthy Again movement, spearheaded by Kennedy, is the focus on reversing chronic disease. The department will prioritize “safe, wholesome food, clean water and the elimination of environmental toxins.”

Robert F. Kennedy Jr. | Department of Hea th and Human Serv ces (HHS) | Dona d Trump | ayoffs | Workforce | un on | Lawsu ts | Office of Personne Management | F nance | Regu atory

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PHARMA

RFK Jr.'s referral fees in litigation over Merck's Gardasil raise conflict-of-interest questions: reports

By **Kevin Dunleavy**
Jan 23, 2025 2:29pm

Merck | Robert F. Kennedy Jr. | anti-vaccine | Department of Health and Human Services (HHS)

Department of Health and Human Services (HHS) secretary nominee Robert F. Kennedy Jr. plans to continue to receive referral fees from a law firm that is suing pharma powerhouse Merck & Co. over the marketing and sale of one of its vaccines.

RFK Jr.'s plan—which was revealed (https://extapps2.oge.gov/201/Presiden.nsf/PAS+Index/F3C8425ED335BB5685258C1A00565D57/$FILE/Kennedy%2C%20Jr.%2C%20Robert%20F.%20%20fi (PDF) in a signed ethics agreement that was made public earlier this week—raises conflict-of-interest issues as he is seeking confirmation to run an agency that regulates Merck and other drugmakers.

The law firm, Wisner Baum, represents (https://www.wisnerbaum.com/prescription-drugs/gardasil-lawsuit/) clients who are suing Merck for not warning that its HPV vaccine Gardasil could cause cervical cancer. RFK Jr. has played a key role in organizing Gardasil litigation in the U.S., according (https://www.reuters.com/world/us/kennedy-would-keep-legal-fees-merck-cases-if-confirmed-2025-01-22/) to Reuters, and has rights to 10% of fees recovered in certain cases.

The New York Times was first to make the link (https://www.nytimes.com/2025/01/22/us/politics/rfk-hpv-vaccine-merck.html) between Wisner Baum and the action it is taking against Merck and to report the associated concerns with RFK Jr. given his ethics statement.

Upon his potential confirmation, RFK Jr. said he would resign as a consultant for the firm but would still collect referral fees for cases that the company won, provided—per HHS and ethics committee review—that they don't involve the U.S.

"I will retain a contingency fee interest in cases that the ethics office of the Department of Health and Human Services has determined do not involve the United States as a party and in which the United States does not have a direct and substantial interest," RFK Jr. wrote in the document. "I am entitled to receive a portion of future recovery in these cases based upon the set percentage as set forth in the referral agreement."

Conversely, in cases that do involve the U.S. government, RFK Jr. pledged to divest his financial interest, according to the filing. The National Vaccine Injury Compensation Program—a special legal system (https://www.hrsa.gov/vaccine-compensation) for suspected vaccine-related injuries—falls under HHS authority, so RFK Jr. would presumably divest his interest in any of those petitions.

RFK Jr. collected $856,000 from Wisner Baum last year, according to his financial disclosure form (https://extapps2.oge.gov/201/Presiden.nsf/PAS+Index/A56222F259495B0D85258C1A00565073/$FILE/Kennedy%2C%20Jr.%2C%20Robert%20F.%20%20fin (PDF).

Besides the Gardasil litigation, Wisner Baum is active in lawsuits concerning Pfizer's injectable birth control drug Depo-Provera, Novo Nordisk's Ozempic, Indivior's pain drug Suboxone and other medicines. The firm has a history of litigation involving the drug industry, according to its website (https://www.wisnerbaum.com/prescription-drugs/).

RFK Jr., for his part, has a decades-long history of spreading anti-vaccine rhetoric and conspiracy theories, including the debunked claim (https://www.factcheck.org/2023/08/scicheck-what-rfk-jr-gets-wrong-about-autism/) that vaccines cause autism. When his HHS nomination was announced, stock prices for many of the world's top vaccine makers dropped (https://www.fiercepharma.com/pharma/around-world-vaccine-stocks-sag-after-rfk-jrs-hhs-appointment).

In his ethics statement, RFK Jr. explained that he has removed himself from the Children's Health Defense (CHD), an organization that has filed nearly 30 vaccine-related lawsuits. During the COVID pandemic, the CHD was active in spreading vaccine misinformation, leading to its suspension (https://apnews.com/article/covid-technology-health-public-misinformation-28019177323c1d50b7ff28c522dde083) from Facebook and Instagram. RFK Jr. resigned from the CHD last month.

In the ethics statement, RFK Jr. also revealed (https://www.fiercebiotech.com/biotech/rfk-jr-will-divest-interests-crispr-tx-dragonfly-if-hhs-role-confirmed-letter) that he plans to divest his holdings in several companies—including CRISPR Therapeutics and Dragonfly Therapeutics.

Most of RFK Jr.'s income comes from work as a partner at his law firm, Kennedy & Madonna, which changed its name to Madonna & Madonna on Jan. 13. He brought in about $8.8 million annually from the firm, per the disclosure.

RFK Jr. faces a confirmation hearing on Jan. 29.

Merck | Robert F. Kennedy Jr. | anti-vaccine | Department of Health and Human Services (HHS) | Gardasil | Pharma

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Senate Finance with HHS Secretary Nominee Kennedy

01/29/2025 10:00 AM EST

Sen. Mike Crapo (R-Idaho)

Good morning. This hearing will come to order. I thank my colleagues and Mr. Kennedy for being here today. Mr. Kennedy, Congratulations on your nomination.

Throughout this process, Mr. Kennedy, you have been accessible to members and staff on both sides of the aisle, and have demonstrated strong commitment to fulfilling the responsibilities of this role. The Department of Health and Human Services oversees our nation's largest health care programs, providing coverage for nearly two in every five Americans. Improving Medicare, Medicaid and CHIP, among other initiatives presents challenges, especially in the face of a rapidly aging population, stubbornly high class and persistent barriers to access. However, this also provides us an opportunity to live to deliver bold, transformative solutions.

As a Committee we share a commitment to advancing common sense bipartisan policies that improve the delivery of health care in this country. This Committee has worked to realign incentives in the prescription drug supply chain to enhance access in rural communities to expand the availability of telehealth and improve the broken clinician payment structure. Across these and other issues, I look forward to working with the administration to continue pursuing meaningful reforms that serve the American people more effectively and more efficiently. Too often, patients encounter a healthcare system that is disjointed, and is a dysfunctional maze.

Complex and bureaucratic Chutes and Ladders have become the norm. Meanwhile, even as healthcare spending claims, outcomes across a range of conditions continue to decline. Mr. Kennedy, if confirmed, you will have the opportunity to chart a new and better course for the federal approach to tackling both the drivers and the consequences of our ailing health care

system. Your commitment to combating chronic conditions that drive health care costs will be critical to our success.

Prioritizing disease prevention and addressing the factors that fuel conditions such as diabetes, cardiovascular, cardiovascular disease, metabolic disease, Alzheimer's disease, COPD and cancer will save lives, reduce costs and build a healthier, stronger country. Private sector breakthroughs from groundbreaking cancer medications to curative gene therapies also offer hope, but misguided government initiatives and market volatility volatility risk eroding American leadership in life saving R&D. Your advocacy for health care transparency has the potential to empower consumers across the country, promoting competition to enhance quality while cutting excessive spending for patients and for taxpayers. Today's hearing will provide a forum to hear more about your vision, particularly for the federal programs under this committee's jurisdiction.

Mr. Kennedy, you represent a voice for an inspiring coalition of Americans who are deeply committed to improving the health and wellbeing of our nation, regardless of political party, everyone in this room shares a common recognition that our current system has fallen short, as well as a common desire to make our country healthier. I look forward to today's conversation as well as your testimony, Mr. Kennedy, and now I recognize Senator Wyden for his opening remarks.

Sen. Ron Wyden (D-Ore.)

Thank you very much, Mr. Chairman. The question before the Finance Committee this morning, is whether Robert F. Kennedy should be trusted with the health and wellbeing of the American people. Committee staff have examined that thousands of pages of statements, books, and podcast transcripts in a review of his record, the receipts show that Mr. Kennedy has embraced conspiracy theories, quacks, charlatans, especially when it comes to the safety and efficacy of vaccines.

He has made it his life's work to sow doubt, and discourage parents from getting their kids lifesaving vaccines. It has been lucrative for him and put him on the verge of immense power. This is the profile of someone who chases money and influence wherever they lead, even if that may mean the tragic deaths, children and other vulnerable people. Now Mr. Kennedy is

found fond of saying he's not making recommendations about whether parents should vaccinate their children.

He's just asking questions and giving people choices. It says slippery tactic to dodge any real responsibility for his words and actions. And it is in my view, absurd. Coming from somebody who's trying to win confirmation for a job that is entirely about making recommendations.

These recommendations are going to help life or death consequences for the American people. Mr. Kennedy, if you are confirmed your recommendations determine which vaccines senior citizens get for free through Medicare. Your recommendation will determine which vaccines are given to millions of kids. peddling these anti-vaccine conspiracy theories as our Chief Health Officer is going to endanger the lives of kids and seniors across the nation.

Just look at what happened when Mr. Kennedy inserted himself into an anti-vaccination crisis. In the island nation of Samoa. He traveled there himself to push his views and pour fuel on the fire of a measles outbreak that began due to low vaccination rates. In the end, 83 Samoans died, mostly kids from a disease that it's easily preventable.

Americans cannot afford to import this experiment to our great nation. On other health care matters from abortion to universal health care, Mr. Kennedy has changed his views. So often, it is nearly impossible to know where he stands on so many of the basic issues that impact Americans daily lives in a gobsmacking statement of irresponsibility. In November 2023, Mr. Kennedy said that he wanted to pause infectious disease research for eight years.

Mr. Kennedy has indicated he's open to restricting access to the abortion medication mifepristone which remains a primary target of the Republican crusade against reproductive freedom. I took the song back in 1990 when I chaired the first congressional hearing on the topic, the science is clear, then it's even clearer today. Mifepristone is safe. The only reason it's under question in 2025 is because people with a political agenda had been out lying about it.

Women deserve to know if Mr. Kennedy will abuse his power as our country's Chief Health Officer to essentially implement a national abortion

ban by restricting access to the safe and legal medication. Meanwhile, as the Trump Budget Office through the Medicaid program into chaos yesterday, Republicans in Congress are proposing deep cuts to the program that will rip away health care from millions of Americans who count on this vital lifeline. Cuts to Medicaid of this magnitude are going to Jack up the cost of health insurance. It'll shutter nursing homes and rural hospitals deprive seniors and Americans with disabilities of home-based care.

That approach amounts to handing over our nation's health system to for profit insurance companies who made a fortune delaying and denying care. Mr. Kennedy has virtually no knowledge or experience in handling these issues. It leaves him unprepared to take on a crisis like the nation witnessed yesterday, when the Trump budget office shut down the federal Medicaid payment portal. After a careful review of Robert F.

Kennedy Jr, statements, actions and views, materials that I have reviewed personally and closely, I reached the conclusion that he should not be entrusted with the health and wellbeing of the American people. When he's taken every side of every issue, how can this Committee and the American people believe he has anything to say? Let me close by saying I believe more strongly than ever. And I have specialized in healthcare during my time in public service, there were a turning point.

With regard to health care in America. There's one word to describe Americans feelings towards the health care system, it's disillusion. At every single turn, people feel like they're rolling as load of dice, loaded dice when they try to get health care. Americans are justifiably angry, fed up and tired of a system that puts profits over patients, instead of debating meaningful ways to prove Americans healthcare.

Now the Committee is being forced to re litigate settled science about vaccines. And whether or not the federal government should help Americans get affordable health care. I know where Democrats on this Finance Committee stand. When it comes to an agenda to lower costs and improve care.

I must say, I cannot say the same about the nominee sitting in front of me. And let me acknowledge finally Mr. Chairman, Terry Mills, from Portland, Oregon, who is here to represent nurses for America. And I'd like to enter a

statement from her organization into the record at this time. Thank you, Mr. Chairman.

Sen. Mike Crapo (R-Idaho)

Without objection, Thank you rank- Thank you, Ranking Member Wyden, Mr. Kennedy, and a few moments you will be given the opportunity to make your opening statement and respond to these attacks and other questions that committed this, the members of this Committee have. I would say that with regard to the attack on Medicaid that we just heard that was a false attack. It's been proven false overnight. The Medicaid portal is operating efficiently today, and was never intended to be shut down.

Sen. Ron Wyden (D-Ore.)

Will the gentleman yields since he's mentioned my name. There was a significant amount of time yesterday where there was Bedlam across the country over the status of the Medicaid portals. I hope it's been corrected. But there were problems all through the day.

Sen. Mike Crapo (R-Idaho)

There certainly were attacks yesterday. The problem has been clarified and Medicaid portal is fully operational as we speak. Mr. Kennedy, before I turn the time over to you to share your opening statement, I would like to give you a brief introduction. The son of Senator Robert F.

Kennedy and nephew of President John F. Kennedy, Robert Kennedy, Jr. has been an advocate for consumers since 1985. After graduating from Harvard University, Mr. Kennedy studied at the London School of Economics and received his law degree from the University of Virginia Law School and a master's degree in environmental law from Pace University.

He has founded two advocacy groups and has spent the last 40 years working to restore and protect children's health. He was a former independent candidate in the 2024 presidential election. And President he President Trump nominated him this year to be the eighth or in November of 2024 to be the HHS Secretary. In announcing his nomination, President Trump stated Mr. Kennedy will restore these agencies to the traditions of

gold standard scientific research and beacons of transparency, and end the chronic disease epidemic and make America great and healthy.

Again. Before you give your opening statement, Mr. Kennedy, I have four obligatory questions that we ask all nominees before this Committee. First, is there anything that you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Robert Kennedy

No.

Sen. Mike Crapo (R-Idaho)

All right, Mr. Chairman, thank you. Do you know of any reason, personal or otherwise that would in any way prevent you from fully and honorably discharging the responsibilities of the office to which you have been nominated?

Robert Kennedy

No.

Sen. Mike Crapo (R-Idaho)

Do you agree without reservation? To respond to any reasonable summons to appear and testify before any duly constituted Committee of Congress? If you are confirmed?

Robert Kennedy

Yes.

Sen. Mike Crapo (R-Idaho)

And finally, do you commit to provide I prompt response in writing to any questions addressed to you by any Senator of this Committee.

Robert Kennedy

Yes.

Sen. Mike Crapo (R-Idaho)

Thank you, Mr. Kennedy. And before we begin, if you would like to you may introduce your wife and children,

Robert Kennedy

Asearl Hines is here. My daughter, Kennedy, my son, Bobby Kennedy, his wife, Amaryllis, Fox Kennedy, and my nephew Jackson. Heinz is here till

Sen. Mike Crapo (R-Idaho)

We welcome you all. Thank you, you may proceed with your statement.

Robert Kennedy

Thank you, Mr. Chairman. Chairman Crapo, Ranking Member Wyden and members of this distinguished Committee, I'm humbled to be sitting here today as President Trump's nominee, oversee the US Department of Health and Human Services. I want to thank President Trump for entrusting me to let deliver on his promise to make America healthy again. I also want to thank Cheryl and kick and Bobbie and all my other children, who are here today and all the many members of my large extended family for the love that they have so generously shared.

Ours has always been a family that has been involved in public service, and I look forward to continuing that tradition. My journey into the issue of health began as my career as an environmental attorney, working with hunters and fishermen and mothers in a small town in the Hudson Valley and along the Hudson River. I learned very early on that human health and environmental injuries are intertwined. The same chemicals that kill fish make people sick.

Also, today, Americans overall health is in grievous condition. Over 70% of adults and a third of children are overweight or obese. Diabetes is 10 times more prevalent and it was during the 1960s. cancer among young people is rising by one or 2% a year.

Autoimmune diseases, neurodevelopmental disorders, Alzheimer's, asthma, ADHD, depression, addiction and a host of other physical and mental health conditions are all on the rise exponentially. The United States has worse health than any other developed nation, we spend more on health care at least apple and in some cases, triple as other countries. Last year, we spent 4.8 trillion not counting the indirect costs of missed work. That's almost a fifth of fifth of GDP, is tantamount to a 20% tax on the entire economy.

No wonder America has trouble competing with countries that pay a third of what we do for health and have better outcomes and a healthier workforce. And I don't want to make this too much about money. It's the human tragedy that moves us to care. President Trump has promised to restore America's global strength and to restore the American Dream but he understands we can't be a strong nation on our people are so sick.

A healthy person has 1000 dreams, a sick person has only one and a over half of our countrymen and women are chronically ill. When I met with President Trump last summer, I discovered that he has more than just concern for this tragic situation but genuine care. President Trump is committed to restoring the American dream and 77 million Americans delivered a mandate to do just that. Due in part to the embrace and elevation of the Make America health IQ and movement.

This movement led largely by Ma moms from every state and you can see many of them behind us today and in the hallways and in the lobbies, is one of the most transcendent and powerful movements I've ever seen. I promise President Trump that if confirmed, I will do everything in my power to put the health of Americans back on track. And I've been greatly heartened to discover a deep level of care among members is Committee to both Democrats and Republicans. I came away from our conversations confident that we can put aside our divisions for the sake of a healthier America.

Are longtime that nation has been locked in a divisive healthcare debate about who pays Oh, when healthcare costs reach 20% There are no good options, all the bad ones shifting the burden around between government and corporations and insurers and providers and families is like rearranging deck chairs on the Titanic. Our country will sink beneath the sea of desperation and debt. If you don't change the course and as I our health care costs so high in the first place. The obvious answer is chronic disease.

The CDC says 90% of healthcare spending goes toward managing chronic disease, which hits lower income Americans the hardest. The President's pledge is not to make some Americans happy again, healthy again, but to make all of our people healthy, and there is no single culprit in chronic disease much as I have criticized certain industries and agencies as Trump and I understand that most of their scientists and experts genuinely care about American health. Therefore, we will bring together all stakeholders in pursuit of this unifying goal. Before I conclude, I want to make sure that Committee is clear about a few things.

News reports have claimed that I'm anti-vaccine or any industry I am neither, I am pro safety. [INTERJECTIONS]

Sen. Mike Crapo (R-Idaho)

We will have order. Please proceed. Mr. Kennedy.

Robert Kennedy

I am pro safety. I worked for years to raise awareness about the mercury and toxic chemicals and fish and nobody called me any fish. And I believe at all my vaccines play a critical role in health care. All of my kids are vaccinated.

I've written many books on vaccines, my first book in 2014. A first line of it is I am not anti-vaccine. And the last line is I am not anti-vaccine, or I the enemy of food producers. American farms are the bedrock of our culture of our politics of our national security.

I was for each kid and I spent my summer working on ranches. I went to work with our farmers, I want to work with our farmers and food producers remove burdensome regulations and unleash American ingenuity. MAHA simply cannot succeed without a partnership, the full partnership of American farmers. In my advocacy, I've often disturbed the status quo.

I asking uncomfortable questions. Well, I'm not gonna apologize for that. We have massive health problems in this country that we must face honestly. And the first thing I've done every morning for the past 20 years, is to get on my knees and pray to God, that he would put me in a position to end the chronic disease epidemic and to help America's children.

That's why I'm so grateful to President Trump. The opportunity to sit before you today and seek your support and partnership in this endeavor. I will conclude with the promise the members of this Committee to the President and to all the tens of billions of parents across America, especially the moms, what propelled this issue to center stage, should I be so privileged as to be confirmed, we will make sure our tax dollars support healthy foods. We will scrutinize the chemical additives in our food supply.

We will remove financial conflicts of interest from our agencies. We will create an honest, unbiased goals and science at HHS accountable to the president to Congress and to the American people. We will reverse the chronic disease epidemic and put the nation back on the road to good health. Thank you.

Sen. Mike Crapo (R-Idaho)

Thank you, Mr. Kennedy. Mr. Kennedy, I will begin. Each of us will have five minutes to ask you questions. And then at the conclusion of the hearing, if there are further questions, there will be an opportunity for those questions to be submitted to you and I ask that you respond to them promptly.

Mr. Kennedy, you have emphasized the importance of nutrition in preventing and managing chronic disease, improving health outcomes and reducing health costs. I share your interest in the relationship between our diet and our wellbeing. And if confirmed, I look forward to partnering with you on those efforts. Would you share with the Committee why you are passionate about the nutrition oriented disease prevention and what you have learned?

Robert Kennedy

Yeah, As Mr. Chairman, I had 11 Brothers and sisters, dozens of first cousins. I was raised in a time where we did not have a chronic disease epidemic. My uncle was President. 2% of American kids had chronic disease, today 66% have chronic disease.

We spent zero on chronic disease during the Kennedy administration. Today we spend $4.3 trillion a year. It was 77% of our kids cannot qualify for military service. When I was a kid, the typical pediatrician would see one case of diabetes in his or her lifetime, 40 or 50 year career.

Today out of every three kids who walks through his office door is diabetic or pre diabetic. And the most reason data from NIH shows 38% of teens are diabetic or pre-diabetic autism rates have gone from one in 10,000 to one at 1,500, depending on what studies you look at. in my generation today. 70 year old man, one in 34, my kids generation we've seen an explosion of autoimmune disease of allergic diseases.

We are, this is not just a economic issue, It's not just a national security issue. It is a spiritual issue, And it is a moral issue. We cannot live up to our role as an exemplary nation as a moral authority around the world, when we're writing off an entire generation of kids.

Sen. Mike Crapo (R-Idaho)

Thank you very much. And if confirmed, how could we work together to integrate nutrition-based interventions into our healthcare programs like Medicaid and Medicare?

Robert Kennedy

Well, there there are, there are many ways that we can do that. A federal funding of the SNAP program for example, and of school lunch programs would be a driver for helpingg, we shouldn't be giving 60% of the kids in school, processed food that is making them sick. We shouldn't be giving we shouldn't be spending 10% of the SNAP program on sugar drinks, when we have a direct ability to change things there. We also know in Medicaid and Medicare we need to focus on outcome based medicine on on putting people in charge of their own healthcare, making them accountable for their own health care, so they understand the relationship between eating and getting sick.

Most importantly, we need to use deploy NIH and FDA doing the research to understand the relationship between these different food additives, and chronic disease so that Americans understand it and make sure that

Americans are aware but I don't want to take food away from anybody. If you like a cheeseburger, a McDonald's cheeseburger, Diet Coke, which my boss loves, I, you should be able to get them. If you want to eat Hostess Twinkies, you should be able to do that. But you should know what the impacts are on your family and on your health.

Sen. Mike Crapo (R-Idaho)

Thank you, Senator Wyden.

Sen. Ron Wyden (D-Ore.)

Thank you very much. Mr. Chairman. Before I begin my questions, I'd like to start by entering into the record a letter The Committee received from Ambassador Caroline Kennedy, outlining what she believes is Mr. Kennedy's lack of personal fitness for the office.

Sen. Mike Crapo (R-Idaho)

Without objection.

Sen. Ron Wyden (D-Ore.)

Mr. Kennedy, you have spent years pushing conflicting stories about vaccines. You say one thing, and then you say another your testimony today under oath you denied that you were anti-vaccine. But during a podcast interview in July of 2023, said, quote, no vaccine is safe and effective.

In your testimony today, in order to prove your anti-Knott anti-Vax, you note that all your kids are vaccinated. But in a podcast in 2020, you said and I quote, you would do anything, pay anything to go back in time, and not vaccinate your kids? Mr. Kennedy? All of these things cannot be true.

So are you lying to Congress today when you say you are pro-vaccine, or did you lie on all those podcasts? We have all of this on tape, by the way.

Robert Kennedy

Senator, as you know, because it's been repeatedly debunked that statement that I made on the Lex Friedman podcast was a fragment of this statement.

He asked me and anybody who actually goes and looks at that podcast and will see this he asked me Are there vaccines that are safe and effective? And I said to him, some of the live virus vaccines are. And I said there are no vaccines that are safe and effective.

And I was going to continue for every person, every medicine has been oversensitive to them, including vaccines.

Sen. Ron Wyden (D-Ore.)

Alright So.

Robert Kennedy

He interrupted me at that point. I've corrected it many times, including on national TV, you know about Senator Wyden. So bringing this up right now dishonest.

Sen. Ron Wyden (D-Ore.)

Let's be clear about what you've actually done then, since you want to deny your statements. For example, you have a history of trying to take vaccines away from people. In May of 2021, you petitioned the Food and Drug Administration to not only block Americans from having access to the COVID vaccine, but to prevent any future access to the life saving vaccine. Are you denying that your name is on the petition?

Robert Kennedy

We brought that petition after CDC recommended a COVID vaccine without any scientific basis, for six year old children. Most experts agree today even the people who did it back then COVID vaccines are inappropriate for a six year old children who basically have zero risk to COVID. That's why I brought that lawsuit. I don't want to I want to emphasize your

[CROSS TALK]

Sen. Mike Crapo (R-Idaho)

Committee will be in order and to the audience. Will you hold on for a second, Mr. Kennedy to the audience. comments from the audience are inappropriate and out of order. And if there are any further disruptions, the Committee will recess until the police can restore order.

Please follow the rules of the Committee. Mr. Kennedy, you may proceed.

Robert Kennedy

I also want to point out that your recitation of what happened in Samoa is absolutely wrong.

Sen. Ron Wyden (D-Ore.)

We'll get to that, We'll get to that, We'll get to that in a moment. Right now. We're talking about the petition that you filed to block American from having access to the vaccine, and to prevent any future access to the vaccine. those facts are on the record.

My third question to you is, you made almost $5 million from book deals, mostly promoting junk science in 2021. And a book called the measles book you wrote that parents had been quote misled into believing that Measles is a deadly disease and that measles vaccines are necessary, safe and effective. The reality is measles are in fact deadly and highly contagious, something that you should have learned after your lives contributed to the deaths of 83 people, most of them children in a measles outbreak in Samoa. So my question here is, Mr. Kennedy, is measles deadly yes or no?

Robert Kennedy

The death rate from measles historically in this country in 1963, that year before the introduction to the vaccine was one in 10,000. Let me explain what happened in Samoa. Samoa in 2017 or 2015, there were two kids who died following the MMR vaccine. And and, and the vaccination rates in Samoa dropped precipitously from about 63% to the mid-30s.

So they've never been very high. And in 2018, two more kids died following the MMR vaccine and the government's ban the MMR vaccine. I arrived here later on vaccination rates were already below the below any any previous level. I went there, nothing to do with vaccines.

I went there to introduce a medical informatics system with digitalize records in Samoa and make health delivery much more efficient. I never taught any public statement about vaccines you cannot find a single Samoan who will say I didn't get a vaccine because of Bobby Kennedy. I went to June of 2019 the measles outbreak started in August. Oh clearly I had nothing to do with the measles.

Not only that

Sen. Ron Wyden (D-Ore.)

Mr. Kennedy.

Robert Kennedy

Let me finished

Robert Kennedy

You plenty of time.

Sen. Ron Wyden (D-Ore.)

If you let me finish at Three people died on the tissue samples were sent to New Zealand. Not most of those people did not have measles. We don't know what was killing them. The same outbreak occurred in Tonga and Fiji and no extra people died.

It was seven measles outbreaks and 13 years prior [CROSS TALK]

Sen. Ron Wyden (D-Ore.)

Mr. Chairman I'd like to get my time back. The nominee wrote a book saying that people had been misled into believing that Measles is a deadly disease. He's trying not to play now in his role in Samoa.

That's not what the parents say. That's not what Governor Green says. It's time to make sure that we blow the whistle on actually what your views are. At least we're starting.

Sen. Mike Crapo (R-Idaho)

We need to move on.

Robert Kennedy

I support the measles vaccine. I support the polio vaccine, I will do nothing as HHS Secretary, that makes it difficult or discourages people from taking vaccines.

Sen. Ron Wyden (D-Ore.)

Any anybody who believes that ought to look at the measles book you wrote saying parents have been misled into believing that Measles is a deadly disease. That's not true.

Sen. Mike Crapo (R-Idaho)

We need to move on Senator Grassley.

Sen. Chuck Grassley (R-Iowa)

Welcome. I'm going to do like I did in my office, I'm just going to make some points to you. I got about seven, I want to quickly get done. And then at the end, I'm going to ask if you disagree with anything I say, and then address those things you disagree with.

I'll make sure I save time for you to do that. A key responsibility of each member of Congress is oversight. Oversight allows us to hold bureaucrats accountable to the rule of law, and it helps keep faith with taxpayers. I expect HHS to provide timely and complete responses to congressional oversight.

Number two, PBMs is something you and I discussed in our office. I've been working to hold pharmacy benefit managers accountable. In order to lower prescription drug prices. I expect you to work with us to hold PBMs accountable.

And that may even ask in your support for legislation that's before the Congress. But drug pricing. Senator Durbin and I have for a while been trying to get a bill passed that requires price disclosures on TV ads for research and drugs. Knowing what something costs before buying it is just common sense.

President Trump tried to do this by regulation and his first term, Vice President fans co-sponsored our bill last Congress, I asked you to support this bill. Or if you didn't do it by regulation to do it by regulation. on rural health care, the previous administration dragged his feet in opening up slots for rural community hospital demonstration programs. It also ignored concerns from rural pharmacies when implementing changes to Medicare Part D and ignored rural needs.

When it comes to distributing physician Reese residency slots. I expect you to prioritize rural Americans health care needs on agriculture in our meeting earlier this month, we talked at length about agriculture. You preface the conversation by saying you will not have jurisdiction over these issues. I expect you to leave agricultural practice regulations to the proper agencies and for the most part, that's USDA, and EPA on dietary guidelines.

I've sent letters to the secretaries of agriculture HHS, requesting that they provide information regarding conflicts of interest on the Dietary Guidelines Advisory Committee. To increase transparency, I expect you to provide Congress with confidential financial disclosures from the advisory Committee before finalizing dietary guidelines. So we know that nobody has a vested interest in it is having undue influence. Lastly, HHS Office of Refugee Resettlement oversight last year I expanded my investigation into HHS's Office of Refugee Resettlement.

I wrote two dozen contractors and grantees whose job it is to place unaccompanied children with sponsors. In many cases children's have been placed with improper vetted sponsors placing them at risk of trafficking. The Biden Administration's HHS directed these tax payer funded contractors and grantees to not respond to my inquiry. This is obstruction by the executive branch.

I expect you to produce to me the records and data I've requested and instruct HHS contractors to fully cooperate with my investigation. I also

expect HHS To not retaliate against any whistleblowers, including those who identify all ORs ORRs failures to embedding sponsors on recovery, you got 45 seconds to respond.

Robert Kennedy

I agree with all of those provisions, Senator. My approach to administration, HHS will be radical transparency. If members of this Committee or other members of Congress want information, the doors are open. I've spent many years litigating against NIH and it's of agencies.

I mean, HHS, and its other agencies, NIH, CDC, FDA, on FOIA issues, trying to get information that we've taxpayers paid for, and oftentimes getting redacted copies after a year or two years of litigation. That should not be the case. And if Congress asked me for information, you will get it immediately.

Sen. Chuck Grassley (R-Iowa)

Thank you.

Sen. Mike Crapo (R-Idaho)

Thank you. Senator Cantwell is next. But until she returns, I will move on to down the list and that would be Senator Cornyn.

Sen. John Cornyn (R-Texas)

Mr. Kennedy, welcome to you and your family, and congratulations. I appreciate it. Senator Grassley raising the issue of the Office of Refugee Resettlement within the auspices of Health and Human Services.

I think this may surprise people. But that's actually the responsibility of HHS, the Office of resettlement relocation. Under the previous administration, as Senator Grassley alluded there were roughly 500,000 Children, unaccompanied minors that were placed with sponsors in the interior of the United States, the previous administration took the position that it was not the federal government's responsibility once these children were placed with these sponsors. But the New York Times in a series of investigative stories pointed out that tens of thousands of these children when they tried to follow up, and find out how they were doing, whether they

were going to school, whether they were being trafficked, or abused, there was no answer, and they took the position that was not their responsibility.

So I look forward to working with you to find those children, and to make sure that they're not being abused. Millions of Americans are experiencing mild to moderate mental health and substance abuse issues. Yet many struggle with timely and effective access. Primary care physicians are most likely to be seeing these individuals as opposed to a specialist.

And it makes it important that these individuals primary care physicians be trained in patient centered care, which would strengthen the integration of behavioral health care with primary care services. Is this something that you are concerned about something you'd be willing to work with us on in order to implement?

Robert Kennedy

Yes, let me just reassure you that President Trump has personally spoken to me about locating those 300,000 children who disappeared over the last four years.

Sen. John Cornyn (R-Texas)

I don't think anybody has a net fully accurate number, but it's hundreds of thousands I agree.

Robert Kennedy

And many of them we know have been sex trafficked, and childhood slavery. And we it is a blight on America's moral authority. And we need to find those kids. In terms of addiction services, and substance abuse services, I this is a priority for me.

It was a priority for me. When I was running for president during my campaign, I was a heroin addict for 14 years. I am 42 years in recovery. I go to 12 step meetings every day.

So I hear the stories every day. And I hear the many stories about denial of the barriers to access to care. And we need to improve that and answer specifically to your question. And I think we can do that through GME to,

which is a program that is funded by HHS, that is the largest funder for medical school students.

And, and that's one of the things for primary care physicians should be should understand addiction care. Addicts almost always go through a cycle where there is a moment where they hit periodic bottoms where they're ready to go into treatment. But it's fleeting, and it's momentary. And we have an opportunity to save their lives.

And then if we miss that little short window, they're off to the races again.

Sen. John Cornyn (R-Texas)

Let me let me let me I appreciate your answer. Our time is short. Let me get to one One more question that I think is very important. Under the first Trump Administration, the number of people receiving HIV treatment in Africa through the President's Emergency Plan for AIDS Relief, otherwise known as PEPFAR.

It increased. This is during the first Trump Administration from 13 million people to 18 million people across 50 countries, primarily in Africa. Africa has about 1.3 billion people today or in 2021, is projected to have 2.5 billion people by 2050, or 25%, of the global population. In 2020, PEPFAR is reported that eight- 2.8 million babies were born without HIV.

That was something that would not have happened, but for the PEPFAR program. So it has simply been one of the most successful public health programs in the world, and saved approximately 26 million lives. Failure to continue this program, in my view, would receding that leadership to adversaries like China. And I'd like to know whether you support the objectives and goals of PEPFAR.

And would you work with me and Mark colleagues to make sure that this program continues to provide lifesaving antiviral drugs to people who are most in need?

Robert Kennedy

I absolutely support PEPFAR. And I will, I will happily work with you to strengthen the program.

Sen. Mike Crapo (R-Idaho)

Thank you, Senator Bennet.

Sen. Michael Bennet (D-Colo.)

Thank you, Mr. Chairman. Thank you, Mr. Kennedy, for being here this morning. And I think that, Mr. Chairman, we are we are truly through the looking glass this morning here in the US Senate. And this Committee is being asked to fulfill a really important responsibility, which is to decide whether to confirm Mr. Kennedy, to one of the most important health care jobs in America.

And the reason I think it's so important is for many of the reasons you said in your opening statement, which is that we live in the richest country in the world. And we have some of the worst health outcomes of any industrialized country in the world. We live in the richest country in the world, and we have some of the lowest expect healthy life expectancy rates of anybody in the industrialized world. I was the school superintendent before I was in this job, Mr. Chairman, and I can tell you that Mr. Kennedy is right.

You know that, when I look at the kids in the Denver Public Schools, if we don't change the way we eat in this country, 40% of them are going to suffer adult on side on adult diabetes as a result of their diet. These are sick. And we're, as I said, spending more than any other country in the world. And our families, every single person's constituents in this Senate are facing chronic shortages when it comes to health care.

My friend from Texas, Senator Cornyn has been a champion on mental health care, we have an epidemic, as he knows, across this country, in mental health care, partly because of what the the massive social media platforms that were sitting behind the president united states have inflicted on our children for their profit in the last decade or so. So we have no shortage of challenges to confront. And I even agree with some of the diagnosis of, of, of Mr. Kennedy, what is so disturbing to me is that out of 330 million Americans, we're being asked to put somebody in this job, who has spent 50 years of his life not honoring the tradition that he talked about at the beginning of this conversation, but peddling in half truths. peddling in

false statements peddling in theories that, you know, create doubt about whether or not things that we know are safe or unsafe.

Not that every vaccine in America is unsafe, not that you can't possibly have adverse reaction, but parents and children in my old school district and school districts all over this country would be better off not getting vaccinated than getting vaccinated. Unlike his own children who were vaccinated, unlike the people he invited to his House in Los Angeles for their party who were vaccinated for everybody else. It's about peddling these half truths, and he says it was such conviction that you want to believe him. And Mr. Kennedy, I just have some there are many, many things in the record, but I hope that you could answer these questions.

Yes or no, I've tried to ask these in a manner that's faithful to what you actually said because I didn't want to have a debate about whether you actually said them. So I'm asking you, yes or no, Mr. Kennedy. Did you say that COVID-19 was a Jim genetically engineered bioweapon that targets black and white people, but spared Ashkenazi Jews and Chinese people?

Robert Kennedy

I didn't say it was deliberately targeted. I just, I just quoted an NIH funded and NIH published study.

Sen. Michael Bennet (D-Colo.)

Did you say that it targets black and white people, but spared Ashkenazi Jews.

Robert Kennedy

I quoted a study Senator I quoted a NIH study.

Sen. Michael Bennet (D-Colo.)

I take that as a yes. [CROSS TALK] I have to I have to move on. Did you say that Lyme disease is a highly likely a materially engineered bioweapon? I made sure I put in the highly likely, did you say Lyme disease is a highly likely militarily engineered bioweapon?

Robert Kennedy

I probably did say that.

Sen. Michael Bennet (D-Colo.)

Did you say that? [CROSS TALK] I want all of our colleagues to hear Mr. Kennedy, I want them to hear it. You said yes. Did you say that exposure to pesticides causes children to become transgender?

Robert Kennedy

And no, I never said that.

Sen. Michael Bennet (D-Colo.)

Okay. I have the record that I'll give to the Chairman and he can make his judgement about what you said. Did you write in your book and I... "it's undeniable that African American African AIDS is an entirely different disease from Western aids"? Yes or no?

Mr. Kennedy?

Robert Kennedy

I'm not sure if... I may have.

Sen. Michael Bennet (D-Colo.)

I'll give it to the Chairman. Mr. Mr. Kennedy, in the My final question, did you say on a podcast, and I quote, "I wouldn't leave it, abortion, to the States. My belief is we should leave it to the woman. We shouldn't have the government involved, even if it's full term".

Did you say that?

Robert Kennedy

Mr. Senator, I believe that abortion is a tragedy.

Sen. Michael Bennet (D-Colo.)

You say it Mr. Kennedy, matters. It doesn't matter what you come here and say, that isn't true. That's not reflective of what you really believe that you haven't said over decade after decade after decade. Because unlike other jobs we're confirming around this place.

This is a job where it is life and death for the kids that I used to work for in the Denver Public Schools, and for families all over this country that are suffering from living in the richest country of the world that can't deliver basic health care and basic mental health care to them. It's too important for the games that you're playing, Mr. Kennedy, and I hope my colleagues will say to the President, I have no influence over him. I hope my colleagues will say to the president, out of 330 million Americans, we can do better than this.

Sen. Mike Crapo (R-Idaho)

Thank you. We need to move on. Senator Cassidy.

Sen. Bill Cassidy (R-La.)

Mr. Kennedy, President Trump has sworn to protect Medicare. Republicans are exploring reforms to Medicaid that could help pay for Trump Administration priorities. With this context, what will you do about dual eligibles?

Robert Kennedy

About...?

Sen. Bill Cassidy (R-La.)

Dual eligibles?

Robert Kennedy

Well, dual eligibles are not right now served very well under this system. Those are people who are eligible for Medicaid and Medicare. And..., you know..., the..., I suppose my answer to that is to make sure that the..., that

the programs are consolidated, or integrated care is integrated. I look forward to working with you, Dr. Cassidy on making sure that we take good care of people who [INAUDIBLE]

Sen. Bill Cassidy (R-La.)

And how would we How do you propose that we integrate those programs? does Medicare pay more, Medicare pay less? Medicaid pay, more Medicaid pay less? How do we do that?

Robert Kennedy

Well, the I'm not exactly sure, because I'm not in there. I mean, it is difficult to integrate them because Medicaid is Medicare's under a fee for service. It's paid for by employer taxes. Medicaid is a..., has a..., is fully paid for by the federal government.

And it's not fee for service. So it's..., I don't..., I do not know the answer to that. I look forward to exploring options with you.

Sen. Bill Cassidy (R-La.)

Republicans, again, are looking at ways to potentially reform Medicaid to help, you know, pay for President Trump's priorities but to improve outcomes. What thoughts do you have regarding Medicaid reform?

Robert Kennedy

Medicaid is not working for Americans. And it's specifically not working for the target population. Most Americans like myself, I'm on Medicare Advantage, and I'm very happy with it. Most people who are on Medicaid are not happy.

The premiums are too high, the deductibles are too high, the networks are narrow, the best doctors will not accepted it in the best hospitals. And particularly Medicaid was originally designed for a target population the poorest Americans. It's now been dramatically expanded. And the irony of the expansion is that the poorest Americans are now being robbed, their

services have dramatically dis..., decreased, even though we've increased the..., price of Medicare by 60% over the last four years..., the target population has been robbed without [CROSS TALK]

Sen. Bill Cassidy (R-La.)

With that. Obviously, you've thought about that. And I appreciate that. What reforms do you recommend, again, that would improve services, I suppose, but also make it more cost efficient?

Robert Kennedy

Oh, President Trump has, has given me the charge of improving quality of care and lowering the price of care for all Americans. There are many things that we can do. We want to..., the ultimate outcome, I think, is to increase transparency to increase accountability, and to transition to a to a value based system rather than a fee based system. Other than a service based system.

Sen. Bill Cassidy (R-La.)

Medicaid in particular, can you just kind of take take those kind of general principles and apply it to the Medicaid program?

Robert Kennedy

You know, I listen, I think that theirs..., are many, many options with telemedicine with AI right now. And you know, there's a, including direct primary care systems or you're seeing that move and grow across the country, there is a one of the largest [CROSS TALK]

Sen. Bill Cassidy (R-La.)

So So knowing so going back to Medicaid, though, and speaking of these specific advances, how would you what reforms are you proposing with these ideas visa vie Medicaid?

Robert Kennedy

Well, I don't have a pro..., Proposal for dismantling the program I just...,

Sen. Bill Cassidy (R-La.)

Say, of course, not saying that.

Robert Kennedy

I think what we need to do as we need to experiment with pilot programs, each state we need to keep our eye on the ultimate goal, which is value based care, which is transparency, accountability acts as...,

Sen. Bill Cassidy (R-La.)

And one more thing going back to Medicare. You mentioned you're an MA, you mentioned earlier, the Medicare fee for service. Do you have any kind of thoughts as to whether or not patients on fee for service should move into MA? Or how should we handle that?

Robert Kennedy

Whether patients...?

Sen. Bill Cassidy (R-La.)

Who are on Medicare fee for service

Robert Kennedy

Traditional Medicare?

Sen. Bill Cassidy (R-La.)

Yes.

Robert Kennedy

That's their choice right now. I mean, we have 32 million Americans, or 30 million Americans on Medicare on traditional Medicare, and then another

34 or 30..., 34 on Medicare Advantage, roughly half and a half. And I think more people would rather be on Medicare Advantage because it offers very good services. People can't afford it.

It's much more expensive. Oh, and answered your first question there. You know, there's all kinds of exciting things that we can be doing, including cooperatives, which Trump has supported, including health savings accounts, which President Trump has supported all of these things to make people more accountable for their own health.

Sen. Bill Cassidy (R-La.)

And so we'd bring the cooperatives in the health savings accounts into Medicare and Medicaid.

Robert Kennedy

Exactly, we try to, we try to increase those, the use of those and to direct primary care to continue to transition to value based program that is, that is private Americans. Americans don't by and large, don't do not like the Affordable Care Act. People are on it. They don't like Medicaid.

They like Medicare. And they like private insurance. We need to listen to what people, they would prefer to be on private insurance. Most Americans if they can afford to be, will be on private insurance.

Oh, we need to figure out ways to improve care, particularly for elderly, for veterans, for the poor in this country. And Medicaid. The current model is not doing that. I would ask you know any of the Democrats who are chuckling just now, do you think all that money that $900 billion that we're sending to Medicaid every year has made Americans healthy?

The do we think it's working for anybody? Are the premiums low enough?

Sen. Mike Crapo (R-Idaho)

We do need to move on Senator Warnock. Mark Warnock

I gotta tell you, for literally hundreds of thousands of Virginians, Medicaid is what prevents them from health crisis on a daily and weekly basis. And some

imaginary new plan, and if there was a new plan, that was the be the basis of what Trump was going to do when repealing Obamacare, I would have thought by now we'd've seen it.

Robert Kennedy

Can I respond to you? Mark Warnock

I gotta tell you, Mr. Kennedy, I got questions. I appreciate our visit. I know you, you take your views seriously.

And I don't reflexively vote. I voted for for President Trump's nominees, already. Got a lot of grief from folks on this panel. But I gotta tell you, I saw an email that you put out Monday night, or your campaign did, in a funding fundraising email, your presidential campaign celebrated, that the freeze on all new regulations, guidance and announcements is a way to protect unelected bureaucrats from further undermining our health freedom.

Then you ask your donors to help pay for your campaign debt. Did your campaign and you put out that?

Robert Kennedy

I don't think my campaign exists anymore. Mark Warnock

Well, listen, I gotta tell you this. somebody's out there soliciting money for it. Maybe you got to find out who is.

So the fact that you celebrate this freeze. Do you think that was a good idea to put all of this on hold for 90 days? funding and any kind of further work NIH research?

Robert Kennedy

As as Chairman Crapo pointed out. Mark Warnock

What do you I'm , I love Mike Crapo, I'm asking you. You're up for a very, very important position.

Robert Kennedy

As As he pointed out, Senator, the the portals that were close, were not closed as a result of the Trump Adminstration. Mark Warnock

Let me just tell you, I'd like to excuse me, sir, I'd like you to explain to a domestic violence Center in Richmond, that same because this freeze, they may have to close down. Where are those battered women to go or a rural nonprofit, I've got in the Shenandoah valley saying that freeze is going to potentially shut down their ability to operate. So I don't I guess if you deny or don't know what your campaign sending, you don't know, if you raise a lot of money Monday night [INAUDIBLE]

Robert Kennedy

I'm saying that Trump

Mark Warnock

You don't know if you raised a lot of money?

Robert Kennedy

The Trump Administration has made clear, that it does not want to freeze benefits for [CROSS TALK] any Americans under Medicaid or Medicare, and I do not want that. Mark Warnock

the Freeze is affecting beyond Medicare and Social Security. I would hope you would have known that. To be able to answer some of this.

Now, you've said publicly, you want to immediately get rid of 600 NIH workers on job one on day one. When we had our meeting, you said you actually like to get rid of 2200 people from HHS, which offices are you going to start cutting and riffing these 2200 workers?

Robert Kennedy

There's 200 political appointees that are changed during every administration. Mark Warnock

So if you got rid of those political appointees, you're not going to replace them with your political appointees.

Robert Kennedy

Well President Biden this year changed 3000 employees at HHS. 3000. 750 at NIH. Mark Warnock

What departments are you going to pick them from?

Robert Kennedy

Well, the same is President Biden did when he changed 3000 out. Mark Warnock

On down to a minute minute 30. The Chairman has been generous with colleagues on both sides and may have to go a couple minutes over. But let me just say so let's just answer.

This would be this. I hope, since you're asking to become the top health care official in the United States and from HHS, huge ramifications. And part of his job is to be the senior adviser to the President on health issues. So when we're looking at this purge, and we're looking at laying off workers when we're looking at potentially the President's illegal offer to try to buy out federal employees, which I would say to any federal employees think twice, has this individual in his business world ever fulfilled his contracts or obligations to any workers in the past?

But if you are in this position, where you pledge that you will not fire federal employees who work on food safety work on trying to preventing things like salmonella?

Robert Kennedy

Uh uh Senator they're 91,000 employees

Mark Warnock

so that I take that as I take it, that's a simple yes or. And I'm gonna take that as a no. [CROSS TALK] That's I take that as well, you actually we talked

about protecting Americans from cybercriminals. So I'm going to do a lot more on it.

Will you commit not to fire anyone in the health arena, who currently works on protecting Americans from cyberattacks in their healthcare files?

Robert Kennedy

I will I will commit, to not firing anybody who's doing their job. Mark Warnock

Based on your opinion, based upon your opinion, or your political agenda or Mr. Trump's political agenda?

Robert Kennedy

Based upon my opinion. Mark Warnock

I guess that means a lot of the folks who've had any type of views on vaccines will be out of work. Will you freeze grant funding for community health centers? Will you fre freeze federal funds for community health centers, the way the current administration has

Robert Kennedy

The White House has made clear and no funds are gonna be denied to any American for benefits. Mark Warnock

Listen-

Robert Kennedy

Any program. Mark Warnock

-Do you know, what happens at community health centers, those are direct

Robert Kennedy

Are you talking about the Indian Health Centers? Mark Warnock

No, I'm talking about community health centers across the country.

Robert Kennedy

I understand that I strongly

Mark Warnock

you're gonna excuse Indian Health Service, which is good, but others are not. They're gonna get their funds frozen.

Robert Kennedy

I strongly support community health centers, as does the President. Mark Warnock

So does that mean we're not going to freeze the funding that is currently frozen,

Robert Kennedy

The White House has made clear that none of that funding is supposed to be frozen,

Mark Warnock

sir, the direct payments are different than how the government operates. We fund the federal government down to community health centers, as a former governor, there's lots and lots of state programs that are related to health care that come from the federal government, they come down to the state, then it goes to local programs. All of those don't directly pay out a dollar at a time. but they come from federal funding.

They are all you know, even though they keep changing the guidance on a minute by minute basis, based upon 9:45 or 10:30 or 10:45. Whatever time it is today, those funds are still frozen. Sorry, I just honestly, I want to give you a fair shot. But I don't feel like I don't feel like you approach this job with the knowledge.

And candidly, your willingness, not willingness not to commit, trying to recommend to the president to make sure these funds are unfrozen and that people's lives are at stake is a very disappointing answer. Thank you, Mr. Chairman.

Sen. Mike Crapo (R-Idaho)

Senator Lankford.

Sen. James Lankford (R-Okla.)

Mr. Chairman, thank you. Mr. Kennedy, Good to see you. Again.

We had some great visits in my office, we've done some follow up calls to be able to go through you and I have talked about 100 different issues and backgrounds and things, you've been able to address a lot of them today, and just different questions to be able to clear up social media rumors, and the things that are out there on it. So I do appreciate that. We've talked about pharmacy benefit managers, we've talked about the nursing home ruled by the administration. But down we talked about views on agriculture, and commercial and row crop agriculture.

We've talked about food issues, and you've made it very, very clear, you're not going to tell Americans what to eat. But you do want Americans to know what they're eating. And I think that's a pretty fair perspective on that. I do want to talk to you about some areas that you and I have talked about as well.

We have some disagreements you and I on the issue of life. And when life begins on that you've been very outspoken on that. And and we've had some good opportunity to be able to talk about that. Title X is specifically in the HHS area.

This has been an area that has been interpreted for a long time. And President Trump in the first administration interpreted that rule to say that his administration will prohibit the performance referral for promotion of abortion as a part of the Title X program that he made that very clear in the first administration. Obviously, that's his decision to make, again on that, on how he wants to handle that. And he's made a lot of public statements on that.

The Biden Administration, we've not only reversed that, and only rescinded that rule. But they went one step the other direction. In my state in Oklahoma, as you and I have talked about, the Biden Administration cut off funding to the state of Oklahoma, for AIDS testing, for breast cancer screening and for other areas of poverty, health care, because my state didn't promote abortion, it wouldn't provide if my state wouldn't promote abortion in the States. We got cut off for federal funds for AIDS testing and for other things.

My simple question to you is, how are you going to handle Title X? On that I saw how President Biden handled that in the punitive measures that came on my state. For those that are in rural health care. How are you going to handle time

Robert Kennedy

To support President Trump's policies when Title X I agree with President Trump that every abortion is a tragedy. I agree. We cannot be a moral nation if we have 1.2 million abortions in the air. I agree with them that the states should control abortion on President Trump has told me that he wants to and late term abortions and he wants to protect conscience exemptions and that he wants to end federal funding for abortions here abroad as Title X.

I'm going to I serve at the pleasure the president I'm going to implement his policy.

Sen. James Lankford (R-Okla.)

So thank you for that. President Biden when he came in immediately closed down The Office of Civil Rights and Conscience Protections within HHS. There's a statement that's come out recently that he's going to reopen that office again, to be able to protect the civil rights of Americans. One of the things that Xavier Becerra did immediately when he came into HHS was conscience protections for medical professionals that were being compelled against their conscience to perform medical procedures that violated their conscience, Xavier Becerra stepped in immediately and HHS and withdrew that and said, No, the federal government will tell you what you believe about these issues, you don't have conscience protections anymore, and refused to protect those folks.

Will you step in and say that healthcare individuals have the right of conscience again, as the federal law allows?

Robert Kennedy

Yeah, I mean, the first thing that occurs to me when you ask that question is what patient would want somebody doing a surgery on them, you know, believes that surgery is against their conscience being forced to perform that I don't know anybody who would want to have a doctor performing a surgery that the doctor is, is morally opposed to listen, I came from a family, I was split on life and choice. I have cousins today who believe that abortion at any stage is equivalent to homicide. Now, there are other people who believe the opposite. But the good thing in my family that I really loved is that we were able to have those conversations and respect each other.

And I wish we could do that nationally. And if if forcing somebody to participate in a medical procedure, as a provider that they believe is murder does not make any sense to me, we need to welcome diversity in this country, we need to respect diversity. And we need to respect each other when we have different opinions and not, you know, not force our opinions on other people.

Sen. James Lankford (R-Okla.)

Thank you for that the FDA, under the Biden Administration changed the rules for the chemical abortion drug, and said, you no longer need to see a physician. So if you have an ectopic pregnancy, or all kinds of other junk don't even go anymore to see a physician. But they also changed an area that has been something has been very particular, you've talked about a lot. That's transparency, they changed the position and said don't tell us if there's a side effect on this drug unless she dies.

But other than that, don't tell us any more literally don't give transparent information to the American people or to the women who take this drug anymore, we don't want that reported. My question to you is, Will FDA move to be able to actually give transparency to the American people and to say this drug is no different than any other drug. We don't want to protect it just because it's political. For some folks, people should know, side effects on this drug and there should be reporting.

Robert Kennedy

I mean, it's it's against everything we believe in this country. Patients or doctors should not be reporting adverse events, we need to know what adverse events are, we need to understand the safety of every drug owner and every other drug. And President Trump has made it clear to me that one of the things he has not taken a position yet and if I press down a detailed position, but he's made it clear to me that he wants me to look at the safety issues. And I'll ask NIH FDA to do.

Thank you.

Sen. Mike Crapo (R-Idaho)

Senator Whitehouse.

Sen. Sheldon Whitehouse (D-R.I.)

Thank you, Chairman. Mr. Kennedy, I only have five minutes with you. So and I've got a lot of experience with CMS. So you're just going to have to listen to things.

One, if you want to move from advocacy, to public responsibility. Americans are going to need to hear a clear and trustworthy recantation of what you have said on vaccinations, including a promise from you never to say vaccines aren't medically safe, when they in fact are and making indisputably clear that you support mandatory vaccinations against diseases where that will keep people safe. You're in that hole pretty deep. We've just had a measles case in Rhode Island, the first since 2013.

And frankly, you frighten people. Two. I want to air harms that Rhode Island has experienced From a remorseless, senseless, CMS bureaucracy. CMS has for years, maintained a reimbursement system that the bureaucracy could never explain, never justify, that persistently pays Rhode Island providers less than neighboring Massachusetts and Connecticut providers, a differential of 23 and 26%.

In our regional health care market, the pending ahead program can begin to remedy this at least for value based care. And it must, there has to be

payment parity in the region. Rhode Island's health care system is bleeding out because we aren't paid what neighboring hospitals and doctors are paid. And the one act CMS took on this years ago was to make it worse.

The CMS bureaucracy has also attacked one of the best accountable care organizations in the country. Rhode Island's Integra family doctors tried to throw them off the Shared Savings Program because they said Integra years ago briefly fell 137 patients short of the 5000 patients that ACOs need. CMS wouldn't listen until a court found that to be unjustified, likely illegal, irreparable harm to this high performing ACO and its patients and contrary to the public interest that must stop. Last, CMS has refused to approve waivers granted elsewhere for Rhode Island from rules that are stupid for Medicare patients who are nearing the end of their days.

Here's what families see. Granny is home dying. She needs to transfer to a nursing home and Medicare insists on putting her three days and two nights in a hospital. Expensive, frightening to granny and the family, and stupid.

Granny's at home dying and can't get palliative and curative care together inhumane and stupid. Granny's home dying and can't get home care, if she can still get out into the yard or be driven to see the shore to see Narragansett beach ,say, one more time to recall childhood memories for she dies. Inhumane and stupid. Granny's home dying and the families exhausted.

And the respite care benefit is not to send a nurse or a caregiver, but to stuff granny in an ambulance and haul her off to a hospital. Some respite. It's all expensive, frightening, inhumane and stupid. But the insensate CMS bureaucracy takes a court order to be awakened to the harm they cause.

I have had enough. CMS should let Rhode Island try humane end of life care through CMMI. Let's see if it works at a state. I bet it will save money, serve families better at a very, very delicate time, and perhaps even make a model for better health care, everywhere.

I've said a lot. My time is out. You're welcome to respond in writing. I ask unanimous consent that the order declaring CMS's actions to constitute irreparable and likely illegal harm be put into the record.

Sen. Mike Crapo (R-Idaho)

Without objection.

Robert Kennedy

Let me let me just respond very briefly, Senator Whitehouse I'm an implacable enemy of tyrannical insensate bureaucracies and stupid roles and I will work with you make the CMS responsive to the needs of Rhode Island and to remedy those disparities that you talked about. I am familiar with the Integra health plan. And it is a template for what we ought to be doing, a value based plan. And I look forward to you, to making sure that we we create pilot programs like this I work [INAUDIBLE] around the country.

Sen. Sheldon Whitehouse (D-R.I.)

Unfortunately, Mr. Chairman, one of the things I've learned in my tenure in the Senate is that a nominee saying that they're willing to work with me amounts to exactly zero. We need to get this fixed. Thank you.

Sen. Mike Crapo (R-Idaho)

Well, I guess at that point, then we will move on to Senator Daines.

Sen. Steve Daines (R-Mont.)

Mr. Chairman. Thank you. Mr. Kennedy.

I'm glad to see you here this morning. I listened to your opening remarks. And you mentioned that you want to make HHS the gold standard of science. I have found my engagements with you both behind closed doors in my office, as well as listened to you publicly, to be very thoughtful, and science based.

I applaud that. I thank you for that. And I realize this will likely be a very partisan vote on this Committee, and on the Senate floor. But let the record state there are three medical doctors on this side of the Dais.

I'm a chemical engineer, we believe in science. I'm thankful that you do too. And you made that comment in your opening remarks. I want to talk about agriculture.

For a moment we talked about our common love for Montana, you've been to Montana many times. It's a wonderful state. A lot of folks have discovered it. They watch the show Yellowstone and people are coming and moving into our state, but it's an amazing place.

But as you know, agriculture is our top economic driver in Montana. We produce some of the highest quality crops, the best livestock in the country in the world. Our farmers and our ranchers are truly some of the most effective environmental stewards and ensuring we have a safe food supply chain in the world. I share your view that protecting the integrity and safety of our food supply is of the utmost importance.

I appreciate the research happening in places like Montana State University to help farmers produce resilient, healthy and safe crops as well as their agricultural product practices. You mentioned you were 4-H kid growing up. I think our 4-H kids and our FFA kids are some of the best kids in America. My question for you, Mr. Kennedy is, If confirmed, as I'm listening to my farmers and ranchers talk about the future, Will you commit to working collaboratively with partners at USDA, at the relevant federal agencies as well as our Montana farmers and ranchers before implementing any policy that might affect or impact food supply?

Robert Kennedy

Absolutely, I'll make that commitment. I shared with you a personal commitment and a long career working with farmers. I want to make sure I understand the very very narrow margins slim margins that American farmers and ranchers are dealing with and I don't want under my watch a single farmer to have to leave his farm for economic reasons or for regulatory or bureaucratic reasons while I serve, if I'm privileged to serve, to be confirmed as HHS Secretary. Even more important, President Trump has a very, very strong commitment to farmers.

President Trump was, is is probably, historically, in modern history, the best farm president in our history of farm income spiked for the first time in decades under his last administration. He got solid support for farmers across the country farm country is Trump country. farmers across the country supported him during this election, he has specifically instructed me that he wants farmers involved in every policy, and that he wants me to work

with Brooke Rollins at USDA. Make sure that we preserve American farmers that all of our policies support them.

Sen. Steve Daines (R-Mont.)

Mr. Kennedy, thank you. And if confirmed, I look forward to having you and Brooke Rollins out to Montana to spend some time

Robert Kennedy

You have my commitment to come there anytime, particularly during ski season or hunting season.

Sen. Steve Daines (R-Mont.)

Deal.

Sen. Steve Daines (R-Mont.)

I want to shift gears for a moment, as we discussed in the meeting we had in my office. mifepristone was approved in 2000. The FDA has been under scrutiny and brought to court for failure to properly assess this drug, as well as subsequent deregulation Senator Lankford described that occurred over the past 25 years. Some of these deregulations included: ending the requirement that these drugs be prescribed by a doctor; ending reporting requirements for adverse events; and allowing these pills to be obtained through the mail.

In fact, the FDA's own prescribing label mentioned that 3-5% of women taking this drug and up in the emergency room. My question is If confirmed as Secretary of HHS, will you commit to working with the FDA FDA commission review these deregulatory actions that are threatening the safety of women?

Robert Kennedy

All right. All right, Senator Senator. As I said to Senator Lankford, I think it's immoral to have a policy where patients are not allowed to report adverse

events or doctors are discouraged from doing that. And President Trump has asked me to study the safety of mifepristone, he has not yet taken a stand on on how to regulate it.

Whatever he does, I will implement those policies and I will work with this Committee. Make those policies make sense. Thank you, Mr. Kennedy.

Sen. Mike Crapo (R-Idaho)

Senator Hassan.

Sen. Maggie Hassan (D-N.H.)

Thank you, Mr. Chairman, Ranking Member Wyden and welcome Mr. Kennedy and to your family as well. I want to start with a couple of concerns I have and just briefly on Medicaid states share in the funding of Medicaid, millions of disabled children in this country are alive because of Medicaid. Millions of people with addiction in this country are in recovery because of the services provided to them by Medicaid, and millions of chronically ill people who until Medicaid expansion was enacted, who couldn't get health care and therefore couldn't work because they were too sick, got health care through Medicaid expansion, then went back to work, and now they're on private insurance. So those are some facts about Medicaid that you might want to brush up on.

Now. I'm also extremely concerned about your endorsement of radical fringe conspiracies that if implemented at HSS, HHS would put American families lives at risks. Vaccines are one of our greatest public health triumphs, and you don't need I'm not talking about abstract medical science. One of the people who helped raise me was my grandfather, who was a pediatrician.

He practiced medicine in this country from 1921 until the mid-1980s. And I heard details about the difference those vaccines made in saving lives in the children who were under his care. Vaccination has helped to eradicate many deadly diseases in the United States, including polio, and smallpox, something we should be proud of as Americans. I am extremely concerned that as Secretary, you would be able to hold critical vaccine research and to exploit parents natural worries by advising them not to vaccinate their children, this will lead to more children getting sick, and some will even die.

Before the measles vaccine, about 500 American children died a year from measles. This is too much of a risk for our country. And there is no reason that any of us should believe that you have reversed the anti-vaccine views that you have promoted for 25 years. For example, you have previously falsely suggested that the polio vaccine killed many, many, many, many more people than polio ever did, by causing fatal cancers, while rigorous safety studies show that to be completely false.

Now, let's go to something we agree upon. I am really heartened to see that one area where we agree on is on women's reproductive freedom. In your own words, it's not the government's place to tell people what to do with their bodies. You said that correct?

Sen. Maggie Hassan (D-N.H.)

Yep. Mr. Kennedy, in 2023, you came to New Hampshire and said, quote, "I'm pro-choice. I don't think the government has any business telling people what they can or cannot do with their body. " You said that right?

Robert Kennedy

Yes.

Sen. Maggie Hassan (D-N.H.)

Yep. But you also said we need to trust the women to make that choice, because I don't trust government to make any choices. You said that too, right?

Robert Kennedy

Yes.

Sen. Maggie Hassan (D-N.H.)

It is remarkable that you have such a long record of fighting for women's reproductive freedom, and really great that my Republican colleagues are so open to voting for a pro-choice HHS Secretary. So Mr. Kennedy, I'm confused. You have clearly stated in the past, that bodily autonomy is one of your core values. The question is do you stand for that value or not?

When was it that you decided to sell out the values you've had your whole life in order to be given power by President Trump?

Robert Kennedy

Senator, I agree with President Trump that every abortion is a tragedy that we can't be a moral authority of this country.

Sen. Maggie Hassan (D-N.H.)

Right. So but that isn't what you said back in New Hampshire in 2023. My question is exactly when did you decide to sell out your life's work and values to get this position?

Robert Kennedy

Senator, I agree with President Trump every abortion is a tragedy.

Sen. Maggie Hassan (D-N.H.)

So what you're telling us just to be clear, because My time is limited, is that regardless of what you believe, regardless of what values you have, if President Trump tells you to do something, you're going to do it. You said just now the discussion about mifepristone? Oh, he's asked me to study the safety of it. Here are the safety studies that tell us mifepristone is safe and effective.

And I asked Mr. Chair, that these 40 about 40 studies be admitted to the record by unanimous consent.

Sen. Mike Crapo (R-Idaho)

Without objection.

Sen. Maggie Hassan (D-N.H.)

So the studies are there. the safety is proved. the science is there. But what you're telling us is if President Trump orders you to take action to make it harder for women to get direly needed health care, you'll follow his order.

If Mr. Trump, as he did yesterday, orders a halt on Medicaid payments that are essential for taking care of people with disabilities all around this country, you're going to follow that order. Because you are willing to sacrifice your values, your knowledge, if President Trump tells you to do that, that, to me is unacceptable in the Secretary of Health and Human Services.

Robert Kennedy

As I explained before, the White House has issued a statement saying that there was that that policy will not deprive any America.

Sen. Maggie Hassan (D-N.H.)

The problem is the White House issued that statement only after we pointed out the damage it would do and it became politically uncomfortable for them. You know, what else that that freeze on federal funding did? It halted funds for critical research that could cure pediatric cancer? So if the president tells you to do that, you're going to stop that, too.

That's enough.

Sen. Mike Crapo (R-Idaho)

Thank you, Senator Cortez Masto is next.

Sen. Catherine Cortez Masto (D-Nev.)

Thank you, Mr. Kennedy. Thank you for coming into my office and having the conversation that we did. I appreciate your passion, and your belief, and you've spent years really talking about the issues that matter to you. And I appreciate that.

Let me ask you a couple of questions, though. I just need some clarification. Right now. There's a 40 year old law that requires hospital ERs accepting payment from Medicare to actually provide emergency care to patients.

So let's say a woman experiencing a life threatening condition, like a heart attack goes to the ER, as a lawyer, you would agree that that federal law protects her right to emergency care, correct?

Robert Kennedy

Yes.

Sen. Catherine Cortez Masto (D-Nev.)

So now, a pregnant woman with life threatening bleeding from an incomplete miscarriage goes to the ER. Let me rephrase that, So you can hear, a pregnant woman with a life threatening bleeding, bleeding from an incomplete miscarriage goes to the ER and her doctor also determines that she needs an emergency abortion. But she's in a state where abortion is banned. You would agree also as an attorney, that federal law protects her right to that emergency care, correct?

Robert Kennedy

I don't know. I mean, answer that [CROSS TALK]

Sen. Catherine Cortez Masto (D-Nev.)

Let me ask you. This as an attorney doesn't federal law preempts state law?

Robert Kennedy

The Federal Constitution does, sometimes not every federal law preempts state laws, it could be unconstitutional. Now, I'm not trying to be evasive I'm just telling you, I don't know.

Sen. Catherine Cortez Masto (D-Nev.)

I appreciate that. But what authority do you have over this as the Director of HHS, what authority do I have to enforce the law?

Robert Kennedy

In what regards?

Sen. Catherine Cortez Masto (D-Nev.)

To make sure that a hospital that receives payment from Medicare is ensuring that they're providing the necessary emergency care to present patients? It's actually the EMTALA law. So what authority as HHS Director do you have with respect when tall?

Robert Kennedy

My understanding is that I have budgetary power? And it's pretty much limited to that. If you tell me I have another authority, I don't even think

Sen. Catherine Cortez Masto (D-Nev.)

Well, let me tell you,

Robert Kennedy

Enforcement branch in HHS.

Sen. Catherine Cortez Masto (D-Nev.)

Actually, you do and that's CMS. CMS actually investigates complaints of EMTALA violations, as well as the Health and Human Services Inspector General, who by the way, was just recently fired by Donald Trump. So you will be enforcing EMTALA laws, and it's important that you understand their impact and don't play politics with the patient presenting at the ER based on a position that this administration has taken. Let me ask you another question.

When we met my office, you said about lowering drug prices that when Big Pharma price gouging the American people suffer. I think we both agree on that. And I think you're sincere in your belief that you want to reduce prices for Americans, correct?

Robert Kennedy

Yes.

Sen. Catherine Cortez Masto (D-Nev.)

Yeah. The Inflation Reduction Act empowered Medicare to negotiate prescription drug prices. It penalizes drug companies for price hikes above inflation. And it kept seniors out of pocket drug costs, along with reducing insulin prices to $35 per month.

But your future boss, Donald Trump, on his first day in office, revoked President Biden's executive order that actually directed the Health Secretary to examine ways to reduce drug prices and improve access to innovative therapies for the American people. And unfortunately, Republicans in Congress want to repeal the Inflation Reduction Act, which means reversing all of those things that we worked on to lower prices for Americans. So my question to you is, what do you do? Why are you there?

Are you there to be a rubber stamp to this administration and cave into all of these possible positions that they're taking, even though you know, they're in disagreement with your positions on lowering drug prices, and that they could harm Americans? How do you handle that as HHS direct?

Robert Kennedy

Senator, my understanding is that the White House issued an executive order, I believe, today, supporting the drug negotiations under the IRA. President Trump was very aggressive during his first term about negotiating drug prices, he has instructed me and I've met with him repeatedly as that we need lower prices and seniors in this country and so many others are.

Sen. Catherine Cortez Masto (D-Nev.)

So let me ask you this, because I only have so much time. So we've already negotiated lowering prices for 10 drugs with Big Pharma and Big Pharma, by the way opposes this, they have not only are asking for a pause, they have filed lawsuits, but we've already negotiated the first 10 drugs. And we want to expand it to the next 10 to 15 that the Biden Administration has put forward would you agree and continue that path of really mandating that big pharma come to the table and negotiate drug prices for Medicare so we can lower those prices? For Americans?

Robert Kennedy

My understanding is that the executive order that was issued today, which I haven't seen, but I've read a summary.

Sen. Catherine Cortez Masto (D-Nev.)

Well, let me ask you this, then because you keep citing the Trump Administration, and you're just going to follow what they say, is that what you're doing, you're just a rubber stamp for them in this position. So anybody, so it doesn't matter that you're before it could be anybody coming before us, as long as they're a rubber stamp for this administration and disregarding your beliefs in what you think. I guess my question to you is, if it really is fundamental to what you believe, how do you live with that? How do you try to address those issues as you're moving forward?

Robert Kennedy

Yeah, I'm gonna answer the question.

Sen. Catherine Cortez Masto (D-Nev.)

No, I'm asking you.

Robert Kennedy

Okay. President Trump has asked me and the chronic disease epidemic and make America healthy again.

Sen. Catherine Cortez Masto (D-Nev.)

Is that only reason why here at HHS, because that's the only reason why then you're at the HHS to address that one issue?

Robert Kennedy

President Trump has asked me because I'm in a unique position to end that. And, and that is what I'm doing. And if we don't solve that problem, Senator, all of the other disputes we have about who's paying and whether it's insurance companies, whether it's providers, whether it's HMOs, whether

it's patients or families, all of those are moving deckchairs around them, the Titanic. Our ship is sinking.

Our 60% increase in Medicaid over the past four years, is the biggest budget line now and it's growing faster than any other and no other nation in the world as we have here. No other nation has chronic disease. We have the highest chronic disease burden of any country in the world. We had during COVID We had 16% of the COVID deaths in a country we only have 4.2% of the world's population.

We had a higher death count than any country in the world. And when CDC was asked why he said it's because Americans are the sickest people on Earth. The average person died from COVID. American had 3.8 chronic diseases.

This is an existential threat economically to our military, or health to our sense of wellbeing. And it is a priority for President Trump. And that's why he asked me run the agency and if I'm privileged to be confirmed thats exactly what I'll do.

Sen. Mike Crapo (R-Idaho)

Senator Barrasso.

Sen. John Barrasso (R-Wyo.)

Thanks so much, Mr. Chairman. Mr. Kennedy, thank you for taking time to visit with me in my office prior to today's hearing to talk about a lot of the important issues affecting health care in my home state of Wyoming as well as the nation, I appreciate your willingness to serve our country. During our meeting, we discussed the challenges that healthcare providers and patients are facing in rural America, financial obstacles facing rural hospitals, workforce shortages, issues of OBGYN and the new regulations that are painful that have come out of the Biden Administration are hurting our ability to provide nursing home staffing. So let me start if I could with rural hospitals and the closures of hospitals like that, the there are a lot of challenges facing hospitals in rural communities in frontier areas.

We have 33 hospitals in Wyoming. 26 are really located in areas locations, often hard to get to weather impacts them, six of the hospitals are at risk of clothing closing to our immediate risk of closing in the next two years. 10 have had to cut available services. And this is a concern of rural hospitals, both Republican and Democrat states either way, bipartisan, critical that though workforce challenges, financial challenges that we're facing are addressed.

Can you commit to working with us on a plan to address the critical nationwide issue of rural health care?

Robert Kennedy

Yes, Senator. And I would say that during my visit, I visited almost 60 senators of our and the most common unifying, I would say issue among both Democrats and Republicans. There were two one was PBM reform, and the others were hospitals and our nation made a commitment over 100 years ago to put up a hospital within 30 miles of every American. We generally succeeded in doing that.

It's absolutely critical. It's life saving. And rural hospitals are closing at an extraordinary rate right now, not only provide important health care for the localities, but also their economic drivers for localities all over this country. President Trump is determined to end the hemorrhage of rural hospitals.

And he's asked me to do that, through the use of AI through telemedicine, which these are innovations that I saw the other day, a Cleveland Clinic has developed an AI nurse that you cannot distinguish from a human being that has diagnostics, as good as any doctor. And we can evaluate we can provide concierge care to every American in this country, even those remote parts of Wyoming, Montana, Alaska etc. We also have opportunities at HHS a GME to finally live up to GME's mission of serving of providing personnel to to rural hospitals. And I intend to use all my power because I've seen the the priority is given by both Democrats and Republicans on this Committee.

I intend to make that a priority of mine. If I'm privileged to be confirmed.

Sen. John Barrasso (R-Wyo.)

I appreciate it because often financial strains on the local hospital, one of the common services to be cut in rural hospitals and maternity services. And now we have women in Wyoming having to drive over 100 miles to access care. 13 counties in Wyoming don't have access to OB GYN we're talking counties larger than the states of Vermont, New Hampshire, Rhode Island, Connecticut, New Jersey, Delaware County is larger than those holes state. So will you commit to working with my office to find solutions to help address these specific maternal health challenges in rural America?

Robert Kennedy

Yes.

Sen. John Barrasso (R-Wyo.)

I look forward to it. Another issue we specifically spoke about with this harmful Biden Administration rule that have really been bad for our world nursing homes. And it's a rule that would triple the registered nurse requirements in nursing homes. This is going to lead we there just aren't enough registered nurses in our state to be able to comply with this.

This would lead to nursing home closures across our state. Will you commit to working with me to fix this serious problem that it was a result of a rule that came out by the Biden Administration who clearly doesn't understand rural America?

Robert Kennedy

Yes, Senator, I think the rule was well intentioned. As you've said, and I've heard from many rural senators, it will be a disaster for their state. Some of the nursing homes these are staffing rules that require 24 hours staffing by medical professionals. Some of the nursing homes in rural areas simply do not have the available personnel or economics be evident.

It will mean a closure of nursing homes and rural areas across our country, which means the parents, elderly parent will be moved a great distance from the local community and their family. And we know that the single greatest driver of high quality nursing home care is the involvement, the proximity of family members, when you move that nursing facility, away from the

community when the kids live, you're gonna get much worse cared. So the intention, although it was noble was in reality for rural areas, at least it is going to be a disaster.

Sen. John Barrasso (R-Wyo.)

Thank you. Thank you, Mr. Chairman.

Sen. Mike Crapo (R-Idaho)

Thank you, Senator Johnson.

Sen. Ron Johnson (R-Wis.)

Because Kennedy, welcome. Thank you for being here. Thank you for your decades long advocacy for a clean environment for children's health. I can't see as I'm surprised by the hostility on the other side.

I'm highly disappointed in it. I don't know if you remember when you called me up and you're contemplating setting your political differences aside, joining forces with President Trump on an area of agreement, addressing chronic illness trying to find the root cause of of all these problems facing this nation. My first response was, Bobby, this is an answer my prayers. We need to get to the answers of this but even more, we need to heal and unify this divided nation.

I'm not necessarily the most optimistic guy because we've got enormous challenges facing this nation. But I thought, wow, here's somebody from the left somebody I don't agree with on many issues politically, coming together with President Trump. And focusing on an area of agreement, so something that the American people desperately want. Finding out the answers what has caused autism?

What is causing chronic illness? Mr. Kennedy, I know. I think I've come to know what's in your heart. I think I know the personal and political price you've paid for this decision.

Guys, I want to say publicly, I thank you for that. I truly appreciate what you're doing here. Can't we come together as a nation? And do this?

Can we do it? Aren't you? Aren't you getting tired of this? I'm getting tired of this.

So again, Mr. Kennedy, I need to enter in the record. This is just these are just 11 letters of support signed by 63,000 people thousands of doctors from the American associate Association American Physicians and Surgeons independent MediCal Alliance, the North Carolina physicians and freedom group. Governor Jeff Landry from Louisiana. These are Americans non-partisan.

A lot of a lot of these people I have no because I've advocated with you. A lot of them are Democrats. They put their political differences aside. So Mr. Chairman, I'd like to enter this in the record without objection.

I also do want to Mr. Mr. Kennedy as long as I have you here. I've written over 70 oversight letters to the federal health agencies under the Biden Administration, I've virtually gotten squat out of them. Okay, what I get is we get, for example, 50 pages of Anthony Fauci his emails redacted. Oh, by the way, the latest one was 17 pages instead of issuing a Health Alert.

On the myocarditis, myocarditis, the news was impacting young men, early in 2021, instead of issuing an alert on the Health Alert network, they developed 17 pages of talking points. That was this was given to the public under FOIA requests, they had to go to court. They've got a new way of redacting, they don't black things out, they just give you white pages. So you don't even know what they have redacted.

So again, I have issued a subpoena now, to cover the information I've requested in 70 oversight letters. My question to you is, as as Secretary of HHS, will you honor these requests from Congress and will you make HHS transparent?

Robert Kennedy

Yes. My approach ah, as I said before, Senator it as radical transparency, Democrats and Republicans ought to be able to come in and get information that was generated at taxpayer expense that is owned by the American

taxpayer. It shouldn't get redacted documents, public health agencies should be transparent. And we if we want Americans to restore trust in the public health agencies, we need transparency.

The you know, the, I want to say something about your first ad. When I launched my campaign, it was about uniting Americans, Democrats and Republicans. There's no issue that she's noticed, or this chronic health epidemic. There's no such thing as Republican children or democratic children.

These are our kids. 66% of them are damaged. I know what a healthy kid looks like. Because I had so many of my family.

I didn't know anybody with a food allergy growing up peanut allergy. Why do five of my kids have allergies? Why are we seeing these explosions in diabetes, rheumatoid arthritis, neurological diseases, depression, all these things that are related to toxic to the environment? Why can't we just agree with each other, to put differences about so many issues, intractable issues aside, as a, we're going to end this, I don't think anybody is going to be able to do this, like I have it because of my peculiar experience.

Because I've litigated against these agencies, when you litigate against them, you get a PhD in corporate capture and how to unravel it. I've written six books about these agencies. I know a lot about them, and I know how to fix it. And there's nobody who will fix it the way that I do because I'm not scared of vested interest.

I don't care. I'm not here because I want a position or a job. I have a very good life and a happy family. This is something I don't need.

I want to do this, because we're gonna fix it. And the other thing is up, we are attracting now, a caliber of people to HHS, like never before in history, and they're entrepreneurs. They're they're disruptors. They're innovators of immense talents that are walking away, many of them from growing concerns, they're not coming there, or position or coming there because they want to save our country.

And they're from across the political spectrum. And all these Democrats are opposed to me for partisan issues. They used to be my friends agreed with

me on all the environmental issues I've been working on for my whole career out there against me because anything that President Trump does any decision as as to be, lampooned, derided, discredited, marginalize vilify, we need to move on.

Sen. Mike Crapo (R-Idaho)

Senator Warren.

Sen. Elizabeth Warren (D-Mass.)

Thank you, Mr. Chairman. So Mr. Kennedy, I want to start with something that I think you and I agree on. And that is that Big Pharma has too much power in Washington. You said that President Trump asked you to, quote, clean up corruption and conflicts.

Sounds great. You've said that you will, quote slam shut the revolving door between government agencies and the companies they regulate. That also sounds great. So here's an easy question Will you commit that when you leave this job, you will not accept compensation from a drug company, a medical device company, a hospital system or a health insurer for at least four years, including as a lobbyist or a board member?

Robert Kennedy

Can you just repeat the last part of the question?

Sen. Elizabeth Warren (D-Mass.)

Will you commit to take money from drug companies in any way? shape or form?

Robert Kennedy

Yes, yeah. Oh, I happen to commit to that.

Sen. Elizabeth Warren (D-Mass.)

That's what I figured. I said, it's an easy question to start with. And I think you're right on this.

Robert Kennedy

I don't think any of them want to give me money. By the way.

Sen. Elizabeth Warren (D-Mass.)

Let's, let's keep going. You're right. Because to say yes, because every American has the right to know that every decision you make, as our number one health officer is to help them and not to make money for yourself in the future. So I want to talk more about money.

I'm looking at your paperwork right now. In the past two years, you've raked in two and a half million dollars from a law firm called Wisner Baum. You go online you do commercials to encourage people to sign up with Wisner Baum, to join lawsuits against vaccine makers. And for everyone who signs up you personally get paid.

And if they win their case, you get 10% of what they win. So if you bring in somebody who is gets $10 million, you walk away with a million dollars. Now you just said that you want the American people to know, you can't be bought your decisions won't depend on how much money you could make in the future. You won't go to work for a drug company after you leave HHS.

But you and I both know, there's another way to make money. So Mr. Kennedy, will you also agree that you won't take any compensation from any lawsuits against drug companies while you are Secretary and for four years afterwards?

Robert Kennedy

Well, I'll certainly commit to that while I'm Secretary, but I do want to clarify something because you're making me sound like a shill. I, I put? I did a science day presentation with a judge on that case to get it into court.

Sen. Elizabeth Warren (D-Mass.)

Mr. Kennedy, Mr. Kennedy? It's just a really simple question. You've taken in $2.5 million.

I want to know if you will commit right now that not only will you not go to work for drug companies, you won't go to work suing the drug companies and taking your rake out of that while you're Secretary? And for four years after

Robert Kennedy

I'll committed to not take any fees from drug companies While I'm Secretary.

Sen. Elizabeth Warren (D-Mass.)

I'm asking about fees from suing drug companies. Will you agree not to do that?

Robert Kennedy

You're asking me to not sue drug companies

Sen. Elizabeth Warren (D-Mass.)

No you can sue drug companies as much as you want.

Robert Kennedy

I am not going to agree to not sue companies or anybody.

Sen. Elizabeth Warren (D-Mass.)

So let's do a quick count here of how as Secretary of HHS, if you get confirmed, you can influence every one of those lawsuits. Well, let me start the list. You can publish your anti-vaccine conspiracies, but this time on US government letterhead, something a jury might be impressed by, you could appoint

Robert Kennedy

I don't understand that.

Sen. Elizabeth Warren (D-Mass.)

[CROSS TALK] vaccine panel who share your anti-Vax views and let them do your dirty work. You can tell the CDC vaccine panel to remove a particular vaccine from the vaccine schedule. You could remove vaccines from special compensation programs, which would open up manufacturers to mass torts, you could make more injuries eligible for compensation, even if there is no causal evidence, you could change vaccine court processes to make it easier to bring junk lawsuits. You could turn over FDA data to your friends at the law firm and they could use it however it benefited them.

You could change vaccine labeling, you could change Vaccine Information rules, you can change which claims are compensated in the Vaccine Injury Compensation Program. There's a lot of ways that you can influence those future lawsuits and pending lawsuits while you are Secretary of HHS. And I'm asking you to commit right now that you will not take a financial stake in every one of those lawsuits so that what you do is Secretary will also benefit you financially down the line.

Robert Kennedy

I'll comply with all the ethical guidelines.

Sen. Elizabeth Warren (D-Mass.)

That's not the question. You and I you [INAUDIBLE].

Robert Kennedy

You're asking me not, to sue [CROSS TALK]

Sen. Elizabeth Warren (D-Mass.)

No, I, am, not.

Robert Kennedy

That's exactly what you're doing.

Sen. Elizabeth Warren (D-Mass.)

Look, one should be fooled. As Secretary of HHS, Robert Kennedy will have the power to undercut vaccines and vaccine manufacturing across our country. And for all of his talk about follow the science and his promise that he won't interfere with those of us who want to vaccinate his kids. The bottom line is the same.

Kennedy can kill off access to vaccines and make millions of dollars while he does it. Kids might die. But Robert Kennedy can keep cashing in.

Robert Kennedy

Senator I support vaccines. I will support the childhood schedule. I will do that. The only thing I want is good science.

And that's it.

Sen. Elizabeth Warren (D-Mass.)

How about then say you won't make money off what you do as Secretary of HHS?

Sen. Mike Crapo (R-Idaho)

Before we go to Senator Tillis, I think it's would be important for me to make it very clear that Mr. Kennedy has gone through the same Office of Government Ethics process as every single other nominee in the Finance Committee this year and in previous administrations. In addition to listing his assets, including items that you've identified, he has signed an ethics letter that has been reviewed by the Office of Government Ethics concerning any possible conflict in light of its functions and the nominees Proposed duties. And we have a letter from the Office of Government Ethics that he has complied completely with all applicable laws and regulations governing conflicts of interest.

Sen. Elizabeth Warren (D-Mass.)

Mr. Chairman, point of information here, have we had a single nominee come through, whose made $2.5 million dollars off suing one of the entities that it would be regulating and plans to keep getting a take of every lawsuit in the future? Have we had that before?

Sen. Mike Crapo (R-Idaho)

I haven't reviewed the past documentation with every other nominees, financial interests, and so no. But I know that every single time we get a nominee, their financial interests are attacked. That's why we have the Office of Government Ethics. That's why they've reviewed everything that's in his record.

And that's why he has even I think, and I don't know that I want to ask him to get into it. But he has listed his assets and has gone through a discussion of the responsibilities under the our ethics laws, and he's complied with all of those requirements. Senator Tillis

Sen. Thom Tillis (R-N.C.)

Thank you, Mr. Chairman. Mr. Kennedy, how's your morning going?

Robert Kennedy

So far, So good.

Sen. Thom Tillis (R-N.C.)

Good. You came prepared? I'm glad that you did. I, you I believe address to my satisfaction and question about Title X.

And the President's priority with respect to Planned Parenthood? Can you just affirm that you are 100% behind the President's policy on Title X and the

Robert Kennedy

100% behind it.

Robert Kennedy

Thank you. You know, you it's, it's amazing to me that people well, first off, you need to understand you're there. I was in a judiciary hearing this morning, it's very clear to me that some of these nominations are going to be shirts and skins. So no matter what you answer in the affirmative, they're

going to ask you one more question so that you won't be able to answer in the affirmative.

It's just the way the game gets played, when we have nominally nominees like yourself, so I think you're handling yourself. Well, I got a real quick question for you, are you conspiracy theorist?

Robert Kennedy

That is a pejorative, Senator that's applied to me. Mainly to keep me from asking difficult questions, of powerful interests. I was told that I was a conspiracy theorists that label was applied to me because I said that the vaccines, the COVID vaccine, didn't prevent transmission, and it wouldn't prevent infection, when the government was telling people, Americans, that it would. I was saying that because I was looking at the monkey studies in May of 2020.

I was called a conspiracy theorist now everybody admits it. I was called a conspiracy theorist because I said red dye caused cancer. And now FDA has acknowledged that and banned it. I was called a conspiracy theorist because I said, flouride lowered IQ.

Last week, Jama published a meta review of 87 studies, saying that there's a direct inverse correlation between IQ loss-

Sen. Thom Tillis (R-N.C.)

All right,

Robert Kennedy

I could go on for about a week.

Sen. Thom Tillis (R-N.C.)

So I'm gonna assume. Is there anyone that you can say, you got me that really was a conspiracy theory? Are you in a position to submit for the record, I think it just be helpful for every one of these narratives for you to submit that maybe for the record. You said something about SNAP lunch, I was in the statehouse in North Carolina before I came here.

And anytime I'd go visit an elementary school, the first thing I would do is go to the trash cans in the cafeteria. And what we have now are kids that are not eating the food, because the dictates of the federal government have made it something that they don't want. But they say, Well, it's a healthy alternative it as processed materials in it, and it's not particularly attractive to them. So they throw it away trash cans full of food that these kids didn't need.

So then what do they do? They go eat snacks, or they go into shirt or they drink a sugar drink, the SNAP program, everything you've said about the SNAP program I agree with, I think that we should be very, very strict about that. And it's going to make some people uncomfortable in the food manufacturing segment produce healthy foods that we can put in the SNAP program as a way to address it. But we also need to look at the school health program.

I was PTA president 2122 years ago at my daughter's High School. And I feel like we've we've got these kids that need help. We've got to guide them through a process. Many of them are probably on Medicaid and Medicaid fell on them.

Everybody here says Medicaid is sacrosanct. Nobody's admitted that Medicaid is not producing positive health outcomes. Is that your problem Medicaid right now and the program or the outcomes?

Robert Kennedy

It's the outcomes we're spending $900 billion our people are getting sicker Every single year,

Sen. Thom Tillis (R-N.C.)

Yeah.

Robert Kennedy

So anyone wants people to have Americans that have a high-quality insurance-

Sen. Thom Tillis (R-N.C.)

Anybody who's building a case for the status quo of Medicaid is is by extension saying that they're happy with the outcomes. I think it's unacceptable. I do have a question for y'all project Warp Speed. We support at the CARES Act.

We had 97 people in the US Senate vote for it, everybody here there was only one member of Congress that voted against it, I believe. And project Warp Speed had CDC, FDA, NIH and BARDA very much in the mix. Now, some people think that you're going to come in here, and, and insert yourself into those agencies in a way that's never been done before. Let's say that they're they're a part of a future project Warp Speed.

Is it your intent to go in and do something that that's never been done before based on my staff's research, and insert yourself in a discussion and the scientists are dealing with and those different agencies?

Robert Kennedy

No, Senator, I would I want to do is, I'm not a scientist. I want to empower scientists, I want to make sure that science is unobstructed by vested or economic interests. That's good culture. And I'll just say about Operation Warp Speed.

It was an extraordinary accomplishment, demonstration of leadership by President Trump. When he when he promoted operation Warp Speed, he was looking at all of the different remedies including vaccines, Therapeutics, therapeutic ivermectin, hydroxychloroquine, Famotidine Chlorine dioxide, all and he was not looking at shutting down our country for the year, forcing people to wear masks for a year, or forcing all social distancing that did not have any scientific basis, which Dr. Fauci has now acknowledged, he said, we took it out of thin air. Oh, but um my, but all of those changed during the Biden Administration. Became very narrowly focused, we ended up with the worst, highest death count of any country in the world.

Sen. Thom Tillis (R-N.C.)

Mr. Chair, if I can just ask one final question. And I think it's a one word answer. I've heard a lot of people complaining about health care delivery, Medicaid.

On the other side of the Dais here, whose been responsible for health care policies over the last four years?

Robert Kennedy

The Biden Administration.

Sen. Thom Tillis (R-N.C.)

I mean, the President, the Biden, okay. So that I'd like to have heard more of those and oversight hearings over the last four years. I haven't. But I'm glad that there's an acknowledgment that you're inheriting a problem that needs to be fixed.

Thank you.

Robert Kennedy

Thank you, Senator.

Sen. Mike Crapo (R-Idaho)

Senator Sanders.

Sen. Bernie Sanders (I-Vt.)

Thank you, Mr. Chairman. Mr. Kennedy, thanks for being with us. I'd very much like the slogan that you coined: Make America Healthy Again. And I strongly agree with that effort.

Despite spending, as you indicated, two or three times as much per capita on health care as other nations. We have 85 million people who are uninsured, underinsured, we have all kinds of chronic illnesses, our life expectancy is lower than other countries and for working class people in this country. They are living six, seven years shorter lives than the top 1%. We got a problem.

Okay. And I'm gonna suggest some ideas that I think can remedy that. Last year, the insurance industry in this country made over $70 billion while at the same time 85 million Americans are uninsured or under insured. Do you

agree with me that the United States join every other major country on Earth and guarantee health care to all people as a human?

Right? Yes, no?

Robert Kennedy

Senator, I can't give you a yes or no Answer to that question

Sen. Bernie Sanders (I-Vt.)

Healthcare human right. Is healthcare a human right.

Robert Kennedy

In a way that free speech the right.

Sen. Bernie Sanders (I-Vt.)

Yeah.

Robert Kennedy

I would say it's different because if I was free speech doesn't cost anybody anything but in healthcare, if you are smoke cigarettes for 20 years, and you get cancer, do you you are now taking from the pool. So are you guaranteed the same [CROSS TALK]

Sen. Bernie Sanders (I-Vt.)

Look, I'm sorry, I, I'd love to talk for an hour with you. We got a few minutes left here. All right. Every other country on Earth says health care whether you're poor or rich, younger role to human right.

I'm not hearing you say that. Alright, you've talked about the drug companies and maybe we agree on this one. As you will know, despite the drug companies making over 100 billion in profits, paying CEOs outrageous compensation packages, we in some cases, pay 10 times more for the same

drug. Will you support legislation that I will introduce, which says that in America, we should not be paying a nickel more for prescription drugs than people around the rest of the world.

Yes, No?

Robert Kennedy

To equalize it?

Sen. Bernie Sanders (I-Vt.)

Not to equalize that, that we should not be paying more than other countries have the same damn drug.

Robert Kennedy

President Trump has asked me when in fact, I had a meeting with President Trump a week ago where we showed him the charts.

Sen. Bernie Sanders (I-Vt.)

He knows the charts

Robert Kennedy

We're 10 times more than Europe.

Sen. Bernie Sanders (I-Vt.)

That's right. And are you going to commit to us that you will end that absurdity?

Robert Kennedy

I think in principle, we can. We should, we should end that disparity.

Sen. Bernie Sanders (I-Vt.)

Okay. That's great. All right. I happen to believe that climate change is real.

It's an existential threat, and it is a health care issue. Donald Trump thinks that it is a hoax originating in China. Question is, in your judgment? Is climate change a hoax?

Or is it real causing devastating problems? President

Robert Kennedy

Trump and I from the beginning, from our first meeting agreed to disagree on that issue, I believe, is existential. My job is to make Americans healthy again.

Sen. Bernie Sanders (I-Vt.)

Alright you believe that? You disagree with Trump? You don't think climate change is a hoax? Is what I'm hearing?

Robert Kennedy

[CROSS TALK]my job here.

Sen. Bernie Sanders (I-Vt.)

It's just not a trick question.

Robert Kennedy

I answered your question, Senator,

Sen. Bernie Sanders (I-Vt.)

Okay so you disagree with the President on that?

Robert Kennedy

I answered your question.

Sen. Bernie Sanders (I-Vt.)

Okay. I want to pick up on a point that Senator Hassan made? Look, there is no question that abortion is a divisive issue in this country. I would say a majority of the people are pro-choice, the strong minority who are pro-life.

A year and a half ago, you went to New Hampshire, running for president gave a speech and you talked about government should not tell a woman what she can do with her own body. That's her choice. Now, I think everybody on that side is pro-life. I think everybody is pro-choice.

I have never seen any major politician flip on that issue quite as quickly as you did when Trump asked you to become HHS Secretary. tell me why you think people should have constant confidence in your consistency And in your work When you really made a major U-turn on an issue of that importance in such a short time.

Robert Kennedy

Senator, I believe and I've always believed every abortion is a tragedy.

Sen. Bernie Sanders (I-Vt.)

But you told the people in New Hampshire that it was their right. Right. Let me do one last question because I'm running out of time. I think the gist of what you're trying to say today is you're really pro-vaccine, you want to ask questions.

You have started a group called the Children's Health defense, your the original note, right now as I understand it on their website, they are selling what's called onesies, these little things, clothing for babies. One of them is titled unvaxxed unafraid. Next one in the sold for 26 bucks a piece by the way. Next one is no vax no problem.

Now you're coming before this Committee and you say you are pro-vaccine, just want to ask some questions. And yet your organization is making money selling a child's product to parents for 26 bucks, which casts fundamental doubt on ud on the usefulness of vaccines. Can you tell us now that you will now that you are pro-vaccine that you're going to have your organization take these products off the market?

Robert Kennedy

Senator, I have no power over that organization. I've not part of it. I resigned from the board.

Sen. Bernie Sanders (I-Vt.)

That was just a few months ago, you found out that you certainly have power. You could make that. [CROSS TALK] Are you supportive of this?

Robert Kennedy

I have had nothing to do with you of vaccines.

Sen. Bernie Sanders (I-Vt.)

Are you supportive of these onesiesm clothing, which is militantly anti-vaccine.

Robert Kennedy

I I'm supportive Well, I I want good science and I want to protect

Sen. Bernie Sanders (I-Vt.)

But you will not tell the organization you founded not to continue selling that product. Thank you, Mr. Chairman.

Sen. Mike Crapo (R-Idaho)

Senator Blackburn.

Sen. Marsha Blackburn (R-Tenn.)

And thank you so much, Mr. Chairman, and thank you so much for being with us today. And I have no doubt that you will be confirmed to, and you are going to do such a solid job for the people of this country. And I do have several issues I wanted to talk with you about and didn't have time to cover them all. When We met prior to the meeting.

But rural healthcare is very important to me. And the people of Tennessee. 78 of our 95 counties are rural counties. Now over the last few years, we've seen hospital closures.

So we have focused on access in rural areas. And my rural health agenda, which is bipartisan, focuses on innovation, telehealth access points. It focuses on work shortages, and also Senator Warnock and I have together focused on making certain that we address that area wage index, and do that fairly for our citizens that are in rural communities. So I would like a commitment from you that when confirmed you and your CMS Administrator will work with us to make certain that the area wage index is balanced and that it is fair to rural areas?

Robert Kennedy

Senator, both Dr. Oz and myself recognize that rural health care is in crisis in this country, and that is catastrophic for our entire country. And I talked a little bit about my commitment to rural health earlier as hearing the the regional price points, as you know, are set by Congress and not by HHS. I will certainly and I know Dr. Oz will certainly work with you to

Sen. Marsha Blackburn (R-Tenn.)

Thank you.

Robert Kennedy

Make them sensible.

Sen. Marsha Blackburn (R-Tenn.)

We we look forward to that also you and I before you came forward as the Secretary, the nominee, we had talked in years past about overmedicating youth, and concerns over that. And I was looking at a report from TennCare, which is our Medicaid program in Tennessee. And I was concerned when I saw a number that TennCare had spent $90 million in 2024 alone on ADHD. This was 417,000 of our children and $90 million.

To me, that is heartbreaking. What is happening there. So how will you prioritize oversight of prescribing practices while promoting alternative

solutions such as counseling, behavioral therapies, community-based interventions for our youth?

Robert Kennedy

Exactly, and that's the solution. 15% of American youth are now on Adderall or some other ADHD medication. Even higher percentages are on SSRIs and benzos. We are not just over medicated our children, We are over medicating our entire population.

Half the pharmaceutical drugs on Earth are now sold here. 70% of the profits from pharmaceutical companies are from the United States, even though we only have 4.2% of the world's population. Not only that, but a recent study by Cochrane Collaboration founder Peter Ghosh found that pharmaceutical drugs are the third cause largest cause of death in our country after heart attacks and cancers. Oh, they're not making us healthier.

We need community health initiatives, we may need access to treatment, we need exercise, we need better food.

Sen. Marsha Blackburn (R-Tenn.)

Okay, let me talk to you about one of those access points in treatment. And this highlights a problem we have in the federal Medicaid law. Since Medicaid, the enactment states have been prohibited from using Medicaid funds for care provided by institutions for mental disease we refer to them as IMDs. These are psychiatric hospitals, residential treatment facilities with more than 16 beds.

This is a discriminatory exclusion. And it denies payment for medically necessary care based on the illness that is being treated and it has perpetuated unequal coverage in mental health care. So if you're confirmed when you're confirmed, will you commit to working with me on repealing this discriminatory exclusion and ensuring equal access to mental health care for Medicaid beneficiaries?

Robert Kennedy

Yes.

Sen. Marsha Blackburn (R-Tenn.)

Thank you so much. I've got a question on PBM Reform. one on artificial intelligence in healthcare, in the interest of time, I will yield back. I look forward to seeing you help make us healthy again.

Thank you, Senator.

Sen. Mike Crapo (R-Idaho)

Senator Luján. [INAUDIBLE] excuse me just I made a mistake. It's Senator Cantwell.

Sen. Maria Cantwell (D-Wash.)

Thank you so much. Thank you, Mr. Chairman. And and just Congratulations on your nomination Mr. Kennedy. And I've been absent only because I've been in another hearing with the nominee to be the Commerce Secretary.

So I will review everything that you've said today and look at that diligently. But one of the things that I wanted to discuss with you is, I represent a very big innovation state, in innovation in healthcare, specifically innovation, like NIH funding to the Fred Hutch Cancer Center, that helped develop the HPV vaccine, which has the potential to eliminate over 95% of cervical cancer. NIH also funds a lot of jobs and grants nearly 11,000 people in the state of Washington and over 1.2... $1.2 billion worth of grants. So while I agree with you on healthy foods, I definitely am troubled by the medical research side of innovation and some of the things that you have said, in fact, this issue about laying off 600 employees at NIH, or giving the fact that to, quote, give infectious disease a break for eight years.

So I, we've had a chance to talk about this a little bit. But the most striking example of this is when COVID hit, and we were the first in the nation, we had the first case. And it really was the fast response by the University of Washington that really helped save lives. So I just want to know that are you aware of how harmful these issues could be for public health, that public health in and of itself could be affected by these kinds of anti-science views?

Robert Kennedy

Senator, I have always been a science person and a pro-science person, and I believe in evidence based medicine, and gold standard science. I said, and I've explained this before, you came in at 600 people out of a population out of a workforce of 91,000 is pretty typical. Last year alone. President Biden replaced 3,000 People at HHS and 700 at NIH, I want to say this, I said, Give infectious disease a break because that's been the principal preoccupation.

Infectious disease. Chronic Disease is 92% accounts for 92% of deaths in this country. And almost nothing is studied at NIH about the epidemiology of our chronic disease epidemic. But right now money is going to infectious disease.

Sen. Maria Cantwell (D-Wash.)

And I get your point. It's an interesting point. The problem is we had to respond. And it's actually the Gates Foundation and a Flu Cove cohort that figured out what was wrong, and that we had an outbreak of COVID that was going beyond the very first case.

And so we had to build a very fast response. So I take this to the University of Washington has conducted groundbreaking stem cell research on fetal tissue. To me, I know there's probably a lot of people that may not agree with this. But we're making regenerative heart tissue now at the University of Washington.

So yes or no do you commit to protecting stem cell research for scientific agencies, if confirmed?

Robert Kennedy

I will protect stem cell research. Stem cell research today can be done on umbilical cords and you don't need fetal tissue.

Sen. Maria Cantwell (D-Wash.)

You'll protect the laws that are on the books today. And the research?

Robert Kennedy

My job is, Senator, to enforce the laws.

Sen. Maria Cantwell (D-Wash.)

Okay, so I want to move to PBMs because PBMs are driving up drug prices. And one of the biggest things that we need to do here I think in a new administration is get a handle on everything that is driving up prices and lower them. The report found that PBMs generated $1.4 billion from spread pricing, that is where they are able to basically set the price not reimburse pharmacies and then pocket the rest. We've had bipartisan legislation in several different committees now to get out this.

What do you think the solution is?

Robert Kennedy

One of the really notable achievements of this panel was the PBM legislation that they put together in a bipartisan way. I haven't met a single Senator will actually one only. Of the 60 Odd senators that I talked to all of them talked about PBMC how important that was and work. President Trump in his first administration pushed through a law or pushed a lot to give transparency to PBMs, it got overruled during the Biden Administration.

Luckily, this panel is resuscitating that ease that President Trump is absolutely committed to fixing the PBM.

Sen. Maria Cantwell (D-Wash.)

My time is running out. So I just want to clarify, you believe that we should pass these laws that now have been proposed in the Senate?

Robert Kennedy

I haven't read the entire laws. So I don't know. But I think that we need to reform the PBM. I think we need to get rid of all of these vested interests that are draining money from the system.

Sen. Maria Cantwell (D-Wash.)

Okay. Somebody suggested, though, that you thought we should, you should convene the PBMs and talk to them about some sort of self-regulation. So I am trying to distinguish between these people who basically are doing illegal activities and ripping up really they're creating pharmacy deserts in my state. So I'm asking you whether you believe that we have to legislate in this area.

Robert Kennedy

I, again, I'm not being evasive. I just don't know exactly what the law says. I met with the PBMs. I met with pharma.

My job is to meet with all the stakeholders. I've been meeting with stakeholders for 40 years, people I was suing people I was you want to hear from the other side? Well, I mean, I would let the PBMs write their own ticket. I think I support the I support the efforts of this Committee to come up with bipartisan legislation, President Trump wants to get the excess profits away from the BBM and send it back to primary care to patients in this country.

Sen. Maria Cantwell (D-Wash.)

And I will ask you for the record since my time has expired to look at the legislation that came out of the Commerce Committee that defines the legal activities that they are doing to drive up prices and get us an answer for the record. Thank you, Mr. Chairman

Robert Kennedy

In principle, I support that legislation.

Sen. Mike Crapo (R-Idaho)

Thank you. And let me just tell you the list as we have to move forward to the ending here. Senator Luján will be next, followed by Senator Marshall, Senator Warnock, Senator Smith, Senator Young, and Senator Welch.

Sen. Ron Wyden (D-Ore.)

And let me say, again, Mr. Chairman, this is a matter of such importance. A number of my colleagues would like a second round, and I think it would be important to offer, say, a modest amount of additional time to get into this on both sides. I know I have some questions. I want my colleagues to have the opportunity to raise their concerns as well.

Sen. Mike Crapo (R-Idaho)

Well, I've said as I have indicated to you, Senator Wyden, I'm not going to do a second round. I have been very generous with the senators. I think almost every single Senator has had seven minutes at least. And I will give you a second as is our practice.

Sen. Ron Wyden (D-Ore.)

I'll then divide my time up with my colleagues.

Sen. Mike Crapo (R-Idaho)

Okay. You're welcome to do that. Thank you. Senator Luján.

Sen. Ben Ray Luján (D-N.M.)

Thank you, Mr. Chairman. Mr. Kennedy, when we met you stated to me that it is not your goal to take away programs that work for Americans. Do you stand by that statement?

Robert Kennedy

Yes, Senator.

Sen. Ben Ray Luján (D-N.M.)

Mr. Kennedy, do you know how many Americans rely on Medicaid?

Robert Kennedy

About 72 million plus the 7 million kids are on CHIPS.

Sen. Ben Ray Luján (D-N.M.)

Appreciate that. 72 million. Yes or no: Is it important that expectant mothers and newborns have access to health coverage?

Robert Kennedy

Uh...

Sen. Ben Ray Luján (D-N.M.)

Is it important that expectant mothers and newborns have access to health coverage?

Robert Kennedy

Absolutely, Senator.

Sen. Ben Ray Luján (D-N.M.)

Mr. Kennedy, do you know how many babies born in this country are covered through Medicaid?

Robert Kennedy

I would guess I don't know the answer, I would guess er uh er uh about 30 million?

Sen. Ben Ray Luján (D-N.M.)

I haven it Mr. Kennedy? Well, 41% or 1.4 million babies births are financed by Medicaid. According to the National Center for Health Statistics. Yes or no: Do you believe that Medicaid is a critical program?

Robert Kennedy

I believe that Medicaid is a critical program, but that it's not working as well as it ought to be and President Trump has asked me to make it to make it work better that most Americans are not happy with it. The premiums are too high. The deductibles are too high. And everybody's getting sick or too much money is going to insurance industry.

Sen. Ben Ray Luján (D-N.M.)

I have a series of yes or no questions. They're pretty simple. Because you heard we're not going to get a second round of questions. I asked for your indulgence to be able to get to them yes or no.

In New Mexico as you know Medicaid is often measured state by state, it might surprise you if you look at some of those surveys in New Mexico the response was 90% of New Mexicans on Medicaid report satisfaction getting care 80% Getting specialist care 85% Getting Urgent Care 95% Ease of filings out of focus not to pick on any one of my colleagues, but in Louisiana. 86% of people on Medicaid are satisfied with their interactions 83% are satisfied getting care 85% are satisfied getting specialized care 82% Getting urgent care, I can go on state by state but we don't have the time today. Yes or no: Do you support cutting Medicaid or reducing? And especially in an area where you and I spoke about with the federal investment in Medicaid, which is known as FMAP.

[INAUDIBLE]

Robert Kennedy

President Trump has not told me to that he wants to cut Medicaid. He's told me to make it better.

Sen. Ben Ray Luján (D-N.M.)

Do you support cutting yes or no? If, President let me ask you this way since you're it's only about Pres-

Robert Kennedy

I support making it better Senator.

Sen. Ben Ray Luján (D-N.M.)

If President Trump asked you to cut Medicaid, will you do it?

Robert Kennedy

Oh, it's not up to me to cut Medicaid, it would be up to Congress.

Sen. Ben Ray Luján (D-N.M.)

And Mr. Kenny, you want to answer I'll move on? Do you know how many states will end? Mr. Chairman, if I may pause my time. So I understand that people are getting asked to leave if they stand up with signs.

But there's a lot of other as well, Mr. Chairman, so it needs to be extended to everyone. As Mr. Kennedy said, we should respect each other when we have a difference of opinion. We're just trying to do our jobs. Here in trying to ask questions.

That's all. And that's all I'm doing to Mr. Kennedy, folks. So

Sen. Mike Crapo (R-Idaho)

Senator, Senator Luján. You are right. And I asked the audience to please be respectful.

Sen. Ben Ray Luján (D-N.M.)

Thank you, Mr. Chairman. I appreciate that very much. Mr. Kennedy, do you know how many states will end their Medicaid expansion if the federal share of Medicaid drops?

Robert Kennedy

Well, there's 40 states that have signed on to the expansion so uh.

Sen. Ben Ray Luján (D-N.M.)

So it's a smaller number. So it's nine states would quickly have to end their expansion, because of the laws that they have. That's about 4 million folks across the country and in New Mexico, Iowa and Idaho, they have triggers, that it would immediately have to go into effect, If in fact that gets cut. The reason I'm asking those questions is there's been a lot of chatter and conversations around Medicaid.

Now, I agree, we can always do better, and we must be doing better in America. But Medicaid has been shown to improve health outcomes, including mortality, quality of life and access to preventative care, as well. And there's some areas, Mr. Kennedy that you and I touched on specific to Native American communities. One of the concerns that I have, are these these programs matter to folks, you shared your passion about caring for folks.

I believe that that passion. My question in this area is, as you know, when folks are doing research, and they're going to check to see if medicine works on someone. If they're not included in that trial, it often doesn't help them. That's what all the evidence shows.

So what are you going to do when programs are eliminated to require the inclusion of Native Americans in clinical trials when it comes to life saving, saving medicine.

Robert Kennedy

I'm gonna do everything I can to make sure there's Native Americans clinical trials. As I said to you, it is your office, I spent 20% of my career working on Native issues. My family has been deeply involved with them. My family and father and uncle were big critics of the Indian Health Service failure to deliver good results or healthcare on the on the reservations, I'm going to bring a native and for the first time in the history into my central office, that all the major decisions in my office will be that he will have a he already interviewed candidate a very, very good candidate will have direct impact on all the major offices and one of my priorities is...

Sen. Ben Ray Luján (D-N.M.)

I appreciate that I will follow up in that space Specifically. Will you commit to finalizing the congressionally mandated FDA guidance to increase clinical trial diversity?

Robert Kennedy

Just repeat that again, I'm sorry,

Sen. Ben Ray Luján (D-N.M.)

Will you commit to finalizing the congressionally mandated FDA guidance to increase the increasing clinical trial diversity?

Robert Kennedy

Yes.

Sen. Ben Ray Luján (D-N.M.)

I appreciate that. Will you commit to reinstating all of the pages that that were eliminated and people that were fired from this administration that have this responsibility?

Robert Kennedy

I cannot commit to that because I don't know. Who they are, [CROSS TALK] I will work with you to make sure those positions are adequately staffed.

Sen. Ben Ray Luján (D-N.M.)

I will follow up in writing in those specific areas because I think there's some commonality here. But answers matter. And so I'd like to get those as timely as possible. The last thing, Mr. Chairman, that I'll say is one of the conversations I had last before.

This hearing was with a family that I've been working with, to work with my Republican colleagues when it comes to autism and federal programs. And making a difference in these families lives in this little girl's life. What I'm asking now, Mr. Chairman, is unanimous consent to enter into the record, an article from Autism Speaks titled quote, Do vaccines cause autism and quote, and I'll note that the first sentence states quote, vaccines do not cause autism end quote, thank you. I yield back.

Sen. Mike Crapo (R-Idaho)

Without objection. And before we move on, we've had a request from several corners for a quick restroom break. We will take a five minute recess I'm sorry to those remaining five or six senators, who must wait a few minutes but we will have a quick break. We will be back as soon as we can.

[RECESS]

Sen. Mike Crapo (R-Idaho)

This Committee will continue and come out of recess and go back into session. Before we go to you, Senator Marshall, I'd like to just tell everybody the remaining list, Senator Marshall, Senator Warnock, Senator Smith, Senator Young and Senator Welch. And then I did indicate earlier that I would give another five minutes to Senator Wyden, I understand he has distributed that five minutes to a few of the other senators. So we will have a few more quick questions.

And then we will proceed. And then I would like to thank the audience. Again, I know we had a couple of outbursts earlier. But I want to thank the audience for being respectful and encourage the audience to continue to be respectful as we conclude the hearing.

With that, Senator Marshall.

Sen. Roger Marshall (R-Kan.)

Thank you Chairman. obesity, diabetes, heart disease, obesity, diabetes, heart disease, account for probably 80% of health challenges in America. You many times I heard my friends across the aisle mentioned any three of those. I don't know if we've lost the horse for the trees, your vaccine is a critical issue.

I understand that. I don't see Mr. Kennedy's position could be any more clear that he's going to support the vaccines. He's going to support the science and empowerment to parents and their doctors to make these choices. 60% of Americans have a chronic disease, that there's an epidemic of chronic diseases across the country.

And this Make America healthy, good movement is palpable to me. It started on the campaign trail in 2020. When moms I'd never met the never involved

in the political process came up to me and said, Look, I want to make these choices about my children with my doctor, not the federal government, that it's a very real thing. Moms, dads, grandparents across the country grabbed me and say, Look why or why do 20% of our children now why are they on a prescription drug?

So, Mr. Kennedy, what what is your prescription to help make America healthy again, what is what's your vision? What does that look like to you?

Robert Kennedy

Thank you, Senator Marshall. We're having epidemics of all these chronic illnesses, autoimmune diseases, neurological diseases, allergic diseases, obesity on when my uncle was President 3% of Americans were obese, and a 74% of Americans are obese or overweight. No other country has anything like this. In Japan, the obesity rate is still 3%.

And epidemics are not caused by genes. Genes may provide the vulnerability, but you need an environmental toxin, or something is poisoning the American people. And we know that the primary culprits are food or changing food supply the switch to highly chemical intensive processed foods. We have 10,000 ingredients in our country in our foods, Europeans have only 400.

If you buy McDonald's french fries in our country, there's 11 Ingredients by understanding in Europe, there's only three. If you buy Froot Loops in our country, they're loaded with flood dyes yellow dye, red dye, blue dye and many other ingredients. Same company makes a the same product with different ingredients for Canada and Europe. And at agent we don't have good science on all these things.

And that is deliberate as a deliberate choice. Not to study the things that are truly making us sick or not only contributing to chronic disease or to mortalities from infectious disease, we need to get a handle on as because if we don't it's an existential threat, our country is not going to it destroyed because we got the marginal tax rate wrong or because we had one of these culture war issues that we've been talking about today. Wrong, it's gonna be destroyed. If we continue down this trajectory of chronic disease we need to fix our food supply.

And that's the number one thing.

Sen. Roger Marshall (R-Kan.)

Thank you, Mr. Kennedy. Certainly I share your concern with ultra processed foods on the other end of this food chain or my farmers and ranchers back home. Would you just take a second and share your compassion how you feel about farmers and ranchers that they respond to the market they don't dictate the market they grow what the market is wanting them to to grow.

Robert Kennedy

And have Senator Kelly told me the other day, his brother in law's are all farmers. And he said four out of every five his brother in law's as Parkinson's disease. And that kind of cluster we're seeing across farm country of cancers, autoimmune diseases, obesity, etc. Oh, it's and we can now not export American food to Europe, because the Europeans won't take our food that's not good for farmers are also destroying our soil because some of the chemicals that farmers use, destroy the microbiome, and that caused the erosion of the soil if you can't get water infiltration, what it pulls up the waters the soil off, agronomists now estimate that we only have if we continue doing these processes, only 60 harvests left before our soil is gone.

What farmers have are using seeds and chemicals that are over the long-term are caused in them and us and we need to do is we need to support the farmers, we need to we need the farmers as partners if we're going to make them work. And I don't want a single farmer to go out of business under our watch. I don't regulate, if I'm privileged to be confirmed, not regulated farms that's under USDA. But I want to partner with all of my decisions with USDA and with the farmer coop farm community to make sure that we don't lose more farmers in this country.

We also transition we offer and incentivize transitions to regenerative agriculture to to no till agriculture and to less chemically intensive. And by the way, I've also met with the chemical industry and the fertilizer and herbicide companies and they want to do the same thing. Oh, and I think we're on the trajectory to do that. And we need to incentivize initiatives to accelerate that trajectory.

Sen. Roger Marshall (R-Kan.)

Mr. Chairman, if I could I you know, the great news is that my farmers in Kansas are selling products to Europe, that today's regenerative practices, soil health, all those things are priorities for Kansas farmers. We aren't many of us are doing many of those things already. We just need it to be more widespread.

If I could just wrap up my remarks, though, is that, again, going back to the big picture here, 60% of Americans have a chronic disease. Mr. Kennedy, I believe for such a time as this, that you're not just one of 300 million people, I think that you are the person to lead HHS to make America healthy again, that God has a divine purpose for you. And I look forward to your confirmation and working with you to make America healthy again.

Sen. Mike Crapo (R-Idaho)

Senator Warnock.

Sen. Raphael Warnock (D-Ga.)

Thank you. Thank you so much, Chairman Crapo and Ranking Member Wyden it's great to be here. Mr. Kennedy. Welcome.

Welcome to UN and to your family. Thank you for meeting with me a few days ago. I'd like to follow up if I might with some of the issues that we discussed in my office. I want to talk to you first about the CDC or the Centers for Disease Control and Prevention.

I'm proud of the work that the CDC does proud that it's located in Georgia, with more than 10,000 employees in my state. If confirmed, you would be the Cabinet Secretary over the CDC. Representing HHS, that's about 29% of the federal budget. CDC is a part of that.

Do you agree that the CDC is work is critical to Georgia critical for our country and the health of the entire world?

Sen. Mike Crapo (R-Idaho)

Yes, Senator.

Sen. Raphael Warnock (D-Ga.)

Senator Isakson, my Republican predecessor would would agree would have agreed with that. bless his memory. He was a fierce advocate for the CDC, as am I. The CDC is an agency filled with hard working dedicated public health servants.

They wake up every single day working to keep us safe. I think. We don't think often enough about their work. Because it's easy not to celebrate the folks who are protecting you from that which doesn't appear because of the work that they're doing.

So grateful for the work that the CDC employees do. Some of them are members of my church. I saw that deep commitment firsthand when I visited the CDC just last summer Mr. Mr. Kennedy, you have compared the CDCs work to Nazi death camps. You've compared it to sexual abusers in the Catholic Church.

You've also said that many of them belong. This is a direct quote, many of them belong in jail. For me, those are disturbing characterizations of the CDC workers that I know who are trying to keep the American public safe every single day. And as you are presented as the nominee for for this position, I need to know Do you stand by those statements that you you made in the past?

Or do you retract those previous statements?

Robert Kennedy

Senator, I don't believe that I ever compared the CDC to Nazi death camps. I support the CDC. My job is to dismantle or arm that CDC, my job is to empower the scientists, if I'm privileged to be confirmed, so So you retract those statement? I didn't.

I'm retracting. I never said it.

Sen. Raphael Warnock (D-Ga.)

Well, well, actually, I have a transcript.

Robert Kennedy

Of me saying that?

Sen. Raphael Warnock (D-Ga.)

It's okay. Let me let me read your words, says that the institution, CDC, and the vaccine program is your description of their work is more important than the children that is supposed to protect. And you know, it's the same reason we had a pedophile scandal in the Catholic Church, is because people were able to convince themselves at the institution of the church was more important than these little boys and girls who were being raped. That's pretty provocative language.

You said in another statement, to me, this is like Nazi death camp.

Robert Kennedy

I mean, one another. I mean,

Sen. Raphael Warnock (D-Ga.)

Let me finish. I'm just reading your words. I mean, what happens? What happened to these kids?

One in 31 boys in this country, their minds are being robbed from them

Robert Kennedy

Yeah, I was not comparing the CDC to Nazi death camps. I was comparing the injury rate to our children to other atrocities. And I wouldn't compare the of course, the CDC to Nazi Afghanistan, any extent. Any statement that I made has been interpreted that way.

Yeah, I don't agree with that. Um, the in 2003, United States Congress government oversight Committee, ended a an over a year investigation that CDC a and used almost that same language. They said that the CDC, just one division, one branch immunization Safety Office, had put institutional self-

interests and pharmaceutical profits ahead of the welfare and health of American children. So that was a conclusion by Congress not.

And I repeat,

Sen. Raphael Warnock (D-Ga.)

I'm asking you because you're the nominee for HHS. It sounds like you stand by those statements.

Robert Kennedy

Senator, my objective is to support the CDC. There's nothing I'm going to do that is going to harm CDC, I want to make sure that our science is gold standard science. So and it's free from that same oversight Investigation Committee. At the panels, it's a panel and within CDC, I think 97% of the people on it had conflicts.

I don't believe that that's right. I think we need to end those conflicts and make sure that scientists are doing unobstructed science.

Sen. Raphael Warnock (D-Ga.)

So So I want to enter the statement by the way into the record. Without objection,

Sen. Mike Crapo (R-Idaho)

Without objection.

Sen. Raphael Warnock (D-Ga.)

Last week, the White House gagged HHS, and the CDC preventing them from communicating all important public health information to anyone, including all of our allies, including our allies in the United States and global disease prevention. Can you just answer yes or no, because I'm running out of time. Do you agree with that action?

Robert Kennedy

I was not consulted on it. But that's pretty much standard procedure for incoming administration's.

Sen. Raphael Warnock (D-Ga.)

So you you agree with the action that that gagged HHS and CDC from communicating important public f public health information?

Robert Kennedy

That directive made sure that no public health and only non-essential travel and mass communications were temporarily suspended. pending a confirmation of a new HHS Secretary This is standard operating procedure [CROSS TALK]

Sen. Raphael Warnock (D-Ga.)

I get it you I don't think what we've seen over the last several days is standard operation for new administration. I think we're seeing some unprecedented actions but you agree with it. Last night, members of the CDC, along with other federal employees were actually invited to to resign these these buyouts. And I got text messages.

And folks I know work from the CDC for the CDC that do this important work, who got that note, And it's really important, because my experience is that when you send out that kind of note the folks who resign, are the folks who you least likely want to see resign, they got other options. They're gifted folks. They got a lot of expertise. They have options.

A lot of them are doing this work because of their patriotism, because of their commitment. Do you agree with the buyouts that were presented to CDC employees? Just

Robert Kennedy

I agree. At the site, the vast majority that scientists and experts at CDC are patriots Government Servants,

Sen. Raphael Warnock (D-Ga.)

I can you

Robert Kennedy

Tell me I don't think anybody's gonna resign who's committed to keeping America healthy?

Sen. Raphael Warnock (D-Ga.)

Can you just answer? Yes. Okay. You agree with the buyouts.

In our meeting? I asked you to confirm your support for the Affordable Care Act. You also mentioned that you and President Trump want to fix the ACA by making premiums more affordable. Can you answer me yes or no?

As I don't have a lot of time. Did you know that tax credits that help families afford health insurance and save George is an average of $531 per month per person are set to expire at the end of the year? Did you know that?

Robert Kennedy

I do.

Sen. Mike Crapo (R-Idaho)

We need to move on.

Sen. Raphael Warnock (D-Ga.)

Do you support Congress extending these tax credits? so that Americans can continue to afford health care?

Robert Kennedy

I you know, Congress has to make its own decisions about that. my instructions from President Trump the

Sen. Raphael Warnock (D-Ga.)

Mr. Chairman, you're saying? I'm having a lot of trouble getting the witness to answer yes or no to a yes or no question. Well, I've got one more question.

I'm I' I'm just

Sen. Mike Crapo (R-Idaho)

Well your almost at nine minutes.

Sen. Raphael Warnock (D-Ga.)

So I need him to answer yes or no. Yes or no?

Robert Kennedy

I'm not going to answer yes or no to a question that's not susceptible to an honest yes or no answer.

Sen. Mike Crapo (R-Idaho)

We need to move on.

Sen. Raphael Warnock (D-Ga.)

I think that the fact that you find it difficult to answer basic questions, is deeply troubling for me, as you present yourself as a nominee to run HHS. Thank you so very much,

Robert Kennedy

Senator. I've been in courts all over the country. And process

Sen. Raphael Warnock (D-Ga.)

The Chairman. You told me I'm out of time. And he continues to filibuster even not that said I'm done.

Sen. Tina Smith (D-Minn.)

Senator Smith. Mr. Chair, thank you. Thank you, Mr. Chair and Ranking Member and welcome, Mr. Kennedy. So Mr. Kennedy, I don't have a question for you on abortion.

I think that my colleagues on both sides of the aisle have covered this. But I want to say I can respect people who have different views than mine on this issue, but it's hard for me to respect people who won't give a straight answer to what they think on this issue in particular. Mr. Chair, I just want to note that I understand that anti-choice advocates have said that in these hearings, they were looking to hear Mr. Kennedy provide some reassurance that he is on their side. And I'm not hearing that.

And I think most Americans are looking for some hint that the decisions that people make about abortion should be personal and private, and they should be free to make those decisions without government interference. And I'm not hearing that either. To make it worse, the answers that you have given tell me that the Trump Administration is more than willing to restrict or even ban medication, abortion without a single act of Congress, and even in states where abortion is legal. And what is clear to me is that you and President Trump are dangerous to women's access to mifepristone.

So having said that, I want to move to a different topic. Mr. Kennedy, I appreciate Senator coronations, questions about mental and behavioral health, something that I care a lot about, I know that you and your family have had personal experience with mental health challenges, as have I and I agree that the mental health crisis in this country is a is a crisis. So let me ask you in an interview in 2023, and again, in 2024, you blamed school shootings on antidepressants, you said and this is a quote, There is no time in American history or human history that kids were going to shoot schools and shooting their classmates. It really started happening coterminous with the introduction of these drugs with Prozac and with other drugs.

So do you believe as you've said that antidepressants cause school shootings? This is a strictly a simple question.

Robert Kennedy

I don't think anybody can answer that question. And I didn't answer that question. I said,

Sen. Tina Smith (D-Minn.)

So your answer is?

Robert Kennedy

I said it should be studied along with other potential culprits, they may call social media. But I don't know I would never make because there's no science on that.

Sen. Tina Smith (D-Minn.)

Well, there is Senator that means excuse me, there is, Mr. Kennedy.

Robert Kennedy

Thank you for the promotion.

Sen. Tina Smith (D-Minn.)

The science shows that there is no link between school shootings and antidepressants. And in fact, most school shooters were not even treated with antidepressants and of those that were there was no evidence of association. You know,

Robert Kennedy

I don't think

Sen. Tina Smith (D-Minn.)

My question is.

Robert Kennedy

Because HIPAA rules, nobody knows.

Sen. Tina Smith (D-Minn.)

What that is. Mr. Kennedy, do you think that people who take anti-depressants are dangerous?

Robert Kennedy

I think, Im listen, I'm not going into HHS, if I'm privileged to be confirmed with any [CROSS TALK] any preconceived ideas that I may have. I'm just wanting good science.

Sen. Tina Smith (D-Minn.)

So you're not saying that they aren't dangerous, which means that they could be dangerous. Let me ask you this.

Robert Kennedy

That's not true.

Sen. Tina Smith (D-Minn.)

Described Americans who take mental health medications as addicts who need to be sent to wellness farms to recover. Is that what you believe?

Robert Kennedy

Oh, of course, I didn't say that. Anybody shouldn't be compelled to do anything.

Sen. Tina Smith (D-Minn.)

No but you said they should be sent.

Robert Kennedy

It available to them. I did say they should be sent kicking and screaming.

Sen. Tina Smith (D-Minn.)

You said that folks that take anti-depressants are like addicts that I can provide that should

Robert Kennedy

Have the availability listen, And I know people, including members of my family, who've had much worse time getting off of SSRIs than they did, then people have getting off heroin. It's the old period is, and it's on the label.

Sen. Tina Smith (D-Minn.)

I have some experience will document myself. Mr. Kennedy, I, this is personal for me when I was a young woman, and I was struggling with depression. Thankfully, I had the resources to help me get through it, including a new generation of SSRI uptake, re-inhibit inhibitors, which helped to clear my mind, get me back on track to being a mom and a wife and a productive happy person. And I'm really grateful for that therapy.

So I have some experience with this. And I think that everyone should have access to that care. And your job as Secretary is to expand access to care not to spread lies, and misinformation. And you know, the things that you say, Mr. Kennedy, they live on, they have impact.

And you know, we're having this conversation at the same moment that my Republican colleagues are looking to try to figure out how to save money any way they can. So, they want to cut Medicaid, let's just think about this for a minute. Because you're gonna be should you be confirmed, you would be responsible for CMS, which provides mental and behavioral health care to millions of Americans, close to 40% of folks on Medicaid, have a behavioral health condition and you will be part of this administration that would be looking to cut Medicaid. So Mr. Kennedy, these statements that you've made linking antidepressants to school shootings, they reinforced the stigma, that people who experience mental health every day face every single day, and I'm very concerned that this is another example of your record of sharing false and misleading information that actually really hurts people.

Robert Kennedy

Characterizing my statement.

Sen. Tina Smith (D-Minn.)

I am only putting into the record what you have said.

Robert Kennedy

You're mischaracterizing my statements. And I I'm happy that you had a good experience on SSRIs. Many Americans have very good experience on it.

Sen. Tina Smith (D-Minn.)

Others have been an issue between them and their physicians and not exactly, HHS to be putting out misinformation about the dangers of SSRIs and other anti-depression medication spreading the stigma and the fear that we're actually trying to overcome.

Robert Kennedy

Do you think physicians when they make that prescription or have access to good science? Of course they do. And that's all I believe, and you and I are in agreement.

Sen. Tina Smith (D-Minn.)

Senator and to your point that you made when you made these statements. It was not based on good science. I don't know what it was saying

Robert Kennedy

The science needed to be done. I wouldn't say these are potential culprits. I weren't coterminous and I named other things. I said video games.

I said social media. I said SSRIs SSRIs. Have a blackbox, warning, warning of suicidal Mr. Chair.

Sen. Tina Smith (D-Minn.)

Mr. Chair, I will submit to the Chair the information that I have about what Mr. Kennedy has said linking antidepressants to school shootings. Thank you.

Sen. Mike Crapo (R-Idaho)

Senator Young.

Sen. Todd Young (R-Ind.)

Thank you, Mr. Chairman. Good to see you, Mr. Kennedy. To follow up on that spirited exchange. In talking with you and reading about your vision for the Department, you said one of your goals is to return public health agencies to the gold standard of scientific review.

You've alluded to the gold standard a number of times today so I'm gonna give you an opportunity uninterrupted but hopefully not too extensive to tell me and others what you mean by this gold standard.

Robert Kennedy

The Gold Standard means real scientific research. With replication of studies, which very rarely happens now at NIH, we should be giving at least 20% of the NIH budgets to replication. We should have to make sure that all the science but it's published the raw data, we should make sure that the peer reviews are also published. We and you know, and I'll give you a quick example.

20 years ago, HHS, NIH scientists did a study on amyloid on Alzheimer's, which they said it was caused by amyloid plaque. After that NIH, shut down studies of any other hypothesis 20 years later, we've now know that those studies were fraudulent. NIH has funded 800 studies on a fraudulent hypothesis. And we've lost 20 years and figuring out how to a cure for Alzheimer's.

And that's just one example. I could give you hundreds, we need to end that we need to end the old boy system. We need to have replication science and be completely transparent about raw data.

Sen. Todd Young (R-Ind.)

Thank you, sir. In recent years, particularly during the COVID pandemic, there has been a lot of skepticism about our public health institutions. Some of this, I would say is warranted. But it's now created a pervasive lack of trust from the public that these institutions are acting in bad faith or failing

to act in objective with objective criteria, failing in short to to act in the best interests of the public.

If confirmed, Mr. Kennedy, how will you work to regain the public's trust? I suspect it will take some time in these important public health institutions.

Robert Kennedy

Through radical transparency. I'm gonna make these The reason people don't trust the the public health agencies because they haven't been trustworthy. And you example of COVID at the beginning of COVID, everybody was rushing to get that vaccine we have over 90% vaccination uptake?

Sen. Todd Young (R-Ind.)

Yes, sir.

Robert Kennedy

CDCs most reasonable recommendation is that Americans take the ACE booster. Only 23% of Americans are complying that yes, 77% of Americans no longer trust CDC. And that is the problem.

Sen. Todd Young (R-Ind.)

Yes, sir. In the absence of full information, might have to I think I agree with you. But I want your response. Might it make sense to share that absence of full information with the American people that uncertainty, I think one of the things by observation and experience that I saw during the pandemic, because we had certain prominent doctors appear on television and indicate no, you absolutely must not wear a mask two weeks later, it's yes, you must wear a mask.

But they were certain. And they even demonize people for not following the latest science knowing there's a high level of uncertainty in that science. What's what's what a measure of humility. And as you say, radical transparency demonstrates humility, help rebuild trust over a period of years.

Robert Kennedy

Absolutely. We need to tell Americans, we don't know. We need to make sure studies that reach a null hypothesis are also published. And that doesn't happen.

Sen. Todd Young (R-Ind.)

Sir. I think you're right about why health care costs are so high in the first place. The answer is indeed chronic disease. 90% of our health care spending goes towards managing it, as you say, in your opening statement.

It's not in the main because of waste, fraud and abuse. Although we know some exists. It's not in the main because we have greedy executives at innovative world-class companies. It's not in the main because we haven't yet adopted an unsustainable Medicare for all scheme.

It's because of this. So I'm encouraged that you you intend to make that a point of of emphasis as it pertains to your your future leadership. I will say with respect to COVID. It's not over for a lot of Americans.

It's not over I know the mission accomplished banner was convenient for the last administration. But as we continue to navigate the ongoing impacts of the COVID pandemic. We have many individuals here in the United States and around the world who are suffering from long-term health effects that significantly impact their quality of life work and daily activities, and they've been largely ignored. Funding for long COVID research was appropriated by Congress in December of 2020, followed by additional funding directed by the Biden Administration.

In February 2024, patient groups and industry publications have criticized the slow pace of clinical trial design and enrollment. If confirmed, will you collaborate with health care providers, researchers and effective communities to better understand and mitigate long COVID 's impact? Yes or No, please?

Robert Kennedy

Absolutely. So there's 6 million Americans. Will you commit to prioritizing long COVID research and integrate this work in a broader health care policies? Yes or No, please?

Sen. Todd Young (R-Ind.)

Yes.

Robert Kennedy

Patient groups, experts and industry publications have raised concerns around existing long COVID funding being spent on observational research. In particular, criticism was directed towards recover funding being used to duplicate existing findings, instead of funding trials for potential treatments, or diagnostics. If confirmed, Mr. Kennedy, will you work with Congress so that going forward long COVID funding will be directed primarily towards trial or novel research directions and not replicating existing observational research? Yes or no?

Robert Kennedy

Absolutely Senator, with enthusiasm.

Sen. Todd Young (R-Ind.)

Thank you so much. If confirmed, how will you create a balance between your personal priorities of chronic disease and healthy lifestyle and the ongoing critical work of the Department in areas that are focused on incentivizing and advancing innovation in modern medicine and pharmaceutical discovery?

Robert Kennedy

Innovation is going to be the key to public health. And we have a unique opportunity now in history because of AI because of telemedicine. And because of the quality of people that are now coming to HHS, actually save public health, but it's all going to rely on innovation. And I don't want to do anything that inhibits or impairs the pace of innovation.

Sen. Todd Young (R-Ind.)

That's encouraging, from approving AI algorithms to determining Medicare coverage we need, we certainly need more innovation, and we need good people in the Department to assist with that effort. So I'll follow up with a question about how you're going to attract and retain good people. Thank you, Chairman, sorry to shut you down

Sen. Mike Crapo (R-Idaho)

A little faster than I did the other Senator. And we are up against a vote deadline here. And we have one more Senator who gets his full time. I hope you'll keep it as close to five minutes as you can Senator, well done, man.

I've promised Senator Wyden, what five more minutes

Sen. Ron Wyden (D-Ore.)

Can be divided one minute with my colleagues.

Sen. Mike Crapo (R-Idaho)

And then if we can do that, we can get over to vote before they call the vote on the floor.

Sen. Peter Welch (D-Vt.)

Thank you very much. Thank you, Mr. Kennedy. And as you know, I'm a big I have great reverence for your family from Massachusetts. When I got when I got out of college, I was in the first class of Robert Kennedy fellows, the memorial created by your family to honor the service to your father, I do community organizing in is in the west side of Chicago.

And I certainly admire your energy in your effort here and desire to serve. You know, there's a couple of things that are really important here. This is not just about a debate on vaccines. It's a debate about the qualifications, experience, and priorities as to the person that will had Health and Human Services.

And it's not just about what your answers are today, or what the questions are, it obviously has a lot to do with your whole record in your whole history.

You know, your sister in her letter, or pardon me, your cousin in her letter said, you've always been charismatic, able to attract others through the strength of your personality, willingness to take risk and break rules. That's, I guess, an attribute, but it can be a danger. The question I fundamentally have is whether you're just willingness to disrupt and maybe break rules is going to be dangerous and destructive.

The character questions we didn't go into here, but there's some sketchy things. You've acknowledged your history with heroin, you've gotten over that. But there's incidents that do, I think, concern, the question of whether the stability is there to be in charge of this major organization. And that's compounded by my concern that you don't have any experience managing a large organization that you don't have any experience in government?

So those are things that have to be taken into account. But the issue for me is also a priority. So a lot of your engagement in health has been on vaccines big important issue. You actually disagreed as I understand it, with President Trump about Operation warp Warp Speed.

I think President Trump deserves a lot of credit for Operation Warp Speed, he knew we had to get a vaccine and these other issues about a mask and whether you should wear it, whether when you got your groceries, the bag had to be left outside. Remember that in the very beginning? Those are incidental to the core question that the President believed we had to have a vaccine and you contested that, that worries me. That really deeply worries me.

The other questions, Senator Cassidy asked you some questions about our health care system. I happen to believe that our health care system is profoundly broken in it's not just about the chronic illnesses, that's about our diet. That's about our exercise. But we are getting premium increases in Vermont if 20% a year 25% A year.

And it's busting the bank for taxpayers, especially the bank for our wonderful Vermont employers who care about having health insurance that they can apply to provide to their employees. Senator Cassidy asked you a couple of questions about how you would reform Medicaid. And I didn't hear an answer. You mentioned that you thought Medicare Advantage was good.

You have a good plan? No, no focus on what an incredible rip off was reported in The Wall Street Journal by United Healthcare, which was marketing Medicare Advantage, and then paying doctors and nurses where they had assignments essentially to over over diagnose illnesses that didn't exist. So they made hundreds they made billions and billions of dollars. And I've seen nothing coming out of the Trump Administration.

And I've seen nothing coming out of your advocacy that is going after what is a rampant abuse by the insurance companies and overcharging people and not doing the job. And by the way, the United Healthcare people when they did that they overdiagnosed when the person really got sick, they dumped them. They dumped them, go to the nursing home on your own. That's a broken healthcare system.

We spend the most and get the least and I think there should be collective anger about this on both sides because all of our people are dependent on that health care system. And you're going to be working for a president who's on a lawless rampage right now. Okay. He has done something reckless with the pardons to these copiers.

I'm appalled by that. But that's just reckless. That's not illegal. He's impounded money.

So right now, the Medicaid website went down. He's impounded money. So the community health centers that Senator Warnock was talking about are up in the air. So what they can do?

Do you believe that a president can impound money that has been appropriated by Congress?

Robert Kennedy

Senator, I let me answer the question about Medicare first. I have never defended that program or the rapacious behavior by the insurance companies or the PBMs. I understand that's a huge problem. And all right, there's a and I don't have time, I gotta get over to vote.

So we can, you've asked me five questions. You gotta give me a chance to answer one of them. Please be brief. Yeah, I, I have a point I brought in if I get confirmed, I've already appointed a general counsel.

The first time in history is a former prosecutor, Prosecutor, the biggest Medicare fraud case in the state of West Virginia. I brought in a prosecutor for that job instead of a bureaucrat, precisely, which was the important issues that you raised here. The only reason I didn't talk about these before is because I wasn't asked about what about I agree with you 100%, right?

Sen. Peter Welch (D-Vt.)

What about impounding, a president impounding money, among other things goes to hell.

Robert Kennedy

And you're saying that that's illegal?

Sen. Peter Welch (D-Vt.)

That's correct.

Robert Kennedy

Well, my job is to uphold the Constitution, I'm going to take an oath to uphold the Constitution, and I will administer the law and uphold the Constitution. Thank you.

Sen. Ron Wyden (D-Ore.)

Mr. Chairman. I believe under what we've discussed, I control five minutes. I'm going to take one and give one to each of my four colleagues that remain.

Sen. Mike Crapo (R-Idaho)

All right. And I would just say we really this vote, they're going to call it in about eight minutes. Thank you. So we have very little time.

Sen. Ron Wyden (D-Ore.)

Two hours ago, colleagues, I asked Mr. Kennedy to reconcile his many anti-vaccine statements with his handful of pro-vaccine statements. Instead, he gave us a word salad and ducked the issue. The same was true with Kennedy, With respect to measles, where you wrote a book playing down the threat of measles, even though American families are very concerned about it, and apparently families are still mourning in Samoa. And my last point would be that Mr. Kennedy said, today really wasn't about him.

And I just want to tell him, it is all about you, because I find your presentation to be both and to be both untrustworthy. And unprepared because my colleagues have been seeing back and forth between Medicare and Medicaid. And it's not clear which program you're using, when. So I want colleagues to know there is a lot more information to learn about, Mr. Kennedy, before we vote, I'm going to urge that to my colleagues on both sides of the aisle to not make decisions on the basis of this session.

I thank you for the additional time. And I guess my next minute is Senator Whitehouse, Senator Warren and Senator Smith.

Sen. Mike Crapo (R-Idaho)

And again, one minute is pleased.

Sen. Sheldon Whitehouse (D-R.I.)

There's been a lot of conversation about long, late term abortions here and I just want to make clear what Rhode Island OBGYN doctors describe as what is almost always happening. When a late term abortion is needed, it is a childbirth going wrong. The family has painted the room. It has bought the crib, maybe even decided on the baby's name, and has gone to the hospital to welcome the new baby into their family and what is supposed to be a happy event.

And then things went wrong. Then the alarm started pinging the lights started flashing, the medical professionals started rushing in and the question became, who lives and who dies. The mom's life is often at risk. And she may have other children she needs to care for the baby's life may be at risk.

And one or both may die in that environment. The doctors and the family own that decision. Government has no place in that room at that point. And I think we need to understand when this late term abortion gets bandied about what you're dealing with is a tragedy that is happening to a family who wanted that child and have suddenly been confronted with a moment in which they have to make what is probably going to be the worst decision of their lives.

And to try to shove the state legislature into that room is really offensive, really morally wrong. And I just want to make very clear what Rhode Island OBGYN is telling me is the situation when these procedures have to be deployed.

Sen. Mike Crapo (R-Idaho)

Senator Warren?

Sen. Elizabeth Warren (D-Mass.)

Thank you, Mr. Chairman. So Mr. Kennedy, I wanted to ask about your role in the 2019 measles outbreak in Samoa in July 2018. Two children died immediately after receiving a measles vaccine nurses had mistakenly mixed with a muscle relaxant. The nurses get charged with manslaughter.

But vaccination rates go down. I asked you about this in my office. You told me flatly that your visit to Samoa had nothing to do with vaccinations we now know that's not true. I have the documentation.

You met with the Prime Minister, you talked about vaccinations. You met with an anti-vaccine influencer, who described the meeting as quote, profoundly monumental for this movement. So what happens? Vaccinations go down, there's a measles outbreak and children start dying.

But you double down you didn't give up just four days after the Prime Minister declared a state of emergency 16 People already dead. You sent a letter to him promoting the idea that the children had died not from measles, but from quote, defective vaccine, you launched the idea that a

measles vaccine caused these deaths. You are a very influential man. In fact, you are called the leader of the disinformation dozen, multiple AI, UNICEF and WHO The World Health Organization investigated this.

They say the claims are false. It is not biologically possible what you claimed. And yet ultimately, more than 70 people died because they didn't get vaccines. So my question is, do you accept Even a scintilla just even a sliver of responsibility for the drop in vaccinations and the subsequent deaths of more than 70 people, anything you do differently?

Robert Kennedy

No, absolutely not. After the there were two incidents with children died in 2015 and 28 2015. It was from the measles vaccine. So the New Zealand General Hospital, I found the government of Samoa banned the measles vaccine after 2018.

I arrived in July of next year, after the band would have been in place for a year, [CROSS TALK]

Sen. Elizabeth Warren (D-Mass.)

Understanding that you wanted to hold this to a minute. And then I don't get to present all the facts and documentation I've got. How about if we just decide to make entries for the record on exactly what the record shows about Mr. Kennedy's participation? And I think he's answered the yes or no question.

He takes no responsibility.

Sen. Mike Crapo (R-Idaho)

Senator Warren, we will do that. And Mr. Kennedy, and to all the senators, every Senator knows that following this hearing, they will be able to ask you questions off the record, and you will be able to put answers back onto the record. So please give that answer. I apologize that we're shutting you off for giving a full response right now.

Senator Smith, we are way over time.

Sen. Tina Smith (D-Minn.)

Thank you, Mr. Chair. So Mr. Kennedy, you have said that you want to give infectious diseases a break for about eight years. You spoke about this with Senator Cantwell. My question to you has to do with avian flu, over 100 million birds called the disease spread to dairy cows and there are now 67 confirmed human cases and one death.

So Mr. Kennedy, do you intend to give research on bird flu a break?

Robert Kennedy

Oh intended about the appropriate resources to preventing pandemics. That's an essential part of my job.

Sen. Tina Smith (D-Minn.)

What do you think is causing the avian influenza?

Robert Kennedy

I think H5n1 viruses.

Sen. Tina Smith (D-Minn.)

So that's good to hear. Because in a recent book, I will submit this for the record because we don't have that much time. Mr. Kennedy has questioned the scientific basis for germs causing disease and the power of vaccines and antibiotics.

Robert Kennedy

Well, I never questioned that.

Sen. Tina Smith (D-Minn.)

I will submit that for the record.

Sen. Mike Crapo (R-Idaho)

Thank you, Senator Warnock one minute.

Sen. Raphael Warnock (D-Ga.)

I liked what you said that to the Baptist preacher. Thank you so much, Mr. Kennedy, based on our conversations, it's my understanding that you support work requirements and Medicaid. In 2020, Trump, President Trump approved a proposal from Georgia State Leaders requiring Georgians to jump through a number of onerous bureaucratic hoops and fill out even more paperwork to verify work and get access to healthcare assets. As someone who represents a state that has not expanded Medicaid, federal government, because of his waiver spent $70 million on Georgia's Medicaid waiver.

82% of that went to administrative costs. The point that I'm making is that the folks that they're insisting need to work 90% of those folks are working. They are they are caregivers, or they have a disability. Let me give you one example, a woman I think of all the time her name is Heather.

She's a traveling nurse from Dalton, Georgia, who falls into the Medicaid coverage gap. Heather experienced a series of small strokes leaving her unable to work full time, she's dedicated her life to caring for patients. But now she can't afford her own medical care out of pocket costs, because she doesn't make enough to qualify for tax credits to buy private insurance. What does have the need that she need work requirements?

Or does she need access to health care, so she can finally get healthy and get back to work

Robert Kennedy

That the individual that you described would need health care and not a work requirement? Thank you.

Robert Kennedy

Thank you.

Sen. Mike Crapo (R-Idaho)

Thank you. And we are done with the questioning now. Mr. Kennedy, I apologize to you to the audience and to all of my colleagues to have to rush it here at the end. But we have a bill on the Senate floor that they're going to close in about three minutes.

I want to thank you for appearing before this Committee, you have been accessible to the members and staff on both sides of the aisle of the Finance Committee throughout a rigorous process. And I want the whole world to know that you spent hours on in meetings, answering questions outside of this hearing, and providing documents and responses on issue after issue after issue. You've gone through the most thorough vetting process that any Committee in this Congress puts anybody through and I think that you have come through well and deserve to be confirmed. I would like to remind my colleagues, my colleagues that the deadline for submitting any questions for the record is 5pm today 5pm Today, and Mr. Kennedy We ask that you respond to those questions as quickly as you possibly can.

With that, I'm going to leave you in this room and run over to vote. This hearing will be adjourned. I still encourage the audience to be polite and respectful no matter what side of the issues you may be on. And Mr. Kennedy, I look forward to working with you.

[END]



Brad Smith, the startup founder who led a cost-cutting push inside HHS. Photo illustration: Christine Kao/STAT; Photos: Alex Brandon/AP

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The shrewd startup founder who led DOGE's cost-cutting at HHS

Brad Smith is the little-known architect of $67 billion in cuts

By Tara Bannow June 2, 2025

Bannow interviewed more than 30 people, including former colleagues and employees of Brad Smith, for this story.

The relentless drumbeat of cuts to U.S. government research and disease prevention have devastated tens of thousands of affected workers and academics. To hear them tell it, today's children and grandchildren will live shorter lives and the brightest scientists will flee the country.

There's one man at the center of it all and, chances are, you haven't even heard of him.

Brad Smith has been a leading figure within the Trump administration's U.S. DOGE Service, directing its cost-cutting efforts at the Department of Health and Human Services, a vast agency whose charges include ensuring

drugs are safe, preventing diseases from spreading, and administering health care for older, disabled, and low-income Americans.

Smith is a Tennessee native who made his fortune launching health care startups that serve poor, sick, and dying patients who rely on taxpayer funded health insurance. Along the way, former colleagues and employees say Smith operated in a manner that was cutthroat and ultimately left several leaders at one of his companies feeling like they'd gotten a raw deal.

Just before Smith joined DOGE, he led the $2.7 billion sale of a company he founded, CareBridge, to a major insurer. To get the deal across the finish line, he pushed senior leaders to sign agreements that delayed their full earn-outs for years following the sale, five people familiar with the deal said. They said that Smith threatened to fire the leaders and take away their equity unless they signed.

"I do think that you don't become so successful without being a little bit ruthless," a former CareBridge executive said of Smith. "And while I acknowledge that, it's never been my style to get a leg up by putting others down."

Given the pain DOGE's cuts have inflicted, it appears Smith brought the same success-at-any-cost mantra to the government. He helped carry out $67 billion in cuts to HHS, by DOGE's count, which includes the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, and other key health agencies. That sounds like a big number, but it amounts to just 4% of the department's spending, which totaled about $1.7 trillion in 2024.

Smith's role as a senior adviser at HHS was always meant to be temporary, and he stepped down before Memorial Day. Elon Musk, the billionaire tech executive who inspired and directed DOGE, also said in late May he was stepping away from government work to focus more on his companies.

Smith's plans aren't clear. No matter his future ties with the Trump administration, this will hardly be his final foray into health care or politics. He's told confidants he might launch a fourth startup or run for office, perhaps for Tennessee governor, or even the White House.

This examination reveals the person at the center of DOGE's health care cuts to be a shrewd startup founder who's left a trail of controversy at his past firms. It's based on interviews with more than 30 people, including Smith's former colleagues and employees, as well as friends, family members, former classmates, and even Smith himself. They described Smith as a person singularly and unapologetically focused on hitting ambitious growth and profit targets, sometimes risking workers' mental health or patients' wellbeing. At one company, workers claim their jobs were to cut services for vulnerable patients, even if they felt it was unsafe. At another, workers say the company oversold its services to clients.

Most of those who spoke with STAT did so on the condition of anonymity because they said they feared Smith, with his wealth and powerful connections, could harm them professionally or pursue them legally.

Even as his colleagues in the Trump administration — big personalities like Elon Musk and Robert F. Kennedy Jr. — seem to thrive on attention, Smith has been content to stay behind the scenes. He was an obvious choice to lead DOGE, and not just because he was part of Trump 1.0's Operation Warp Speed. He's a workhorse. His mom told STAT he's worked upwards of 18 hours a day his whole career and has only recently started to cut back.

Not only that, he's smart. "The smartest person I've ever met," per multiple former colleagues. At 42, Smith has already launched three health care startups from his homebase, Nashville, and sold two of them for over $3 billion in total.

Smart can mean a lot of things. In Smith's case, people said it means cunning, tactical.

But he's not someone focused on developing deep, meaningful relationships with his colleagues. One former executive who occasionally traveled with Smith said at the end of a long day, Smith would be eager to get back to his hotel room and keep plugging away. No fancy dinners. No hanging out over beers.

"There was always a relentless focus on the work," the executive said.

Some of the people Smith hired said he sold them on a philosophy of providing quality care and treating patients like family. Only later did they come to feel the real priority was rapid growth toward an eventual sale.

"He picks his people, throws them at a problem, they scale it fast, and then they flip it," said Paul Keckley, a longtime health care industry analyst based in Nashville who knows Smith. "From day one, they're having discussions about the exit strategy. From day one."

In an interview with STAT, Smith acknowledged that the startup world is hard, but said he thinks his businesses struck the right balance between improving patients' daily lives and lowering costs.

"One of the things you learn in business is that those things are not in tension," he said. "You have capital that you raise and you have to be very thoughtful about every single dollar you spend and every single person that you hire, but you have to do it in a way that achieves the goal you're trying to achieve. In our case, it was treating vulnerable patient populations."

The value-based care conundrum

When he does give interviews, Smith keeps his cards close to his chest, careful not to divulge much of consequence. In a rare sitdown with Fox News in March, Smith said his goals at HHS were to ensure the U.S. continues to have the best biomedical research in the world and to protect Medicare and Medicaid.

Aside from that, he defended cuts to indirect research costs at The National Institutes of Health that sent shockwaves through the scientific community. He criticized the fact that NIH had 27 different centers, 27 different chief information officers, and 700 different information technology systems that can't speak to one another, according to the administration.

"When you think about making great medical discoveries, you have to connect the data," Smith said.

Even as Smith and his DOGE colleagues insist the cuts helped, not harmed, the affected agencies, people inside those agencies have said otherwise. The firings were chaotic, with some workers only learning they were cut when their office entry badges didn't work, and others being rehired. Those fired included everyone from scientists studying reproductive health and tobacco control to key decision-makers at the National Institutes of Health.

Several people criticized what they perceive to be conflicts of interest between Smith's roles within the government and his ongoing work in the private sector, including running a company called Main Street Health, which sends so-called health navigators into rural clinics to help with their most complicated patients. As a special government employee, Smith was not required to divest from his companies when he took on the DOGE role, though he is still subject to conflict of interest laws.

Rep. Jake Auchincloss (D-Mass.) has been particularly vocal in calling out what he sees as Smith's conflicts. In an interview with STAT, he said he doesn't think it's a coincidence that the Centers for Medicare and Medicaid Services, the agency that regulates Smith's companies, has been spared from the worst of DOGE's cuts.

"It became evident that DOGE's health care portfolio was being run by Brad Smith, and Brad Smith is regulated and reimbursed by CMS," Auchincloss said. "So he was simultaneously really functioning behind CMS and profiting from CMS."

Auchincloss' district is the health care hub of greater Boston, and he said he's spoken with many people who know Smith's companies. He said they effectively work by finding loopholes in the way Medicaid and Medicare pay for care, and make money in ways that are "financially clever" but don't improve care.

"Both CareBridge and Main Street Health are functionally just low value, rent-seeking behavior, which is frustrating and is part of why Americans are so frustrated with health care," Auchincloss said. "But when you couple that with his incredible degree of power over HHS, it becomes, to me, a glaring conflict of interest."

The disconnect between Smith's stated focus on making health care better and the external perception that money was his priority was also present during Trump's first term. At that time, Smith headed the Center for Medicare and Medicaid Innovation, a testing ground for new ways of delivering and paying for medical care. People who worked under him at CMMI described frustration over Smith's focus on whether the experiments saved money instead of whether they helped patients. Under the law, CMMI is supposed to do both.

"Let's be real: Very few models were turning a profit," said a former CMMI official who worked under Smith and asked to remain anonymous. "But that wasn't the only reason we were doing it. A lot of these models were set up to improve care quality and outreach to rural and underserved areas. So you weren't necessarily banking on cost savings all around."

Smith said he was looking at both cost and quality, but the former happens to be easier to measure.

"Sometimes with costs it's easier to do that than with quality data because you're dealing with one number: Did you save or lose money? With quality there might be five or six metrics and it can be hard to get control groups."

CMMI's work centers on what's known as value-based care, the idea of paying providers to keep patients healthy rather than for each service they deliver. Near the end of his stint, Smith published an article in the New England Journal of Medicine highlighting, with charts, how much money the various models the agency tested were losing.

Value-based care has been around for decades and researchers have, by and large, not been able to prove that its various iterations save money, said Lawton Robert Burns, a professor of health care management at the University of Pennsylvania's Wharton School of Business.

"They all seem like good ideas, but then when you dig into it, you say, 'Geez, that didn't work out the way it was supposed to,'" Burns said.

Even as Smith's own conclusion was that value-based care, by and large, doesn't save money, the companies he founded all hinge on that very concept: making money from saving insurers money by taking better care of their members.

Does that mean Smith's companies have the special sauce to finally make it work? Maybe. Or maybe the people buying the services don't know better, Burns said.

"I don't want to say he's selling alchemy or voodoo, but maybe the people he's selling this stuff to don't connect all the dots," Burns said. "I think this stuff is just such harder work than anybody gives it credit for."

And even if they do cut costs, Keckley wondered whether they do so to the point of burning people out or potentially harming people. That's always been the rub with models like this, he said.

"Nashville people make money in health care by exposing inefficiencies in the way it's done and finding an operating model that makes them money and saves others money," Keckley said. "But how much of it ends up as investor income versus helping the greater good?"



The controversial CareBridge sale

In the months before Smith joined DOGE in January, he was busy negotiating the sale of his second company, CareBridge, to Elevance Health, one of the country's biggest health insurers. He did so in a way that left some senior executives feeling ripped off, according to six people with knowledge of the situation, all of whom asked to remain anonymous for fear of retribution from Smith or CareBridge.

Health insurers hire CareBridge to lower the costs of their most expensive members, and pay CareBridge a portion of the savings it generates. Most of those members have physical or intellectual disabilities and rely on Medicaid or both Medicare and Medicaid. The company helps those patients live at home with 24/7 support and medical equipment.

"If their options were to stay at home with their families or live in nursing homes, most folks want to end up staying at home," Smith said. "It also turns out staying at home is about half the cost of staying in a nursing home. So again, by doing the right thing for patients, you also help lower costs."

Smith unveiled CareBridge in 2020 with more than $40 million in backing from venture capital firms and strategic investors, one of whom was former Senator Bill Frist, a physician investor whose brother co-founded the hospital chain HCA Healthcare. As is common at startups, former and current executives said the pay was relatively low; the real reward came in their ability to gain equity in the company that would turn into a windfall when CareBridge sold.

Elevance's $2.7 billion offer for CareBridge included an unusually expansive holdback agreement, a provision where top executives get only a portion of their equity earnout at the deal's close, and have to work at the company for several years to get the rest, the people familiar explained. Agreements like that are common in large deals, but they typically only apply to a handful of top executives. In this case, Elevance wanted to retain between 20 and 30 CareBridge leaders.

"I'd say darn near 100% of deals have some level of that, but usually it's held to the top seven to 10 people at the company," said Brad Haller, senior partner of mergers and acquisitions at the consultancy West Monroe, who was not involved in the CareBridge deal. "What makes this one unique is it's trickling down to level two and level three within the organization. I wasn't surprised by that. It's a heavy reliance on the human capital business and you're wanting to make sure those folks don't walk out the door."

Elevance did not respond to requests for comment on the transaction and Smith declined to comment on it.

The agreement stipulated that executives would only receive a portion of their equity pay-out at the deal's close — 50% or, in many cases, less than that. They would get half of the remainder if they continued working at the company for two to three more years and the other half if the company met revenue and profitability targets.

But five people with knowledge of the situation said executives felt forced into signing the agreement. After they received the document, they said either Smith or his attorney told them if they did not sign it, they would be terminated and have their equity revoked. They said Smith sent the agreement on a Saturday and gave people until Sunday or Monday to sign it.

"You either stopped being an employee and didn't get a dime or you signed this miserable document and got at least a small percentage of the worth," said one of the executives who received the holdback agreement, and asked to remain anonymous. "So there was no option. In fact, some people would call it coercion."

Smith himself was not subject to the same conditions, and neither were the members of CareBridge's board of directors, nor its non-management investors, the people familiar said.

Some of the people interviewed said Smith fought for the best deal possible for his team.

"Elevance's bid was the best offer for management that the board received and Brad made the offer even stronger for CareBridge's exceptional leadership team through his negotiations with Elevance," Annie Lamont, a CareBridge investor and former board member, said in a statement. "Anyone who was privy to the details of the negotiation knows that Brad did the best job possible fighting for the team."

An individual intimately involved in the CareBridge deal echoed Lamont's perspective and said negotiating the best deal possible for the executives was a top priority for Smith. That person asked to remain anonymous because they are not authorized to discuss confidential aspects of the transaction.

Once it became clear that Elevance would not back down on the holdback agreement, Smith convinced CareBridge's board to adopt a separate bonus pool for the management team, which reduced the proceeds that went to shareholders, including himself, the individual said. The individual also noted that the executive team made out well financially in the transaction and only have to remain at Elevance for a few years.

"No one ever wants to sign one of these," the individual said. "With every M&A deal, sure, we all want to get everything we want before the deal closes, but that's just not reality. We have to also think about the art of the possible. If there was a better deal, we would have taken it. This was by far the best deal from a price and terms perspective for shareholders and for management."

The reason Smith could threaten to take away all of executives' equity was because of an equity incentive plan that was referenced in their original offer letters, several people said. That plan included a provision that allowed the company, in the event of termination, to repurchase their equity but at no cost, according to a lawyer familiar with the matter. The attorney asked not to be identified because of the possibility of future litigation.

"It effectively gave Brad the ability to say: 'Do the following thing or I will fire you and, under the terms of this equity incentive plan, I can basically make your equity worth zero,'" the attorney said.

West Monroe's Haller said much of this hinges on the tricky fine print of employment agreements, which usually include a change of control provision and the ability to take away employees' equity if they're fired for cause.

"I'm sure whoever wrote it was anticipating an event like this and taking advantage of it," Haller said.

A kid with two Bibles

Smith grew up in Knoxville, Tennessee. He attended The Webb School of Knoxville, a private school where uniforms were required and teachers inspected students' binders to make sure they weren't messy.

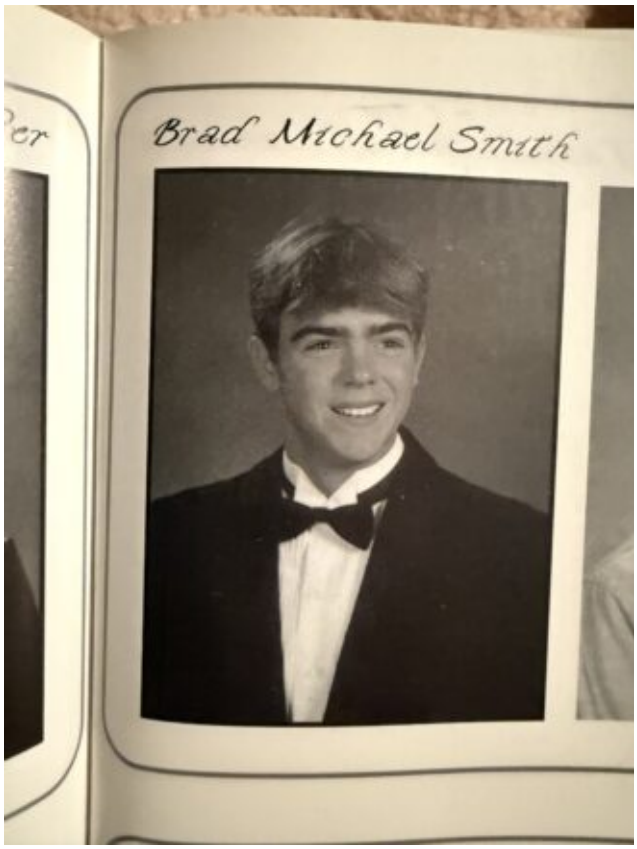
Most of the kids at Webb came from wealth, but Smith's mom, Jan Henley, insists Smith did not. Though she's a dentist, Henley said in an interview that she and Smith's father had to work hard and save to send their two sons to Webb. They skipped vacations. When Smith's younger brother, Grant, got a fellowship from Duke University, Henley remembers someone from the school telling her they almost didn't pick Grant, who's now a doctor, because he hadn't traveled.

"I said, 'We couldn't afford to go to Europe or the Caribbean or Australia or all these different places because we didn't have the money to do it, but we educated our sons,'" Henley said.

Smith didn't squander the opportunity. He worked hard and graduated in 2001 as the class valedictorian. Yearbook photos from that year show him smiling in a tie alongside members of six student groups, three involving politics. His graduating class didn't number much over 100. Everyone knew each other.

Smith's Webb classmates remember him as a quiet kid who studied hard. He was smart but not boastful.

"He wouldn't be up there trying to flaunt it by any means," said Denny Fulk, who graduated with Smith in 2001 and is now a wealth manager in Charlotte, N.C. "He was humble and had a kind of quiet confidence about his intelligence."



Brad Smith in a high school yearbook. Courtesy

Tennessee is smack dab in the middle of the Bible Belt, and Smith's classmates said most of the kids at Webb were Christian, although the school does not adhere to a particular religion. Classmates said most of the families were Republican. They recalled Smith being active in Young Life, a Christian group.

Smith was raised to be, and remains, a strong Christian, Henley said. In the eighth grade, she remembers him carrying around two Bibles, so that he'd have different versions on hand.

"He followed God's lead and I do think that's why he's been extremely successful," Henley said.

Even at a young age, Smith was savvy about making connections with powerful people. As a high school senior, he got to know Bill Haslam, the billionaire who would eventually become Tennessee's governor, because his kids went to Webb. Smith would later work on Haslam's campaigns, and he's still in his Bible study group today. His close relationship with Trump's son-in-law, Jared Kushner, would eventually help him land a role in the first Trump administration.

After Webb, Smith attended Harvard University, where he graduated summa cum laude, and then received a Rhodes Scholarship to study at Oxford University in England.

Six years later, he married Lauren Hayes, who was also the valedictorian at her private school — this one in Alabama — and who also crossed the pond for her master's degree at the University of Cambridge in England. Today, Lauren Smith is an education consultant. The couple has three daughters.

Smith's first company: Aspire Health

Smith has said in interviews that his grandmother's experience at the end of her life — she was in and out of the hospital, where she ultimately died — inspired him to launch his first company, an in-home palliative care provider called Aspire Health, in 2013.

Health insurers pay Aspire to treat their sickest members in hopes of preventing catastrophic health events and hospitalizations. In return, the company gets a cut of the savings generated. When Smith ran the company, its patients were mostly on Medicare Advantage, the private form of Medicare.

Health spending tends to spike in the last year of people's lives, and the idea behind Aspire is to blunt that trend, primarily by keeping them out of hospitals. That's one of the metrics insurers use to evaluate the company, in addition to measures of patient satisfaction.

"It's one of those places where there's a true win-win," Smith said. "Doing the right things for the patients and their families also results in lower costs."

In American health care, the instinct is to do everything to keep patients alive, be it inpatient treatment, surgeries, or chemotherapy. Too often, patients aren't told about treatments that prioritize quality of life over quantity, said Sumair Akhtar, a physician who served as chief medical officer of Aspire's East region until early 2021.

"The ultimate clinical goal at Aspire was: Give patients a really good understanding of where they are in their health journey," Akhtar said. "The idea is that if you do that well, enough patients will choose not to go down that super aggressive path, which will ultimately result in improved quality of life and lower cost, because you're not doing all these procedures, et cetera."

After Smith launched Aspire, the company hired a number of palliative care experts who were drawn to the mission Smith laid out.

Some of those people struggled to come to grips with what startup culture entailed. They didn't know when they took the jobs that the company was seeking an exit. They said Aspire's growth eventually ate into their ability to provide good care.

One former executive recalls having to pull clinicians from other markets when Aspire expanded to new areas in the scramble to have enough people in place.

"When we were scaling, there were areas where we didn't always have staff, it kind of broke the concept a little bit," the executive said.

Several former executives said the company enrolled too many patients who weren't good fits for its service because it used a flawed algorithm to identify them. They said the company could have figured that out during initial assessments, but opted not to because it wanted to keep growing quickly.

Former executives described a relentless pace — 100-hour weeks, responding to emails in the middle of the night, and taking calls at all hours.

Another former executive said the environment was so stressful, they eventually became sick and had to quit. Their spouse was unhappy and they had young kids at home.

The health insurer Anthem, now Elevance, bought Aspire for $440 million in 2018. That was a decent premium over the $195 million valuation the company earned when it last raised cash from investors two years earlier, according to PitchBook. It's now part of Elevance's Carelon subsidiary.



President Donald Trump at a press briefing in April 2020, with Brad Smith (far left), then-director of the Center for Medicare & Medicaid Innovation at CMS, and Adm. Brett Giroir, then-assistant secretary of Health and Human Services. (AP Photo/Alex Brandon) Alex Brandon/AP

Smith's second company: CareBridge

It's not just CareBridge's senior leaders who feel wronged. Some rank-and-file employees have grievances of their own.

Every day, employees known as clinical assessors said they'd call members and run through a questionnaire on their ability to do things like walk, prepare meals, dress themselves, and enter and leave their homes. It was done under the guise of providing support, but they said their managers urged them to find ways to cut hours.

"At the end of the day we're calling you to see if we can cut your paid caregiver hours," said a former clinical assessor in Massachusetts, who asked to remain anonymous.

Unlike Aspire, where clinicians go to people's homes, former employees said when they worked there, most of CareBridge's care was delivered through video calls, primarily by clinical assessors.

Liza Norton, a former CareBridge clinical assessor in Florida, alleged in an ongoing lawsuit filed in January that clinical assessors were required to cut caregiver hours by specific percentages, even if they felt it would harm patients. If they didn't, Norton said they risked being fired. The main thrust of Norton's lawsuit, a proposed class-action case, is that CareBridge failed to pay its clinical assessors overtime, even as it set high daily quotas on patient assessments.

Smith said he wasn't familiar with Norton's lawsuit, and noted that it was filed after he sold the company at the end of 2024. He added that a huge part of all his companies is ensuring they have good quality metrics. At CareBridge, for example, surveys from patients and their families tended to come back positive, Smith said.

The complaint says CareBridge pressured its clinical assessors to "abandon their duties and obligations as licensed clinical therapists and therapy assistants in favor of pumping out report or assessment one after the other" that insurers like UnitedHealthcare would use to cut their spending on home health aides for policyholders. More than 20 former clinical assessors have joined the case, which is currently paused pending mediation.

CareBridge denied the allegations in its response to the lawsuit. The company maintained that assessors can make independent judgments.

Brandy Hawthorne wasn't a clinical assessor, but she talked to patients who were upset about losing services. Her job at CareBridge was to handle issues with the insurer clients and patients. When she joined in 2021, Hawthorne said she was excited to work for a startup and energized by the mission. But she soon came to feel the real priority was not care, but growth and monetary gain. She left after six months.

"There were not enough boots on the ground for that amount of growth," Hawthorne said. "Someone is going to suffer, and it was always the patients who suffered."

Former employees said CareBridge was hard on its workers, too.

Chloe Evans, who worked there in 2022 in a similar role to Hawthorne, said she and her coworkers were micromanaged down to the minute. If employees wanted to use the bathroom outside of their breaktime, she said they were expected to dip into their 10 to 12 minutes a day of personal time.

When she broke her back caring for her young child, Evans asked if she could work remotely for two weeks. Instead, she was fired. Evans was told it was because management didn't get her doctor's notes for her previous doctor visits. She says she provided them.

Evans said she worked closely with Smith and CareBridge's chief of staff at the time to go over staff metrics and assess whether employees were meeting their productivity goals. But every six weeks or so, Evans said bonus tiers would change, making it difficult for anyone to cash in. Leadership explained that's just what working at a startup was like.

"It just kind of seems like a rinse and repeat structure that they have going on," Evans said, "where they'll build it, they have the same techs, they partner with the same people, they develop it, they make money, they sell it, and start over."

Elevance, the same company that bought Aspire, paid $2.7 billion for CareBridge at the end of 2024, compared with a $1.2 billion estimated valuation in 2022, per PitchBook. A spokesperson for Elevance did not respond to a request for comment on the complaints concerning Aspire or CareBridge.

In 2021, Smith launched two more companies. The first, Main Street Health, works for health insurers and takes a cut of the savings it generates, much like Aspire and CareBridge. Unlike the others, Main Street also contracts with the physicians, taking a cut of the savings from them, too.

The other company, Russell Street Ventures, is a venture capital firm that launches and scales value-based companies. Main Street was its first company.

The inner circle

People who've worked closely with Smith said he's intense, but they described it as a quiet intensity. He's not a yeller, but if someone pushed back in a way he didn't like, they'd find themselves outside of his inner circle. No longer invited to certain meetings, excluded from big decision-making.

"When he kicked people out of the inner circle, everybody knew it," one of the former Aspire executives recalled. "That was devastating to people. I saw it happen and it was very much that, 'You're dead to me,' kind of thing. You wanted to stay on his good side."

None of Smith's former colleagues were surprised he ended up in DOGE. Sure, he worked in the first Trump administration, but it's more than that. The DOGE work is precisely his skillset. Smith is wired with a quiet intensity, a relentlessness toward his goals, no matter how little sleep he gets or who he has to align himself with.

He pushes colleagues to match that level of intensity, and resisting doesn't always feel like an option. Many of them quit. A former executive at one of Smith's companies said he respected and learned a lot from Smith, but he wouldn't work with him again. The company he's at now is successful, and he can still make it to the gym every morning.

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Statement on House Reconciliation Bill

May 21, 2025

STAFF

FOR IMMEDIATE RELEASE

Statement attributable to:
Bruce Siegel, MD, MPH
President and CEO
America's Essential Hospitals

WASHINGTON — America's Essential Hospitals remains strongly opposed to the deep Medicaid cuts contained in the reconciliation bill approved by the House Rules Committee and now headed to the

House floor.

The cuts would threaten the health and well-being of millions of Americans and harm the essential hospitals that serve as community lifelines.

We look forward to continuing our work with lawmakers to find real solutions to sustain and strengthen Medicaid.

# # #

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America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our more than 350 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

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Dedicated staff at America's Essential Hospitals work together to produce high-quality, reliable content.

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Statement on Senate Reconciliation Bill

June 16, 2025

STAFF

FOR IMMEDIATE RELEASE

Statement attributable to:
Bruce Siegel, MD, MPH
President and CEO
America's Essential Hospitals

Washington, D.C. – The draconian Medicaid cuts contained in the Senate bill would devastate health care access for millions of Americans and hollow out the vital role essential hospitals play in their communities.

This bill would take away health insurance coverage for millions of beneficiaries, including those who rely on Medicaid for essential and mental health services, and jeopardize the health and economic stability of our communities.

We will continue to work with lawmakers to find positive solutions to sustain and strengthen Medicaid as the bill makes its way back to the House.

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TELL CONGRESS:

TAKE A(

POLITICS

Takeaways from AP's report on financial interests of RFK Jr. adviser who runs wellness platform

BY MATTHEW PERRONE
Updated 3:53 PM EDT, June 10, 2025

WASHINGTON (AP) — Calley Means has built a following by railing against the U.S. health system, often hammering on alleged financial conflicts within the medical establishment.

Means, a top aide to Health Secretary Robert F. Kennedy Jr., was hired as a White House adviser in March. He has used that position to accuse physician groups, federal agencies and government scientists of financial interests that bias their work.

Means, however, has his own stake in the sprawling health system. He's the co-founder of an online platform that offers dietary supplements, herbal remedies, exercise equipment, light thera wellness products.

The Associated Press found that Means' heated rhetoric against the medical mair the interests of his company Truemed, which features vendors who are prominen "Make America Healthy Again" movement. Because of his status as a temporary g Means is exempt from publicly disclosing his financial details.

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The AP reviewed more than two dozen interviews, speeches, articles and podcast appearances by Means both before and after he joined the government.

Here are some takeaways from the AP's reporting:

Attacking prescription drugs, promoting wellness alternatives

Means' company, Truemed, helps users take tax-free money out of their health savings accounts, or HSAs, to spend on things that wouldn't normally qualify as medical expenses, such as meal delivery services and homeopathic products — remedies based on a centuries-old, debunked theory of medicine.

As a top messenger for the administration, Means has been promoting a new government report that calls for scaling back prescription drugs for depression, weight loss and other conditions.

By criticizing the use of drugs and other rigorously tested products, health experts say Means is furthering the interests of his company, which offers alternatives to traditional medicine.

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"It reeks of hypocrisy," said Dr. Reshma Ramachandran, a health researcher at Yale University. "In effect, he is representing another industry that is touting nonregulated products and using his platform within the government to financially benefit himself."

In a written statement, Means said his government work has not dealt with matters affecting Truemed and has focused on issues like reforming nutrition programs and pressuring companie

"Pursuing these large-scale MAHA goals to make America healthy has been the sc work," Means said.

Undisclosed interests

The full extent of Means' potential financial conflicts are unclear because of his status as a special government employee.

Unlike presidential appointees and other senior officials, special government employees do not have to leave companies or sell investments that could be impacted by their work. Also, their financial disclosure forms are shielded from public release.

"It's a big problem," says Richard Painter, former White House ethics lawyer under George W. Bush. "I think it's a loophole."

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While promoting the administration's accomplishments, Means has not shied away from plugging his own brand or those of his business partners.

When asked to offer health advice to listeners of a sports podcast, Outkick The Show, in April, Means suggested they read his book "Good Energy," which he co-authored with his sister, Dr. Casey Means.

He also recommended blood tests sold by Function Health, which provides subscription-based testing for $500 annually. The company was cofounded by Dr. Mark Hyman, a friend of Kennedy and an investor in Truemed, which also offers Hyman's supplements through its platform.

Like dietary supplements, the tests marketed by Function Health are not clinically approved by the Food and Drug Administration.

"It ends up favoring these products and services that rest on flimsy grounds, at the expense of products that have actually survived a rigorous FDA approval process," said Dr. Peter Lurie, a former FDA official who is now president of the Center for Science in the Public Interest.

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Steering medical dollars into health savings account

Means says he has not worked on issues impacting HSAs since joining the federal government. Federal ethics laws forbid government employees from taking part in decisions that could impact their financial situation.

But before joining government, Means said the mission of his company "is to steer medical dollars into flexible spending."

"I want to get that $4.5 trillion of Medicare, Medicaid, everything into a flexible account," he told fitness celebrity Jillian Michaels, on her podcast last year.

Truemed collects fees when users and partnering companies use its platform.

Means also founded a lobbying group, made up of MAHA entrepreneurs and Truemed vendors, that listed expanding HSAs as a goal on its website.

Means said in a statement that the group focused only on broad topics like "health care incentives and patient choice — but did not lobby for specific bills."

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Benefits of HSAs questioned

Expanding HSAs has been part of the Republican health platform for more than 20 years. The tax-free accounts were created in 2003 to encourage Americans in high-deductible plans to be judicious with their health dollars.

But HSAs have not brought down spending, economists say. They are disproportionately used by the wealthiest Americans, who have more income to fund them and bigger incentives to lower their tax rate.

Americans who earn more than $1 million annually are the group most likely to make regular HSA contributions, according to an analysis by the nonprofit Center on Budget and Policy Priorities. Most Americans with HSAs have balances less than $500.

HSA expansions in Trump's "One Big Beautiful Bill" are projected to cost the federal government $180 billion over the next 10 years.

"These are really just tax breaks in the guise of health policy that overwhelmingly benefit people with high incomes," said Gideon Lukens, a former White House budget official during the Obama and Trump administrations.

⊗

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MATTHEW PERRONE
Perrone covers the intersection of medicine, business and health policy. He is based in Washin

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Tucker Carlson, RFK Jr, and Larry Elder React to Second Trump Shooting

The Tucker Carlson Show

1,020 views · 17 Sep 2024

Tucker Carlson Live Tour in Milwaukee, WI. Larry Elder and Bobby Kennedy, Jr. on Donald Trump's second assassination attempt.
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[00:00:01]

Did you know there's a scheme called
help adapt workplaces, including rem
supports, and training. So for more in
Government of Ireland initiative broug

[00:00:30]

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Thank you. Thank you. I'm really happy to be here. I've spent… Thank you. It's so funny. I was just in this

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States. I'm from here. I was born here. I will die here. Hopefully not too soon. But I've made that commitment, and I'm going to be buried near my dogs. But I love the whole country. I grew up on one Coast, I live on the other. Whoever clapped for me being buried next to my dogs, I like you because I feel that way. But I have to say, and this is not pandering, this is totally This year, I especially love this part of the Midwest. I just love it. I love it for incredibly shallow reasons that I'll just... First of all, I love to hunt and fish here. I love your muskies. I love your grouse. The friends who I go on an annual hunting trip with in two weeks, the first thing I'm doing when I get off tour is coming back to Wisconsin.

[00:02:11]

To catch your fish and try to shoot your birds. I probably won't. Don't worry, they're safe. But the real reason I love the Midwest, particularly this part of it, is because I married a girl from this area. I just love the accent. I think it's hilarious. I've been with her 40 years next week. I met her 40 years ago next week. When I first started dating her, I thought, I'm sure the accent will lighten up a little bit over time. It has not at all. It's still a car, a car, which is like a motor vehicle. If I say to my dogs, Let's go to the park, they look at me like, What? But if I say, The park, bam, they're up. I associate that accent with niceness and particularly nice women. I'm walking through downtown Milwaukee today, and I hear people speaking in this accent, and I almost want to walk up and introduce myself and be like, Oh, it's so nice to meet you. I thought, I don't know, maybe you get a shot doing that. But everyone actually was nice. I just think it's just the sweetest part of the country. So thank you so much.

[00:03:26]

We have it even in my kitchen, the Midwestern sensibility. We're very big on meatloaf in my house, actually. I don't even know if they still serve it here, but in the '70s and the Midwest, everyone ate meatloaf every day, and so we still do. It's funny, the reason that we're doing This tour we're doing, this is our eighth night, and we're doing the entire month of September. The real reason I wanted to do it was I now work on the internet. Before then, I worked on television. The frustrating thing about... I know. Yeah, okay. The frustrating thing about both of them is there's a lot of censorship, and now more than ever. I just thought to myself, the one thing that you can't censor is a live event. You can really be completely honest because the people are right there. If you're in a room full of thousands of people, you can feel very strong. Now, I'm revealing I'm from California, but a vibe coming off the people. It's just wonderful. People can be as honest as they want, which is extremely honest. I thought, I just need to do that after spending all day worried about what YouTube is doing to our videos.

[00:04:39]

I just want to get out and talk to people directly. After eight days, I'm thinking, maybe I overstated it. Maybe the censorship, the distortion of the facts, the lying, the massive deception machine I've been a part of for 33 years now in the media, maybe it's not as bad as I thought. Then someone tries to shoot Trump again. I was here. Actually, the last time some
two days after. I am shocked watchin
sudden we're getting these reports. I
in the media about it? The first thing,
which totally makes sense. The guy l

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murder him. I mean, that's the way it works. It's like Putin blowing up his own natural gas pipeline. That

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I'm watching this. They're literally telling me that this guy, whom they've arrested, is a Trump supporter. Huh? You flipped channels, and then you learn that, I flipped over to a channel I used to work on. There's Lindsay Graham. I know. I know. I know. He's a Republican senator from one of the most conservative states. How does that happen, by the way? If democracy is real, how is Lindsay Graham, a senator, but whatever. I'm watching Lindsay Graham, and Lindsay Graham is looking right into the camera. He's like, You know who did this? Iran. Iran? I look into this. Yeah, that's for sure. Well, it turns out someone has yelled warmonger. Well, the guy who shot Trump was also a warmonger. In fact, the closer you look at it, the more you realize his politics are exactly the same as Lindsay Graham's. He's a neocon. He literally volunteered in Ukraine. Lindsay Graham was like, No, Iran did. I was like, No, you have no opinions that are different from this guy's, and you're lying to me. In the audience I used to speak to five nights a week, you were lying to them. I'm shouting this in my hotel room.

[00:07:06]

Nobody heard me. My wife was brushing her teeth. She's like, What is that? They're lying. It drove me completely insane. There's no mention of the fact that this guy, who, by the way, has been interviewed by every media outlet in Washington, this guy was a very famous guy. You may not even know this. There's only really one place to learn any facts at all, and that's Elon Musk's social media app. It's crazy. I don't have a TV at home, so I'm spared most of this. I have no idea what's going on. By the way, I strongly recommend ignorance. If you're looking to stay happy in a moment like this, just know less. Unfortunately, my job requires me to know more, but if you think about it, did God punish Adam and Eve for ignorance? I don't think he He punished them for knowledge, so maybe I shouldn't watch cable news. I don't want to know what they're saying, but this week I've had to pay close attention. Every single thing is a lie, either directly or it's a lie much more prevalent and much more sinister. It's a lie by omission. They're just not telling you the facts.

[00:08:23]

Without belaboring the point, I'm using this as just one example among a countless number of examples where The reality is completely distorted, and the average person has not only no idea, but no way of knowing what the truth is. The guy who is now in custody for attempted murder against the Republican nominee, the former US President, Donald Trump, that guy has been interviewed countless times by every big media outlet in the United States. He's got a criminal record, the length of your arm, 20 charges, including possession of weapons of mass destruction. The New York Times didn't bother learn any of that before they held him up as a freedom fighter in Ukraine, where he was living. Then the piece describes the contact he's had with members of Congress and their staffs and other US government agencies. You're like, Wait a second. That's the same guy who brought a rifle with a scope to a golf course in South Florida to murder Donald Trump, and he's had all these contacts with US government agencies. He's like, I don't know what that's about, but I think it's time t

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[00:09:31]

It's just going to be memory holding. I
remembering. People are like, What?
control or something? No, no, no, no,

York Times. who has the exact same worldview as Lindsay Graham. decided to try and murder Donald

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do you know if someone is being honest? It's very hard. But one of the main reasons you know, I don't know what you're saying, but I know that I agree with you. If I could hear you, I would shout back whatever you're shouting because I feel like you're on. From the pitch of your voice, I can tell you're on to something. Well, I love you, too. I heard that. Here's the answer to the question. How do you know if someone is telling the truth?

[00:10:37]

This has been my obsession for the last year, having worked in the middle of the deception machine and not even realizing it. Until the day you get fired, you're like, What was it like having an alcoholic spouse? Everyone knows except you. I'm very fixated on this fact, which is that almost all of the information that we who received has been curated and spun and reduced in size. Relevant facts have been omitted. Irrelevant facts have been pushed to the fore in order to manipulate how we feel. How do you defeat that? Well, The main way that you defeat that, your first line of defense, are your instincts. I have come to believe this. You know when someone's lying, you can feel it. I know this because I have so many dogs. No, I'm serious. My dogs cannot speak English that I'm aware of. And yet if you come to my house and you're weird, my dogs know immediately. They can smell weirdness on you. They can smell deception on you. They don't like you at all. They will bark at you. They will cower in the corner. Now, how is that? They haven't seen your tax returns.

[00:11:49]

They haven't talked to your wife, but they know. And they know because we all know if you get a vibe off someone that suggests deception, that person is lying. If you get a vibe that suggests weirdness, Tim Walls, for example. I'm just saying. First of all, I went to boarding school in the '80s in New England, We had dorm masters like Mr. Walls. The second I saw that guy, he's not babysitting in my house. I'm sorry. No way. Oh, that's so unfair. No, it's not. No, it's not. Because my My instincts didn't just alert me to this. They screamed it full volume, this guy's a creeper, period. Therefore, I don't have the evidence necessary to indict in a court of law. I don't. I'm not going to press charges against him. Well, someone may at some point, it's not going to be me because I don't have the information. I have the instinct, and that's all I need. The same is true, very true for deception. If you're watching someone, I don't want to name names because I don't want to be mean, Lindsay Graham, and you look at that person and you're like, I think that person is trying to sell me something.

[00:13:03]

I think that person may not be telling the full truth. You are right. You are right. Our main weakness as people is that we override the truth as delivered by our instincts, by our higher mind, and we talk ourselves out of knowing what we already know. You already know. You know because God gave you those instincts as maybe the most important gift you received at birth to protect protect you from deception and harm. Your instincts are not trying to sell you som
to serve you, so do not ignore them. Y
passed high school biology. Pretty su
girlfriend, now my wife. Actually, I did.
that to anyone. Don't tell my children.

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grounded in the hard sciences because I'm not. I'm deeply grounded in human nature and in the way that

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When they started telling me things on television, I knew instantly they were lying. I had no idea why. I didn't know what the larger purpose was. I still I have no idea. I can speculate. I won't do it here. What was that? What was the point of that? Well, to increase their power, to make weed stores more profitable and close down churches. Yeah, I got that. But what was the big picture goal of that? I don't know. But I knew the first day when I watched Tony Fauci talk on my show, I interviewed him. I had no idea Tony Fauci was lying. I booked Tony Fauci. Tony Fauci is the longest federal employee. He lives in my neighborhood in DC. Lock him up. Yeah, lock him up. Well, he's not locked up. He's wandering through our dog park with Secret Service protection at your expense, by the way. Do you have Secret Service protection? Yeah, no. He hasn't been locked up. He's been rewarded in Georgetown University's paying him even more money in federal tax dollars as a hero. But I, on the basis of no evidence whatsoever, only unairing instinct, saw Tony Fauci in that interview, and I was You're lying.

[00:15:31]

I didn't say that on TV, but I felt it so strongly, and I spent the next week trying to figure out what he was lying about, and then it became really obvious. All of us are capable of that. Every one of us is capable of that. The truth, by contrast, hits very differently when When you hear somebody tell a true thing, say something out loud, something you never heard before, something you've heard a million times but never thought about, when you hear a true word, it resonates within you like a tuning fork. It hums. You can't get it out of your head. You may not know why it's true, but you know that it is. The word, the true word, is the most powerful force in the world. In the beginning was the word. When we hear something true, we know it. The only reason that we don't act on it is because we've been talked out of it by professional liars or we doubt our own gut instincts about it. What I would say to you is, do not doubt your instincts. If you see someone, if you see Carmela Harris up there saying, vote for me, I'm actually a farmer from downstate Illinois.

[00:16:49]

You can see the black earth in my hand. That's my tractor behind me. Vote for me. I'll give you a tax cut and a free AR-15 or whatever. She's basically making that pitch. She's running as some right winger. Have you noticed this? Yeah. The defund the police check is somehow now a conservative? Right. Okay, got it. I don't even need to know her history. I don't need to know anything about her. I listen to her talk and I think, You're lying. This is before I even know that she was Montell Williams' sidepiece or whatever. I know nothing about her. That's just verification of what I already felt. I knew that without even calling Montell and asking him. I knew who you were, and we all do. I would say, Hone your spidey senses these next six weeks because you're going to be lied to at a volume with a level of aggression you've never seen before. The command will always be the same. Ignore what's right in front of your face. You didn't see that. That's not real. You're crazy. That's really the message. You're crazy. You can only trust us. The rest is disinformation.

[00:18:06]

Okay. First of all, anyone who uses th
not a category. There's only one cate
saying something that's inconvenient
or go to jail. That's not a valid category.

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disinformation is immediately on the liar side. Don't listen to another word. That person is your enemy.

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and they're your only guides, and they're not many of them. I just want to say I'm so grateful that we have two of them tonight, and I'm going to introduce them in order. All right, consider doing this. Imagine going to your computer, looking at your entire browsing history on the web, everything you've looked at. Now, imagine hitting print and then signing your full your name at the bottom, maybe with your social security number, printing out that browsing history with your name on it and nailing it to the front door of, say, your house for everybody in the world to see.

[00:19:40]

Maybe that would be fine, maybe not. And while you're at it, actually, take a copy of that same list of everything you've looked at on the internet and post it in the break room at work. And then, in fact, go farther than that. Blow that up and put it on a billboard over a major highway on your commute to work. Here's everything I've been looking at on the internet. Would you want to do that? You don't have to be a creep to think, Maybe that's not something I'd want to do. But in effect, that's what you're already doing every single day, unless you already use the sponsor of this video, ExpressVPN. You are allowing all of your online activity to become public. Why? Because Internet service providers can see every website you have ever visited. Yes, even if you're in incognito or private browsing mode, that doesn't really work. And in the United States, your Internet service provider can then sell your data to whomever they please, including the government. And they do, by the way. So what can you do about that? Well, you can do what people in our office do, particularly when we're abroad, but also when we're here.

[00:20:44]

And that's encrypt your online activity before it even reaches the Internet service provider, so no one can see it. It's private. Privacy is a prerequisite for freedom, so keep it close. We use ExpressVPN to do that. That's our Internet provider. Our internet provider cannot see what we're doing on the Internet because we use ExpressVPN. They can't record it, they can't share it, they can't sell our browsing history because they never have it to begin with. Why don't they have it to begin with? Because ExpressVPN reroutes our online activity through secure servers and changes our IP address and makes you more anonymous to apps and website trying to track us. It'll do the same for you. What we like about it is it's so easy to use, even if you're not a tech genius. You tap one button on whatever device using, whether it's your phone, your laptop, your tablet, your desktop, and you know that your privacy is secure. Once again, privacy is a prerequisite for freedom. You can't be free unless you have privacy. If you want to start reclaiming your privacy, do yourself a favor and use our special link to get three months of ExpressVPN for free.

[00:21:49]

Just go to ExpressVPN/Tucker. That's Express-E-X-P-R-E-S-S-V-P-N. Com/tucker. The first who's going to join me in just a second is my friend Larry Alder, who I've known for a really long time, who's a wonderful man. Of the many things that we have in common. Larry Alder and I are both from Southern California. which used to be the thing that you br
believes me, but I tell them that. Actua
kid, we felt very sorry for anybody wh
face because you don't want to be me
just didn't know or they couldn't afford
we were sad for you because it was such a wonderful place. It was the greatest place. It was the apogee of

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human civilization. and I still think that. It matters what's happened to California. I find myself, since I live as

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It's like a typhoon in Bangladesh. I feel sad, but it doesn't really affect me. But it actually does affect me. It's our largest state, actually, and it is a bellwether. What happens in California does tend to move east inexorably, and so we have to care. What is happening in California? Well, I can promise you the entire American news media colludes to hide the truth of what's happening in California from you because they don't want you to know what they want to do to you is the truth. Larry Alder knows he cares enough to have run for the governorship California. He's probably the last sensible person who ever will. It's a one-party state. But he made an honorable and good faith effort to dislodge Gavin Newsom. Some of us were really rooting for him. I had him on for his announcement one Thursday night, and the next night was my last show because I got fired, so I wasn't able to cheer him on from my perch at a TV channel, but I was certainly from the sidelines. Larry Alder is going to come out in about 30 seconds and tell us what the state's actually like, because you should know, even if you live here in the beautiful, unchanged Midwest.

[00:24:35]

The second person we're going to talk to is Robert F. Kennedy Jr. The one thing I would say about Bobby, who I've been friendly with and really admired for a long time, before it was even cool, I had some secret opinions about pharma that I didn't want to share in public since they were our biggest advertiser. I have for many years thought he was on the scent. Like one of my dogs hunting down a pheasant in a cornrow. I was like, Yeah, you're getting warmer there, Bobby. But Bobby's life is amazing. I could go in for hours, I'll do it in one sentence. What's happened to Bobby Kennedy over the last 18 months gives me hope for this country because there's no one who's more of a Democrat than Bobby Kennedy. He's now campaigning for Donald Trump. How did that happen? It happened because partisan politics, I'm just learning this in my advanced middle age, is a lie, actually. If you wake up in a world where Lindsay Graham goes on cable news and pretends that he's on your side as he's lying right to your face to send your children to go die in some pointless foreign war, and Bobby Kennedy is actually trying to save your children from dying young from preventable disease.

[00:26:02]

If you're like me, you've never voted for a Democrat in your life, and you never are going to, but you ask yourself, Wait a second, maybe this is all fake, actually. It is. The real divide is not between Republicans and Democrats. The real divide is between the liars and people brave enough to tell the truth. Bobby Kennedy is in the latter category, as you're about to find out. With that, I am honored to introduce for an update on the biggest, most important state, the Golden State of California, my friend Larry Elder. Larry Alder. I'm so honored you're here.

[00:26:56]

Are you aware that Tucker does not wear socks?

[00:27:00]

I don't wear socks. No, I don't. You ge
license, but there's some things I'm n

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[00:27:10]

I don't want to know what else vou don't wear.

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right to the vulgar newsroom and deep inside me. Larry, as I said, I got fired right after you announced I was sitting.

[00:27:33]
I killed your show.

[00:27:34]
You did.

[00:27:35]
I came on this show on Thursday, and I announced I was running for President. And by the way, this is the scene of the crime for me. You had the first GOP debate here in Milwaukee, and I was required to get three polls where I was at 1% or a better to qualify. So I turned in three polls where I had 1% or better. I got a phone call from Ron McDaniel, and she said, One of the polls you can't use. I said, Which one? She said, Rasmussen. I said, Why? She said, Because it's affiliated with the Trump campaign. It is true that the rules are if anybody commissions a poll, that person can't use it, nor can any other candidate use it. So after the announcement was made that elder didn't qualify, Rasmussen puts out a tweet and says, We're not affiliated with Trump. There's no reason why elder can't use me. So I submitted a fourth one, and she said, You submitted it too late. So my lawyer is the former chair of the Federal Election Commission, Tucker, and he told me that by failing to apply the debate criteria fairly to elder, what the RNC did essentially was to give an in-kind contribution to the eight candidates who did make it on the debate stage.

[00:28:42]
Based on the value of the time at Fox News, that's $100 million. So I told them, I flew here to Milwaukee, anyway, on the eve of the debate, I said, If you don't put me up there by 2:00, I'm going to file a complaint with the FEC for $100 million. And tick, tick, tick. I thought they were going to blink. They did not. So they didn't put me on, as you know, and I have filed that complaint. So we'll find out what happens.

[00:29:04]
I guess my takeaway would be, are you saying the RNC is not totally on the level?

[00:29:11]
Shockingly. I think their goal, Tucker, was to reduce the number of candidates. They thought that 17 was too many in 2016. They wanted to reduce it to a more manageable number, I guess. I don't really know. And Tucker, I wasn't trying to displace Donald Trump. I knew he was going to be the nominee, but there are some issues I thought were not talked about, and I felt if I could get those issues front and center, I do my job. Most notably, the number one domestic problem in America, by far, is the epidemic of fatherlessness. 40 % of all-American kids now enter t
black kids in 1965, now 70 %. 25 % o
mother. The stats are clear. If you're r
commit crime, nine times more likely
what's happened? In the mid '60s, a D

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[00:30:17]

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[00:30:29]

The neighborhood you grew up in the state you grew up in. You grew up with your dad at home. We've talked about your dad. It sounds like an amazing guy. But that wasn't weird, was it?

[00:30:39]

It was unusual when I was growing up for a mother and a father not to be in the home. Now, it is unusual for a mother and the father in the inner city to be in the home. That's the big difference. My father never knew his biological father. My last name, elder, is the name of some man who was in his life the longest, maybe three, four years. I'm not even sure that elder He formerly adopted my dad, but my dad began using his name. His mother could neither read nor write. She was irresponsible, lived off a series of boyfriends. My dad, at the age of 13, comes home and starts quarreling with his mom's then-boyfriend, elder was long gone. The mother sided with the boyfriend and threw my father out of the house, never to return. Athens, Georgia, Jim Crow South at the beginning of the Great Depression. My father picked up trash, cleaned up barns, did whatever he could, became a Pullman porter on the train. They were the largest private employer of blacks in those days. This little black boy from Athens, Georgia, traveled all over the country, Tucker, and came to this state called California, the city called Los Angeles.

[00:31:38]

My dad was blown away. You could walk through the front door of a restaurant, sit down and get served. He made a mental note, maybe someday he'll relocate to California. My dad always had packages of crackers and 10 cans of tuna because you never knew in the south if you'd be able to get a meal. Pearl Harbor, my dad joins the Marines. I asked him why. Are there any Marines here? There are any Marines here? Ura. You know what I'm going to say? I asked my dad why he joined the Marines. He said, Two reasons. They go where the action is, and I love the uniforms. Good reason. So my dad was stationed on the island of Guam. He was in charge of cooking for the colored soldiers because the military was segregated in those days. My dad can look at a cake and tell you what's in it. So the war is over. He goes back to Chattanooga, Tennessee, where he met and married my mom to get him a job as a short order cook. He goes to three or four restaurants, and he's told, We don't hire niggers. Goes to an unemployment office.

[00:32:31]

The lady says, You went through the wrong door. My dad goes to the hall and sees colored only, goes to that door to the very same lady who sent him out. My dad came home to my mom and said, This is BS. I'm going to LA where I was before the war. Get me a job as a cook. He comes out to LA, he walks around, and he's told, You don't have any references. My dad said, I need references to make ham and eggs. Goes to an unemployment office, this time, just one door. Nothing's available. He said, What time do you open? She says, 9:00 What time do you close? She said, Five. My dad said, I'll be sitting in that chair until you find something. Sat in the chair for a whol
up. She said, I have a job for you. I d
going to want it. I'm starting a family.
did that for 10 years, took a second fu
family in the weekend because he wa
his GED.

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[00:33:25]

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my dad He had retired. He owned that building. He owned the property next to it. Plus, the house is still in our family right now. He retired with a networth of above a million dollars. I tell you that story, Tucker, to that being raised by a single mom is not a death sentence. You're still responsible. Life is still all about choices. My dad was a lifelong Republican. My mom was a lifelong Democrat. You should have been in the house. My dad said, Democrats want to give you something for nothing. You're trying to get something for nothing. You almost always end up getting nothing for something. My dad would say this, Hard work wins. You get out of life what you put into it. You cannot control the outcome, Larry, but you are 100% in control of the effort. Before you bitch, moan, or whine about what somebody did to you or said to you, go to mirror, look at it, and ask yourself, What could I have done to change the outcome?

[00:34:33]

Finally, he said, No matter how hard you work, how good you are, sooner or later, bad things are going to happen. How you deal with those bad things will tell your mother and me, If we raised a man.

[00:34:44]

He sounds like an amazing man, but he never made this sale politically with your mom. No.

[00:34:53]

Lived to be 95 years old. During Watergate, you should have been a fly on the wall. My dad thought Watergate was inconsequential. Even if Nixon sent the plumbers in there to bug Larry O'Brien's office, my dad thought it was, so what? No evidence whatsoever that Nixon did it. He covered it up. My dad thought it was inconsequential. He said, Over time, you're going to realize this is no reason to get rid of a president. My mom thought it was horrific. She hated Nixon. The polls now show most people believe that what Nixon did does not rise to the level of him leaving office. My dad was right.

[00:35:28]

It turned It turned out that Deep Throat was the number two man at the FBI working in concert with the CIA to crush his sitting president. So you consider the-We've seen subsequently, but your dad was onto that.

[00:35:43]

You graded on the curve now. Look at the Biden crime family, $27 million, all this corruption. What Nixon did was inconsequential compared to what's going on right now.

[00:35:53]

He didn't get rich in China. That's true.

[00:35:55]

No, he sure didn't.

[00:35:56]

So California But your home state, my

[00:36:06]

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I think this story probably illustrates how bad things are. I ran for governor, as Tucker pointed out, I ran in

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percentage as Torstenegger got in 2003 when he successfully recalled a previous governor. Since then, there are 5% more registered Democrats, 25% fewer registered Republicans, and 50% more registered independents, and independents in California vote Democrat. There hasn't been a Republican elected statewide in California in 20 years. So the race is over. I collected, I raised $27 million in eight weeks, three and a half million votes. California has 58 counties. On the replacement side, I carried 57 to 58 counties. The only one I didn't carry was San Francisco. I didn't spend one dime or one minute campaigning there because I thought it was a lost cause. I lost that by 149 votes. So the race is over, Tucker.

[00:37:15]

I go to a restaurant in the west side of LA to meet a buddy of mine. He's late. I'm sitting at a table. There's a table next to me with two ladies. I think they feel sorry for me because I'm sitting by myself. We start talking. It turns out they're 85 years old. They've known each other since the second grade. One was celebrating her 85th birthday, and they told me they were Jewish. One said she was a human rights activist. One said she was a psychotherapist. Then about 15, 20 minutes into the conversation, one of them said, Wait a minute. I know you. You're that guy that ran for governor. You're that Larry elder. She said, Guess who we voted for? She said, You didn't vote for me. She said, How do you know that? I said, Let's see. We're on the west side of LA. You're both Jewish. You're a human rights activist. It doesn't take Colombo to put that together. You didn't vote for me. They said, We didn't. Let me ask you something. How do you feel about the way Gavin Newsom shut down the state in a more severe way than did any other governor because of COVID?

[00:38:10]

While sitting up there at that French laundry restaurant, yucking it up with the very same people that drafted the mandates, not wearing a mask, not social distancing. They said, We were outraged by that. How do you feel about the fact that a million people have left California in the last three years, the first time anybody has left this state in 150 years? We've lost friends. How do you feel about the homelessness? They both told me that they had a homeless encampment near their homes, and they were outraged by it. I said, How do you feel about the quality of schools? Do you have kids? Yes. Did you put any of your kids in the Los Angeles Unified School district? No, we would not because the schools are substandard. Here we are completing each other's sentences, and you didn't vote for me. I said, Have you ever had a conversation with a conservative Republican before? They said, No. She said, What are you drinking? I said, Double vodka, splash of cranberry. Other one said, What are you eating? I said, Well, I was going to have steak. Now I'm going to upgrade it to lobster. You pay for the meal.

[00:39:04]

So we had a marvelous time. They had never had a conversation. Another one. I have some back issues. A buddy of mine recommended a mass
office building. I turned down a reside
She's got tattoos everywhere, ear pie
marijuana. Not that I would know wha
back and she's playing Motown music
can tell you about it. They played My Girl. I said, That was written by Smoky Robinson. He wrote the song

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for David Ruffin, the lead singer of the Temptations. This song is written by Marvin Gay. Marvin Gay was

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who you were. I wasn't going to say anything.

[00:40:03]

Had I known you were this funny and this personable, I would have voted for you. I said, Do you know any Republicans? She said, No. I said, None. She said, No. I said, News bulletin. We have personalities. We have senses of humor. I mean, honestly.

[00:40:21]

Well, I mean, in her defense, I remember that campaign very well, and I think the LA Times called you a white supremacist.

[00:40:29]

No, no, no, No.

[00:40:31]

Maybe she thought you were a white supremacist.

[00:40:32]

I don't know. Let's be accurate. I was called the Blackface of White Supremacy. Sorry. I worked very hard for that title, Tucker.

[00:40:40]

What does that even mean? I never figured. It's like a Zen cone. That's the sound of one hand clapping. I don't even understand it.

[00:40:48]

I've been on radio for 30 years. The first six months I was on radio, every third caller called me an Uncle Tom or a sellout or a bootlicker, Bug-Eye, Bootlicking Uncle Tom, Sam Bo Tom. So I'm on the radio for about six months and I'm walking to a restaurant and there are a couple of brothers sitting on a brick wall based on the way they were dressed. They weren't investment bankers. One of them said, Larry Alder, I hate you and I love you. Come on over here. Now, Tucker, I'm thinking, if they were going to shoot me, they'd have done it by now. I can't outrun a bullet, might as well go over there. So I went over, he goes, I've been listening to you about four, five months now, and at first I couldn't stand your black ass. But the more I started listening to you, the more I said, he ain't doing nothing but telling people to get off their ass and stop complaining. You're like castor oil. It don't taste good going down, but it's good for you. Keep it up.

[00:41:51]

A lot of bad things going on in the world that honestly, not many of us can have an effect on. Rising crime, failing schools, a tanking economy. W
house in order. And above all, you ca
values, that are making this a better c
companies? Well, that's where Public
from America's small businesses to h
lives. That means fewer errands to big box stores, less searching to find wholesome alternatives to the

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garbage being offered in our culture, and more quality time spent with people you love most. If you want to

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spending, supporting people who support your family, not funding people who hate you. If you want to do that, publicsquare.

[00:42:59]

Com is the answer. Publicsquare. Com. That's such a great description.

[00:43:19]

All I'm doing is telling the truth. You mentioned truth. George Floyd, Four months worth of protests, violent protests, 25 people killed, 2,000 police officers wounded, $2 billion in insured property damage, maybe another billion or two in uninsured property damage, Tucker. All because of what happened to George Floyd. However you feel about what happened to George Floyd, however you feel about what Derek Chauvin did or didn't do, there is zero evidence that what happened to George Floyd had anything whatever to do with his race. Zero. The lead prosecutor was a black man. I'm a lawyer. The most important part of a trial is the opening statement. In the opening statement, he took pains to say the police in general were not on trial. The Minneapolis PD in general was not on trial. This individual is on trial for what he did or what he didn't do to George Floyd. And he never even intimated that the officer committed a hate crime. He was never charged with a hate crime. Yet you had all these protests all over the country based upon the assumption that what happened to George Floyd had to do with his race when there was zero evidence of it.

[00:44:36]

Police kill more Whites every year than Blacks. They kill more unarmed Whites every year than Blacks. Most people couldn't name an unarmed White person because nobody cares. If an unarmed White person gets killed, as my mother puts it, he's just a dead fly. But an unarmed Black person gets killed, in comes CNN, in comes the New York Times. They make a big deal out of it without any understanding whatsoever what's really going on. It's been studied for decades. The police are more hesitant, more reluctant to pull the trigger on a black person than a white person. By far, it's a lie. There's a website called policemag. Com, and they ask self-described, very liberal people, how many unarmed black men did the police kill in 2019. 50% of the self-described unarmed black people thought the... 50% of the unarmed... 50% of the self-described liberals thought the police killed 1,000 unarmed black men in 2019. 8% thought they killed 10,000. What you ask about the regular liberal people, self-described? 39% of self-described liberal people thought the police killed 1,000 unarmed black men in 2019. 5% thought they killed 10,000. The answer, according to the Washington Post database, was 12.

[00:45:49]

That's the gap between what the left thinks is going on, but versus what is really going on, which accounts for why we had four months of protests in the streets of America in 2020.

[00:45:58]

So the numbers you just cited,publicly
except you and a few other people. S
Bobby Kennedy out. What advice wou
1% of the population who says what h

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the same? What makes you different? Why are you able to just go on the website, see that it's incorrect.

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It's what you said in your monolog, think for yourself. Use your own judgment. Be skeptical. Injust the news in a discriminating way. The Media Research Center found that ABC, NBC, 85% of their coverage was positive regarding Kamala Harris and Walsh. 93% of it was negative regarding Trump and Vans. And ABC News was the worst. Of 25 stories they've done since Kamala Harris became the presumptive nominee, 100% have been positive. 93% of the ones for Donald Trump have been negative. And ABC alone from CBS, NBC is the only one of those three that has never referred to Kamala Harris as a liberal or even a progressive. You're being lied to. Use your own common sense, use your own judgment, and thank goodness for alternative sources of news like Tucker, like a Glenn Beck.

[00:47:29]

Think for yourself. It's not that hard.

[00:47:33]

It's not that hard.

[00:47:35]

Larry Alder, you're a hero.Thank you.Thank you. Thank you. So as noted at the outset, I would like to ask this man to join us. Bobby, thank you for doing this. It's an I hate to ask you this because it's almost too sensitive, but it just happened, and so I can't not ask you. There was a second, appears to be a second assassination attempt on Donald Trump in just a couple of months. What do you make of this?

[00:48:25]

I don't know what to make. I think we're seeing an impact, at least partially. I just don't know enough about what's happened, and I've been reading some of the internet stuff about the connections that this man may or may not have had to the intelligence agencies, et cetera. I don't know what to make of it. I do know that there's an antagonism and a violence in our society now that I feel is orchestrated. I feel that we're living in a... You remember a couple of years ago when they had the Occupy Wall Street movement, and they were trying to frame this debate as the 99% against the 1%. I feel Like, since then, we've all been turned against each other, where it's 50% against 50%. When the king and queen go out on the balustrades of their castle and they look out across their people and they're all fighting each other, they go back to the banquet hall and they pop champagne corks because they know nobody's coming over the wall against them.

[00:49:57]

Boy, is that true?

[00:50:00]

I think so many of the... I mean, I announced my campaign almost 18 months ago. What I said at that point is, I'm not going to feed into the vitriol I'm going to be civil to all of them. I'm rather than focusing on these smaller each other's throes. Because I've wat that have been put in place to shift we

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rest of us. And they all culminated during COVID, where we saw all of our three 3 million businesses shut

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days of the lockdown. And the American middle class has essentially been obliterated in this country. I think all this money is being shifted up to to Black Rock and State Street and Vanguard and the other big financial houses and big pharma and big tech and big act and big food that are strip mining the American public of wealth, sucking it upward and leaving nothing below.

[00:52:03]

The way that they keep that system in place, that they keep us from doing anything about it, is to keep us all hating on each other.

[00:52:12]

One of the things that I admire about you is that you have more children than I do, which is not that easy. You have a lot of children, and you have made your campaign about them, which It used to be a pretty conventional thing. Politicians would run on children, help the children, save the children, the next generation. You're one of the very few people who still talks like that. Explain, if you would, because I think you're sincere when you talk about it, how children, your children, and other people's children, mine, have inspired you to stay in politics when you could have just gone away and gone back to LA?

[00:52:54]

How my kids inspired me? Let me finish the thought. That I think I left incomplete on that last question. I think the anger that we have at each other also turns into violence. When my uncle was running for President, I mean, when my uncle was President in 1963, there was a tremendous anger that was coming out of the civil rights movement and other things that he was doing, shutting down the war against cash on the war against Russia. There was tremendous anger and poison. When he landed in Dallas on November 22nd, there was a full-page ad in the big newspaper in Dallas saying, Wanted Dead or Alive, and with a picture of my uncle on it, and there were posters all over the street that day. My uncle was clearly killed by the CIA, but there were But there was also an anger that had been sown across the American landscapes at that time that I think contributed to this atmosphere of violence that led to his death, Martin Luther King's death, my father's death five years later, and all the other assassinations that we saw during the 1960s. So I just wanted to complete that thought.

[00:54:27]

But that was over 60 years ago, and that institution, those files are still classified as you well know, better than most, and those institutions remain intact. And except for one series of hearings in 1975, there's been no meaningful effort to reform them. And you wonder, at what point do we learn the truth about everything federal agencies have done with our money in our name, and at what point are they reformed?

[00:54:53]

I think it's really... There's an act calle
be released to the American public by
Trump, when he ran the first time in 2
struck me as odd. Then President Bid
recently asked President Trump direc

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him and said. Please do not make me to release these. It is going to be a calamity for our country. President

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Can I ask why would Mike Pompeo Rodeo, who I don't think was even born or had just been born when your uncle was murdered, why would he have an interest in keeping those documents secret?

[00:56:08]

Well, clearly, it's not to protect any individual because virtually all the individuals who were directly involved in my uncle's death, and many are now dead. Many of those have gave deathbed confessions or gave confessions of various kinds before they died. But in I think the only supposition that is rational is that it's about protecting an institution. I think in the last tranche of documents that were released, and the New York Times even reported this, and the Times has been one of the major bulwarks against conspiracy theories that depart from the single shooter, Lee Harvey Oswald killed John Kennedy. They've been the big bulwark against that. So it was extraordinary that they finally reported that Lee Harvey Oswald was a CIA asset and that the CIA went to great lengths to conceal that not only for the Warrant Commission. As most of you probably know, Alan Dulles, who was the head of the CIA, who my uncle fired after the Bay of Pigs, had then come back into public life to get himself appointed to the Warren Commission. He was really the only Commissioner that was there for every meeting. He was the only one that was paying attention.

[00:57:40]

All of the other ones, like Chief Justice Warren was the Chief Justice Supreme Court. He had a full-time job. The other ones were congressmen and senators, other well-known individuals were fully occupied by their work. The only one for whom it was a full-time job was Alan Dulles. His function was to make sure that any questions about the CIA involvement were quashed. He concealed the fact that Lee Harvey Oswald had been recruited into the agency in 1957 and 1958 and sent on a mission to Russia, which was a false defection mission, and then brought back to this country. Many of us who've been studying the assassination knew this, but has never been reported in mainstream press. And after that last tranche of documents was released five years ago, the New York Times finally acknowledged that. And there may be other information related to that that they don't want to release, but I have no idea what it is.

[00:58:47]

So what does it take... I mean, you can't have a democracy in a system where the public has no idea what its government is doing, and that's what we have now. So how do you fix that? What would it take to actually bring transparency to the federal agency?

[00:59:00]

Yeah, I mean, let me answer that in a second. But to follow up on why this is important for democracy, when I was a kid, it was unthinkable that the United States government would lie to the American public. It was just no American would believe that. The first time, and we There'd been this tremendous resistance to starting the CIA in this country. The O
had during World War II. But Congres
do it because they said secret police
Stasi, Sivak in Iran, Pippin in Chile, ar
consistent. They're antithetical to dem
democracy. They'd been very reluctar

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War II. Then Truman became convinced that we had one weapon, really, which was the atomic bomb. He

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They created the CIA to do certain things, to do espionage, which is intelligence gathering in 1948. Dulles had come in very early and changed the function of the agency to be a paramilitary agency to fix elections, assassinate leaders, and do all the dirty tricks. My uncle fired him. But until when I was a kid, it was just incomprehensible that the US government would lie. The first time Americans had inklings that the government would lie, was in May of 1960, while my uncle was running for President and a U-2, a secret CIA plane, a U-2, was not Air Force, it was a CIA, was shot down over Russia. The US government, it was a secret program. Those planes flew so high, and you could not see them with the naked eye. Nobody in the world knew that we had them. They were flying at 60 or 70,000 feet, and we believe they couldn't be shot down. In fact, there was a mole in Langley in the CIA who had given the plans to the U2 to the Russians, and it allowed them to shoot it down. When they shot them down, the Russians accused us of violating their airspace.

[01:02:06]

Alan Dulles told Eisenhower, Just lie about it, because there's no way they have proof, and the pilot has committed suicide, because they gave him a cyanide shot, and they were under orders to kill themselves. Well, Gary Francis Power had chickened out, and he had parachuted to the ground, and they had captured him. And the Russians didn't say at first. They just made the accusation. Eisenhower, at Dulles' advice, went on national TV and told the world, the American public, This is a lie. The Russians are lying. We do not have this program. Then the Russians produced Gary Francis Power's and Americans for the first time said, Oh, my God, our President lied to us. It was shocking. I remember back then. Then when my uncle was killed, the A Warrant Commission report came out, and about half the people in this country just said, That's not true. The government's lying. But they were dismissed as conspiracy theories. Then in 1973, the Pentagon papers were released, and that was 27 volumes of thousands and thousands of systematic lies. Us government officials, including presidents, had been lying to the American people, and that's when everybody just said, Oh, they lie all the time.

[01:03:33]

Then since then, we've now been convinced, I think most of the people in this room believe that any time a government official tells you anything, if his lips are moving, he's lying to you.

[01:03:48]

The most interesting and newsworthy television show of the year is coming here to TCN. We are not bragging. That's actually true.

[01:03:59]

The President's been shot.

[01:04:00]

I repeat, the President's been shot. O
with no publicity at all, with Donald Tr
what is going on on the campaign in r
presidency across the country, and th

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there. If you're a member, you will soon be able to get this docuseries covering the historic campaign. The

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embedded inside the campaign. I can't wait to see it personally. But to get it first, go to tuckercarlson.com, become a member, the greatest television event of the year. We're proud to offer it. So why did so many people fall for the COVID lies?

[01:05:17]

I think that the COVID was... I won't say the whole thing was a PSYOP, but there was a PSYOP accompanying COVID. They were manipulating, they were using these... We were hardwired in our reptilian core of our brain to, when we encountered something fearful, to retreat into authorities, into authorities that are going to protect us. Those buttons were being pushed full-time. We were seeing on the CNN, the Kairons, every 20 minutes, the new death counts from COVID. The announcement on TV. And by the way, television and radio and newspapers were calling all of that time when we made that big departure and the government really started systematically lying to us, which I think began with the War and Commission report. And that's why I think we have to go back and really get the answers on that to ride the ship. During many of those years, the The press was calling government on its lies. But during COVID, they completely stopped, and they were going along with it. If any of us tried to say, Well, wait a minute. In May of 2020, I said, all the government agencies were saying, The vaccines are going to prevent transmissions.

[01:06:55]

I said on my Instagram account, The The monkey studies show that they cannot prevent transmission. I didn't say that because I was guessing it or I was paranoid. I was reading the monkey studies. And the monkey studies, they had given the vaccines to half the monkeys, and they had given a placebo to the other half. They all got COVID, and they all got the same amount of concentrations in their nasal pharynxes. I reported those studies, which were their studies, and I got thrown off of Instagram and called a There's a conspiracy there. You had all the press. And then, as you know, for the next year, they were telling us, You got to get this because it's going to protect grandma. You remember when they were telling us that? And they knew it was a lie. And yet all the press went along with it and everybody else. And I think most Americans were terrified. I'll tell you, you and I have talked in the past about the CIA program called MK Ultra. The CIA, during the 1950s and 1960s, developed all of these programs to do social controls to control individuals and populations. They were trying to develop, for example, a Manchurian candidate, an unwilling assassin, using hypnosis, using psychedelic drugs, using Using torture, using isolation, sensory deprivation, all kinds of methods that they were exploring, not only for manipulating individuals, but manipulating entire populations.

[01:08:41]

How do you get populations to comply? That group of studies was called MK. Mk Naomi, MK Dietrich, MK Ultra. Mk stands for mind control, and that's what they they were looking for, ways to control people's minds and perceptions. One of the studies that they funded was a study called the Milgram Experiment that took place at Yale. It was a young associa
subjects into this experiment. They w
students. They were professors. They
sit the subject at a table, and there wa
hear. They were told that person is tra
twist this tile. The subject would be told to twist the tile. Dr. Milgram was there with a white lab coat and all

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these these kinds of monuments that bespoke his authority and his trustworthiness. He would tell them.

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[01:10:15]

A lot of the subjects would say to Dr. Milgram, I don't want to do it again. He would tell them, Do it anyway. Some of them began crying because they did not want to twist it up. But 67% of them turned it up to 250 volts where it was marked potentially lethal. What Dr. Milgram says, and you can look this up, Milgram experiment on Wikipedia. I wouldn't believe Wikipedia, anything you read in Wikipedia, but this thing is actually true. 67% turned it up to potentially fatal. What The program concluded was that a figure of authority can persuade people, the average person, 67% of people, to override their most closely and fundamentally held values and do things that they know are totally wrong if they're told to do that by authority. During the COVID, I felt like we were all involved in a giant Milgram experiment where we had a medical doctor.

[01:11:38]

Which doctor, to be more specific?

[01:11:42]

Well, we had Dr. Fauci. We Who is telling us to do things that we knew were wrong? And he knew they were wrong. He would say, One week, masks don't work, privately and publicly. Publicly, and two weeks later, everybody put them on. Everybody put two of them on. And he would say, he said very publicly that if you get an infectious respiratory illness, you do not need a vaccination. And yet he changed his mind and he said, The best vaccine you can have is to have to have the disease. There's nothing better. You'll never beat it. Then he said, Even if you've had it, you to get the shot. So they were telling us things that they knew were wrong, but we were doing it because it was an authority telling us. And then also there's another phenomenon that anybody who disagrees with that authority becomes the enemy. They become dangerous. They have to be silenced. Now, the good news is that 33% of the people in the Milgram experiment got up and walked out.

[01:13:03]

That's the people in this room right now.

[01:13:06]

That's the people here right now.

[01:13:17]

How do you break this spell? I just think it's the most interesting thing about you, if I can say as an outsider, watching carefully, is you don't need to do any of this. You've suffered great personal cost, I would say, certainly in prestige in the world that you've grown up in and banned from the New York Times. People call you crazy, but you do it anyway.

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[01:13:40]

I'm not that crazy.

[01:13:42]

No, but it's true. You've taken a lot of heat from people who are close to you, but you do it anyway. Do you

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I think that's how we break it. Enough people have to say, We're not going to do that. When you do it... There's a couple of rules about totalitarian systems. One is, Any power that the government takes away from us, it will never relinquish voluntarily. Rule number two, any power that the government takes from us, it will ultimately abuse to the greatest extent possible. Number three, nobody ever complied their way out of totalitarianism. You have to resist.

[01:14:48]

What powers does the government now have that it didn't have 10 years ago?

[01:14:54]

Well, they have the power now to revoke all of our constitutional rights. So That sounds like hyperbole, but think about it. They figured out the most important right is freedom of speech. Hamilton, Madison, and Adam said, We put that in the First Amendment, freedom of expression, because all the other rights are dependent on it. I've said this to you before, Tucker than any government that has the power to silence its critics has license for any atrocity. They knew that. They put it first. We saw this dynamic during COVID, as soon as they realized that they could silence us, they could censor doctors, they could censor scientists, they could censor individuals who were injured. They could stop them from talking about their injuries. They could stop parents from talking about their children's injuries. They did all these things to us, and we put up with it, and the press went along with it. Very shamefully, they became vehicles stenographers for government propaganda. We all went along with it. Then what did they do? They immediately went after the other leg of the First Amendment, was freedom of Religion. They closed every church in this country for a year.

[01:16:16]

Can you imagine if somebody told you five years ago, the government's going to close every church in this country, you would say, there's no way that that's going to happen. And yet it happened. They went after the third leg of the First Amendment, which is freedom of assembly, with these social distancing mandates that had no scientific basis. They went after the Fifth Amendment, which is property rights. They shut down 3.3 million businesses with no due process, no just compensation, no public hearing, no environmental impact statement, no notice and comment rulemaking. All of the procedures that guaranteed democracy in the regulatory process were abandoned. You just had one guy, a 50-year bureaucrat who's never been elected to anything, who says, Shut down all your businesses. Shut down the small businesses, but keep Target and Walmart open. Shut down the churches, but keep the liquor stores open, and keep Facebook, and all the people who are cooperating with the government, Facebook, Instagram, Google, and are censoring speech for us, keep all them open, and shut down all the little guys, and destroy our communities. We put up with it. Then they got rid of jury trials. The Seventh Amendment says, No American shall be denied the right of a trial before a jury of his peer

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[01:17:58]

Well, there's There's no pandemic ex
Shut down. Any corporation, any hosp
involved in applying a countermeasur

how egregious your injury. For the first time, so these are all... And then the Fourth Amendment guarantees

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home. So virtually all of that rights in the Constitution except the Second Amendment, and probably because there is a Second Amendment. That was the only one they didn't mess with. But all the other ones, they got rid of. So if you're asking what's changed? That's what's changed now. They said to us, Oh, we're going to give all those back to you. And they did. So today we have those back. But they've established this very, very dangerous precedent where if there's another emergency, and they can cook up a pandemic anytime they want, as would gain of function is all about.

[01:19:32]

And anytime if there's the next, the monkeypox pandemic or the Dengue pandemic or the Ebola pandemic that are all in the pipeline, When those happen, we again are going to be asked to abandon all of our rights, and most people are going to put up with it. Yeah. Not all people.

[01:19:57]

So what happens when there is a the next emergency? Maybe it's a war.

[01:20:03]

Maybe it's a war. Maybe it's an economic collapse.

[01:20:07]

Well, that's right. How do we respond when we're told to abandon the Bill of Rights, our birthright? How do we respond?

[01:20:15]

As I said, we resist, resist, resist. The Constitution The Constitution was written for hard times. It wasn't written for easy times. It was written for hard times. I've said this to you before, Tucker, that during the American Revolution, there were two large epidemics, one of them a malaria epidemic that decimated the armies of Virginia. Then there was a smallpox epidemic that decimated the army of New England. At the very time, that Benedict Arnold, who was our greatest general, our greatest military strategist during the war, had captured the city of Montreal and captured Canada. Because of the smallpox epidemic in the American troops. He didn't have the manpower to hold the city and had to withdraw. Otherwise, Canada today would be part of the United States. The framers of the Constitution knew that, and Between the end of the Revolution and 1792, when we ratified the Bill of Rights through that 10-year period, there were epidemics in every city in our country, malaria epidemic, smallpox, yellow fever, cholera, typhus, typhoid that killed tens of thousands of people, decimated population. All the framers knew about that, but they did not put an epidemic, exception in the United States Constitution.

[01:21:57]

During the Civil War, the Confederate
up draft riots, and those draft riots we
efforts. And Abraham Lincoln, in an ef
agent provocateurs when they came
violation of habeas corpus. But he sa
time, over 600,000 Americans had die

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today. Our country was being torn apart, and we didn't know if it was going to survive. So the life of the

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nation is at stake. Even if tens of thousands of lives are at stake, you can't do it. It's the Constitution. It was written for hard times. There is no circumstance in which it can be waived.

[01:23:28]

I think that we all have to I remember that.

[01:23:32]

Do you foresee... You said resist, resist, resist. I remember growing up, nonviolent resistance in the name of Civil Liberties was considered a great virtue, the most American of all virtues. I don't hear that anymore. But is that what you foresee?

[01:23:53]

I would say we all have a duty to do that. We all have a duty to resist in whatever way is going to be most effective in resisting the tyranny. Right now, Tucker, it's really more important than ever, and it's going to take more courage than ever. It'll probably take whatever it's going to take. It's going to take more than we've ever given. The reason for that is because of the emergence of all of these new technologies for surveillance and control. We all know about them. I mean, the emergence of AI is going to allow the intelligence agencies, powerful entities, not only to control us, but to warp our vision, our understanding of reality. We already have all of the... It's been the ambition of every totalitarian system in the history of mankind to control every aspect of human behavior, our interactions with each other, our relationships, our communications, our transactions, our movements, the books we read, our letters to each other, communications with each other. Of course, they've never been able to do that, but now they can. They can look at everything. You all have had this experience. Two years ago, my wife and I, in the privacy of our bedroom, were talking about the fact that our mattress was was becoming saggy.

[01:25:33]

The next morning, both of us got three mattress ads on our cell phones, and that's when it brought it home to me that they're listening to everything we say all the time.

[01:25:44]

Did you replace the mattress?

[01:25:46]

I replaced my cell phone. We have all these devices. You have GPS. A lot of you are We have GPS watches. We have GPS on our cell phone that is tracking us all the time. We have GPS in our car. There's facial recognition systems with... There are now permits issued for 415,000 low altitude satellites that are going to circle the globe or that are stationary across the globe all the time. Bill Gates, his company, has 65,000 permits for satellites. He says
every square inch of the Earth 24 hou
but Siri is not working for you. Siri is w
data. Every time you cough, every tim
being logged somewhere. All these co
This isn't paranoid. Corporations are

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the same companies that are mining our data are also sharing that data with the NSA. and all of it is stored

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For all the reasons that we've always... Human beings in democracies, have been paranoid about government, keeping track of their private conversations, of their personal interactions. We need to be worried about that today. All of these technologies mean that it's going to be very, very difficult for us to hold on to our constitutional rights in the coming decades. Particularly, I think, if President Trump lose this election and Kamala Harris wins, I think I don't think there's any consciousness in the Democratic Party that this is a bad thing. I think the Democratic Party now believes they no longer trust the public. They don't trust the demos. They believe that the public needs to be controlled, that the information we get needs to be controlled. It has to be censored, that the big threat to us is disinformation and misinformation, which is anybody who tells you that is lying to Anybody who tells you that is trying to manipulate you. You're a big person. You can make up your own mind about what is true and not true. My kids do it. I say to my kids, Look at this posting on Instagram where the dog is eating the alligator, and they're like, You need to fact-check that.

[01:28:57]

Everybody knows that You got to do research, right? And that you don't believe everything you read on the internet. Louis Brandeis, our Supreme Court Justice, the remedy for bad information is more information. It's never censorship. Censorship is a way to control.

[01:29:19]

Bobby, speaking of President Trump, you've endorsed him for a number of reasons, but he did give us Operation Warp Speed. To what degree do you hold him culpable for succumbing to the fear you've talked about?

[01:29:36]

I absolutely hold him culpable. But here's what, and for a lot of other things that I disagreed with in the first Trump administration, I didn't like seeing Scott Gottlie cash in at FDA and Alex Azar running HHS. Oil lobbyists running the Interior Department, coal lobbyists running EPA, telecommunication lobbyists running the FCC, etc. I talked to President Trump at length about this, and he said, Look, when I get elected in 2016, I didn't know how to govern. To tell you the truth, it was surprising that we got to win the election. He said, I was immediately inundated by lobbyists and business people, and they were all saying, Appoint this guy, appoint that guy, appoint that guy. He said, I did it, and I wish I had. He understands that Scott Gottlieb was cashing in, and he did a $100 billion favorite for Pfizer, and then went back to work for Pfizer on his board of directors. I think that President Trump has said to me that we're going to do something different this That's why he launched the transition team Five months before he takes power. The last time he did his transition team, he started in January.

[01:31:21]

He's now launched, and I'm on it. Tuls
lightweight, but I've gotten to know hir
really well-informed, and he understa
like the constant wars. He does He w

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rivers and the streams and the waterways, and he wants to protect those things. I have nothing but respect

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That leads to my... I agree with your assessment of John Jr. Completely. As you know, having lived around famous people your whole life, the perceptions of people are sometimes accurate, sometimes are the opposite of what you're told, and he's definitely in that category. How do you envision your role in a Trump administration?

[01:32:44]

President Trump has asked me specifically to do two things. One, to help unravel the capture of the agencies by corrupt influence. In other words, to drain the swamp. I got to say something about President Trump. President Trump has to make extraordinary gifts, and one of them is that he has very, very good instincts. When he came out the first time, you remember, he was very against the lockdowns publicly. He was for hydroxychloroquine. He was for alternative medicines. He was against the mass. But he was surrounded by bureaucrats and knowledgeable experts who ultimately pushed back on those assumptions and got us into some policies that I think were really bad for our country. He He's not going to do that again. And he wanted to **end the** wars. He said back then, We don't want to go into Ukraine war. I'd rather make a deal than have a war. So I think that And he's asked me to do that, and he's asked me to help him **end the** childhood disease, chronic disease, epidemic, and make Americans healthy again.

[01:34:26]

And if given the power to do that, what will you do?

[01:34:32]

That's unclear because there's no... At this point... Thank you. Like I said, I'm on the transition committee, and there's no We don't have... I don't have a post for myself that's picked out. I know that I'm going to be deeply involved in helping to choose the people who can run FDA and NIH and CDC in a way that restores public health rather than... Rather than...

[01:35:12]

Can you imagine if you're at FDA or NIH and Bobby Kennedy all of a sudden? I mean, they must be dying. They must be dying.

[01:35:26]

But I'll bring in people run those agencies like Calleigh means, like Casey means.

[01:35:38]

You think they're going to mean? They have nightmares about that.

[01:35:45]

Yeah, they should.

[01:35:47]

And they should. Bobby Kennedy, tha
much. The big tech companies censo
know what they can't censor? Live ev

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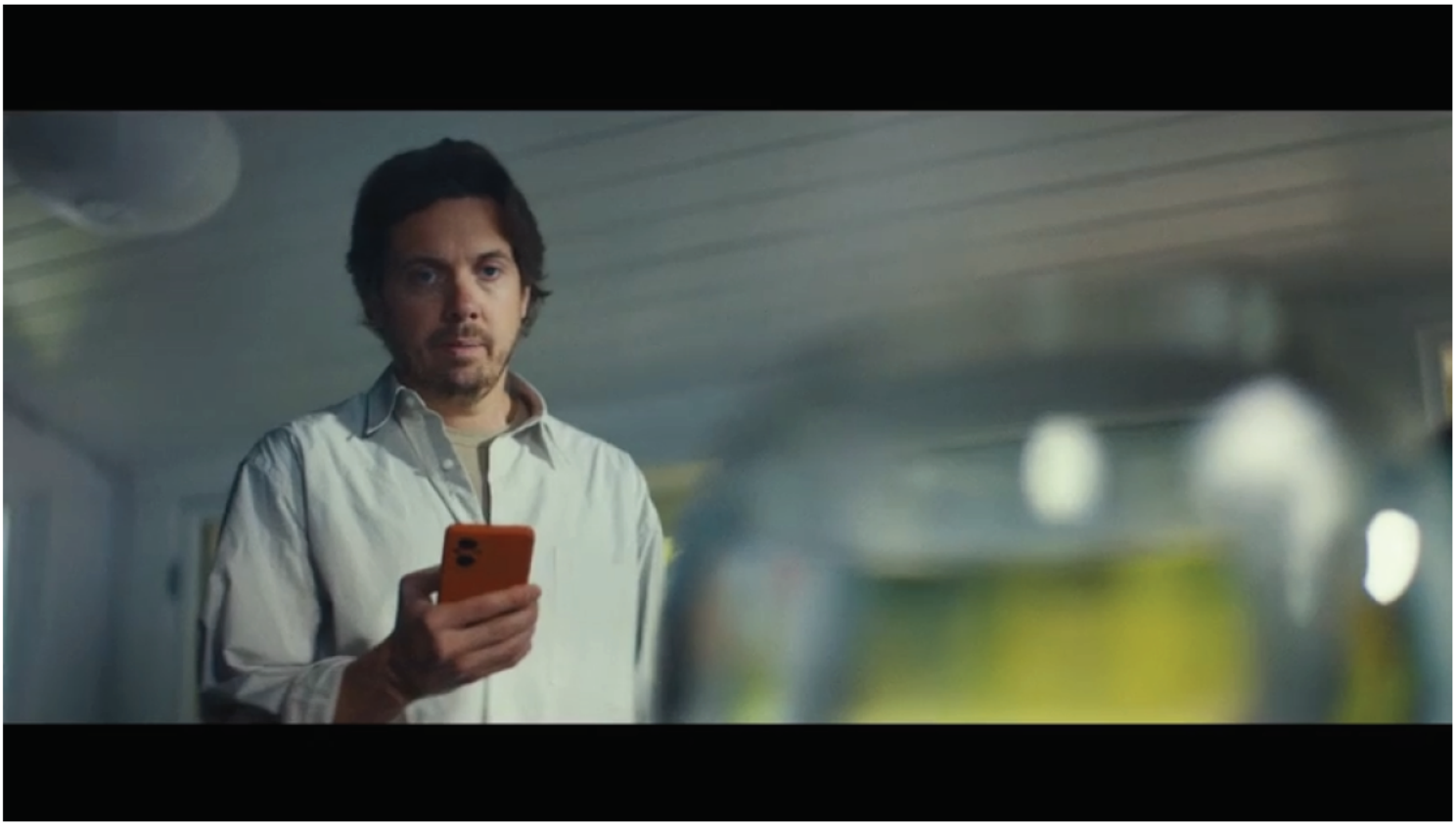
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HEALTHWATCH

Trump administration ending multiple HIV vaccine studies, scientists and officials say

By **Dr. Céline Gounder**, **Alexander Tin**
Edited By Melissa Gaffney
May 30, 2025 / 7:37 PM EDT / CBS News



The Trump administration has moved to end funding for a broad swath of HIV vaccine research, saying current approaches are enough to counter the virus, multiple scientists and federal health officials say.

Notifications that the funding would not be extended were relayed Friday to researchers, who were told by rtment of Health and Human Services had elected "to go IV" instead.

rch efforts that were first funded by the NIH in 2012 at the search Institute, multiple scientists said. A spokesperson al trials through the NIH's HIV Vaccine Trials Network

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One senior NIH official said the HHS had also instructed the agency not to issue any more funding in the next fiscal year for HIV vaccine research, with only a small handful of exceptions.

A budgetary rule change specifically targeted at HIV vaccine research is also expected to lead to another cut to the NIH's awards for studies initiated by scientists, an official said.

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The change, to be finalized shortly, inflates the accounting for the upfront cost of studies into HIV vaccines funded by the agency. Instead of the cost of a five-year grant being spread out over five years, the NIH plans to make HIV vaccine dollars from multi-year grants all count toward a single year, the official said, making it harder for them to get funded.

A spokesperson for HHS told CBS News that "complex and duplicative health programs have resulted in serious duplication of efforts," saying that "27 separate programs that address HIV/AIDS" had spent $7.5 billion.

"The Administration believes the United States should have the best medical research in the world. To that end, we are advancing policies to maximize the impact of every federal taxpayer dollar and ensure proper oversight of this funding," HHS spokesperson Emily Hilliard said.

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ontinue" under the new agency that Health and Human
sed creating, dubbed the Administration for a Healthy

"For HIV vaccine design and development, we've begun to see light at the end of the tunnel after many years of research. This is a terrible time to cut it off. We're beginning to get close. We're getting good results out of clinical trials," said Dennis Burton, an immunology professor at Scripps Research.

Burton warned that their HIV vaccine research could not simply be turned back on, even if a future administration decided to change course on HIV funding. He said ongoing experiments would be shuttered, and researchers assembled to study the issue would be forced to refocus their careers on other topics.

"This is a decision with consequences that will linger. This is a setback of probably a decade for HIV vaccine research," Burton said.

The cancellation of the funds comes weeks ahead of the Food and Drug Administration's June 19 deadline for deciding on approval of lenacapavir, a twice-yearly injectable drug to prevent HIV.

The drug, which is being brought to the commercial market by drugmaker Gilead Sciences, builds on NIH-backed research into earlier HIV medications. The drug's availability could lead to a significant drop in HIV cases worldwide, since a study found it was 100% effective in preventing transmission.

An NIH official, who was not authorized to speak publicly, rebuked the claim that the effectiveness of current HIV prevention strategies meant a vaccine was no longer needed. "The only way of ending the HIV epidemic in the U.S. and AIDS pandemic worldwide" is with a vaccine, they said.

Developing an effective HIV vaccine has been an elusive target for researchers, though scientists have hailed recent breakthroughs in the field.

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f, which are unparalleled in vaccinology. We've had to
e ways to overcome it. This virus mutates so quickly," said
es, who is part of the Duke Human Vaccine Institute.

Haynes said their work was essentially combining multiple different vaccines as part of their approach to designing an effective HIV vaccine.

He praised lenacapavir as a "wonderful development for the field," but said there was still a need for a vaccine. Lenacapavir requires injections every six months to remain effective, a challenging proposition even before steep cuts to the Centers for Disease Control and Prevention's domestic HIV programs and U.S.-backed HIV/AIDS foreign aid programs.

"The hope was that adding an HIV vaccine to all the preventive measures that we have would finally allow us to end the pandemic," Haynes said.

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Dr. Céline Gounder

Dr. Céline Gounder, an internist, epidemiologist and infectious disease specialist, is a CBS News medical contributor as well as senior fellow and editor-at-large for public health at KFF Health News.

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Trump Administration Ends Program Critical to Search for an H.I.V. Vaccine

The termination is the latest in a series of cuts to H.I.V. research and programs to prevent the disease.

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By Apoorva Mandavilli

Published May 30, 2025 Updated June 23, 2025, 12:10 p.m. ET

The Trump administration has dealt a sharp blow to work on H.I.V. vaccines, terminating a $258 million program whose work was instrumental to the search for a vaccine.

Officials from the H.I.V. division of the National Institutes of Health delivered the news on Friday to the program's two leaders, at Duke University and the Scripps Research Institute.

Both teams were collaborating with numerous other research partners. The work was broadly applicable to a wide range of treatments for other illnesses, from Covid drugs to snake antivenom and therapies for autoimmune diseases.

"The consortia for H.I.V./AIDS vaccine development and immunology was reviewed by N.I.H. leadership, which does not support it moving forward," said a senior official at the agency who was not authorized to speak on the matter and asked not to be identified.

"N.I.H. expects to be shifting its focus toward using currently available approaches to eliminate H.I.V./AIDS," the official said.

The program's elimination is the latest in a series of cuts to H.I.V.-related initiatives, and to prevention of the disease in particular. Separately, the N.I.H. also paused funding for a clinical trial of an H.I.V. vaccine made by Moderna.

"I find it very disappointing that, at this critical juncture, the funding for highly successful H.I.V. vaccine research programs should be pulled," said Dennis Burton, an immunologist who led the program at Scripps.

The cuts will derail hard-won progress against H.I.V. over the past few decades, public health experts said. This week, the administration also withheld funds that were due to states and territories for H.I.V. prevention work. In Texas, the State Department of Health Services asked grantees to pause all activities "until further notice." In Mecklenburg County in North Carolina, the health department has already had to lay off 10 staffers. Already, many African countries have reported serious disruptions in their efforts to curb the epidemic.

"It's just inconceivable how shortsighted this is," said Mitchell Warren, executive director of the H.I.V. prevention organization AVAC.

The number of new H.I.V. infections had been declining steadily since 2010. Still, in 2023, the World Health Organization reported 1.3 million new cases, including about 120,000 children.

"The H.I.V. pandemic will never be ended without a vaccine, so killing research on one will end up killing people," said John Moore, an H.I.V. researcher at Weill Cornell Medical in New York.

"The N.I.H.'s multiyear investment in advanced vaccine technologies shouldn't be abandoned on a whim like this," he said.

In his first term, President Trump embraced initiatives to end the H.I.V. epidemic in the United States. But his second administration has slashed federal support of such efforts. The N.I.H. terminated several grants related to PrEP, the regimen of preventive drugs that are highly effective in thwarting H.I.V. infection.

The Trump administration also shut down the H.I.V. prevention division of the Centers for Disease Control and Prevention, which provided funds to states and territories for H.I.V. prevention and for detecting and responding to H.I.V. outbreaks. Officials at the health department have said some of the work will be shifted to the yet to be formed federal Administration for a Healthy America, but no details have been provided.

The Department of Health and Human Services, which oversees the C.D.C., N.I.H. and other federal health agencies, did not immediately respond to a request for comment.

In January, the Trump administration halted disbursement of funds from the President's Emergency Plan for AIDS Relief, known as Pepfar, a $7.5 billion program that supplied most of the treatment for H.I.V. in Africa and developing countries worldwide.

The State Department later issued waivers to allow treatments to resume but did not restore funding for H.I.V. prevention.

Trial after trial has failed to produce an H.I.V. vaccine, leading some experts to question whether it is possible to design a traditional vaccine at all against the wily virus. The Scripps and Duke teams had taken a different tack, studying the body's immune response to the virus.

With funding from seven-year awards made in 2019, they focused on so-called broadly neutralizing antibodies, which have been shown in animal studies to provide long-lasting protection against exposure to multiple H.I.V. strains.

The clinical trials based on their work may continue, as long as N.I.H. funding for the H.I.V. Vaccine Trial Network is maintained.

But ending the research programs now means that in a few years, there will be no new candidates in trials, Mr. Warren said.

"Almost everything in the field is hinged on work that those two programs are doing," he said. "The pipeline just got clogged."

***A correction was made on June 23, 2025**: An earlier version of this article misspelled the name of a county in North Carolina. It is Mecklenburg, not Mecklenberg.*

When we learn of a mistake, we acknowledge it with a correction. If you spot an error, please let us know at nytnews@nytimes.com. Learn more

Apoorva Mandavilli reports on science and global health for The Times, with a focus on infectious diseases and pandemics and the public health agencies that try to manage them.

A version of this article appears in print on , Section A, Page 22 of the New York edition with the headline: Trump Administration Ends Program Critical to Search for an H.I.V. Vaccine



Photo illustration by Andrea Wise/ProPublica. Source photos: Bill Clark/CQ-Roll Call/Getty Images, Mark Peterson/Pool/Getty Images, Kayla Bartkowski/Getty Images, Joel Eichler/Getty Images.

Trump Administration

Federal Judge Deems Trump Administration's Termination of NIH Grants Illegal

by Annie Waldman

June 17, 2025, 11:15 a.m. EDT

In a ruling issued Monday, the judge called the government's directives "arbitrary and capricious" and ordered funding for some of the NIH grants, including many profiled by ProPublica in recent months, to be restored.

ProPublica is a nonprofit newsroom that investigates abuses of power. Sign up to receive our biggest stories as soon as they're published.

What Happened: A federal judge ruled on Monday that the Trump administration's termination of hundreds of grants by the National Institutes of Health was "void and illegal," ordering some of them to be reinstated, including many profiled by ProPublica in recent months.

District Judge William G. Young made the ruling in two lawsuits challenging the Trump administration's directives and cancellations: One case was brought by more than a dozen states' attorneys general, and the other was led by the American Public Health Association alongside several other organizations and researchers.

In Monday's ruling, the judge determined that the directives that led to the grant terminations were "arbitrary and capricious" and said they had "no force and effect." The judge's ruling ordered the funding of the grants to be restored. It only covers grants that have been identified by the plaintiffs in the cases.

What the Judge Said: After Young ruled that the agency directives and terminations were illegal, he noted that the government's practices were discriminatory.

"This represents racial discrimination, and discrimination against America's LGBTQ community," he said. "That's what this is. I would be blind not to call it out. My duty is to call it out, and I do so."

This year, the Trump administration banned the NIH from funding grants that had a connection to "diversity, equity and inclusion," alleging that such research may be discriminatory. ProPublica previously found that caught up in mass terminations was research focused on why some populations — including women and sexual, racial or ethnic minorities — may be more at risk of certain disorders or diseases.

"I have never seen a record where racial discrimination was so palpable," Young said during Monday's hearing. "I've sat on this bench now for 40 years, and I've never seen government racial discrimination like this, and I confine my remarks to this record, to health care."

He also noted the administration's targeting of LGBTQ+ research. "It is palpably clear these directives and the set of terminated grants here also are designed to frustrate, to stop research that may bear on the health — we are talking about health here — the health of Americans, of our LGBTQ community," he said. "That's appalling."

Background: In recent months, ProPublica has been covering the toll of the grant cancellations by the NIH. More than 150 researchers, scientists and investigators have reached out to ProPublica and shared their experiences, revealing how the terminations are dramatically reshaping the biomedical and scientific enterprise of the nation at large.

They described how years of federally funded research may never be published, how critical treatments may never be developed and how millions of patients could be harmed.

"Two and a half years into a three-year grant, and to all of a sudden stop and not fully be able to answer the original questions, it's just a waste," said Brown University associate professor Ethan Moitra, whose grant studying mental health treatment for LGBTQ+ people was terminated.

Response: White House spokesperson Kush Desai said it was "appalling that a federal judge would use court proceedings to express his political views and preferences," adding that "justice ceases to be administered when a judge clearly rules on the basis of his political ideologies."

Desai also defended the administration's policies targeting "diversity, equity and inclusion," calling it a "flawed and racist logic." He also said that the administration was committed to "restoring the Gold Standard of Science," which he claimed involves a recognition of the "biological reality of the male and female sexes." The NIH, he said, is shifting "research spending to address our chronic disease crisis instead, not to validate ideological activism."

Andrew G. Nixon, the director of communications for the Department of Health and Human Services, told ProPublica that the agency "stands by its decision to end funding for research that prioritized ideological agendas over scientific rigor and meaningful outcomes for the American people," and that it was "exploring all legal options, including filing an appeal and moving to stay the order."

Why It Matters: The mass cancellation of grants in response to political policy shifts has no historical precedent, experts told ProPublica, and marks an extraordinary departure from the agency's established practices. ProPublica previously revealed that the Department of Government Efficiency — the administration's cost-cutting initiative —— gave the agency direction on what to cut and why, raising questions about the provenance of the terminations.

The judge's ruling adds to a growing number of legal decisions halting or scaling back the administration's actions. As of Monday, according to The New York Times, there have been more than 180 rulings that have "at least temporarily paused" the administration's practices.

Whether the administration follows Monday's ruling, however, remains an open question. As ProPublica reported, the NIH has previously terminated research grants even after a federal judge blocked such cuts, and the administration has disregarded several other rulings.

"If the vacation of these particular grant terminations, the vacation of these directives, taken as a whole, does not result in forthwith disbursement of funds," Young said in Monday's hearing, "the court has ample jurisdiction."

Were you involved in a clinical trial, participating in research or receiving services that have ended, been paused or been delayed because of canceled federal funding? Our reporters want to hear from you. To share your experience, contact our reporting team at healthfunding@propublica.org.

Asia Fields contributed reporting.

Annie Waldman 𝕏
Annie Waldman is a reporter at ProPublica covering health care.



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What We're Watching

During Donald Trump's second presidency, ProPublica will focus on the areas most in need of scrutiny. Here are some of the issues our reporters will be watching — and how to get in touch with them securely.



Learn more about our reporting team. We will continue to share our areas of interest as the news develops.

Sharon Lerner

I cover health and the environment and the agencies that govern them, including the Environmental Protection Agency.



Contact Me

Andy Kroll

I cover justice and the rule of law, including the Justice Department, U.S. attorneys and the courts.



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Melissa Sanchez



I report on immigration and labor, and I am based in Chicago.

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Jesse Coburn



I cover housing and transportation, including the companies working in those fields and the regulators overseeing them.

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If you don't have a specific tip or story in mind, we could still use your help. Sign up to be a member of our **federal worker source network** to stay in touch.

Update on Proposed Cuts to Medicaid Funding

June 6, 2025

Background

Medicaid is a key component of the U.S. healthcare system, providing health insurance coverage for approximately one in five Americans, including low-income children, adults, and people with disabilities. Medicaid plays a significant role in the behavioral health system, accounting for a quarter of all spending for both mental health and substance use treatment, making it the largest single payer of behavioral health services in the United States. Nearly 40% of adults under the age of 65 enrolled in Medicaid have a mental health or substance use disorder – a higher prevalence rate among those with private health insurance, Medicare, or without insurance.

Medicaid also covers the costs of prenatal care, labor and delivery, and other maternity-related services for an estimated 41% of births in the U.S. It also supports health care for almost half of all children in the country and covers more than 60% of services for nursing home residents. In addition, it provides long-term services and supports, as well as cost-sharing assistance, for millions of Medicare beneficiaries, including 1 in 10 veterans.

With the enactment of the Affordable Care Act in 2010, states were allowed to expand Medicaid coverage to include adults without children with income up to 138% of the federal poverty level ($21,597 in annual income for 2025). All but ten states have implemented “Medicaid expansion” coverage, extending health insurance coverage to more than 20 million people.

On May 22, 2025, the House of Representatives passed H.R. 1, the “One Big Beautiful Bill Act”. The bill includes $4 trillion in proposed tax cuts. These cuts are partially offset by proposed reductions of more than $800 billion in federal Medicaid funding. The legislation is now being considered by the Senate.

The House passed the legislation before the Congressional Budget Office (CBO) was able to complete a full analysis of the combined effects of the provisions developed by various House committees. However, CBO’s initial estimates indicate that the legislation would result in almost 8 million individuals losing their health insurance coverage under Medicaid, and roughly 3 million people losing coverage under marketplace plans. CBO projects that another 5 million people covered under

marketplace plans would become uninsured with the expiration later this year of the expanded premium tax credits for purchasing marketplace plans.

The largest share of Medicaid spending reductions is tied to a new requirement that, beginning in 2026, states implement verification systems to ensure enrollees have completed at least 80 hours of community engagement activities in the month prior to enrolling. Although referred to as new "work requirements," more than 90% of Medicaid enrollees are either already employed, in school, serving as caregivers, or are unable to work due to a disability or health condition.

The process of documenting community engagement activities, as well as exemptions, adds administrative complexity for both enrollees and administrative staff. For example, a previous effort to implement work requirements in Arkansas led to 18,000 people losing coverage before the initiative was stopped by a court order. In Georgia, only a small fraction of the potential enrollee population was able to meet the paperwork and reporting requirements, and the state reportedly spent nearly five times more on implementation costs than on health care services.

In the name of reducing fraud, the legislation would also eliminate recently adopted rules that simplified eligibility and enrollment processes for both Medicaid coverage, as well as financial assistance for low-income Medicare beneficiaries to help pay premiums and cover cost-sharing requirements.

APA/APASI Assessment

APA is deeply concerned about the potential impacts of H.R. 1 on access to health insurance coverage and services under Medicaid. These proposed cuts are expected to impact state budgets, healthcare access, and public health with particular implications for individuals in need of behavioral health services.

Key concerns include:

- Behavioral health access: Reductions in federal Medicaid funding may lead states to limit eligibility, reduce covered benefits, or lower provider reimbursement rates. Behavioral health services, which are classified as optional under Medicaid, are frequently among the first to be reduced when states face budget constraints. This could result in significantly reduced access to mental health and substance use disorder treatment for those who need it.
- Impact on health care providers, facilities, and clinics: Medicaid typically reimburses providers at lower rates than Medicare and private insurance. However, many community-based healthcare providers, especially those in underserved or rural areas, rely heavily on Medicaid reimbursement to remain operational. A significant decrease in federal funding may challenge the financial viability of many providers, and potentially further reduce access to care. It could also have a

negative impact on psychology training sites that rely on Medicaid, reducing future training options.

- Protection of vulnerable populations: Medicaid serves vulnerable and underserved populations across the country, including children (who make up over one-third of enrollees), people with disabilities, individuals living with mental health conditions, and low-income adults. Non-elderly adults and children in small towns and rural areas are more likely to rely on Medicaid than those living in metro areas. Proposed funding reductions would likely have a disproportionate impact on these populations.
- Reduced access to reproductive and gender-related health care: H.R. 1 would eliminate Medicaid funding for any health care services provided by affiliates of Planned Parenthood. It would also prohibit coverage or reimbursement for gender-affirming care under Medicaid, CHIP, and marketplace plans.

APA's Position

Consistent with our mission to advance the application of psychological science to benefit society and improve lives, APA and APA Services support efforts to protect and expand, not restrict, access to affordable, comprehensive mental and behavioral health services, including through Medicaid.

Medicaid plays a key role in facilitating access to behavioral health care, advancing health equity among underserved populations, and supporting health throughout the lifespan. APA advocates for preserving Medicaid's ability to adjust to meet population needs and provide access to essential behavioral health services for all, including vulnerable populations.

What Psychologists Can Do

As this situation develops, psychologists are encouraged to:

- Talk to your Medicaid patients: Help your patients understand the potential impact to their benefits. If there are options for your patients to continue obtaining care without Medicaid benefits, discuss them.
- Engage in informed advocacy on behalf of your patients and their families: Connect and collaborate with APA/APASI, your state, provincial, or territorial psychological association, and other

relevant professional and community organizations. Participate in advocacy efforts aimed at protecting Medicaid.

APA Services Action Alert: Ask your Senators to vote against budget legislation that will remove health insurance coverage from millions of Americans.

What the Science Says

Psychological research provides critical insights into the role of Medicaid in supporting mental and behavioral health. Several studies have shown that individuals from low-income backgrounds tend to experience higher rates of mental illness and encounter greater barriers to accessing treatment, making Medicaid's coverage of behavioral health services essential for addressing these disparities (Lund et al., 2010; Santiago et al., 2013; Reiss, 2013; Hodgkinson et al., 2017). More recently, Zhang et al. (2024) found that Medicaid beneficiaries in socioeconomically deprived areas had higher incidences of co-occurring mental and physical health conditions but limited access to mental health facilities. Similarly, Smith and Doe (2023) highlighted significant disparities in mental health service access among children from low-income families, with the caregivers of children who sometimes or never had health insurance coverage for mental or behavioral health reporting more difficulties in obtaining care than the caregivers of children who usually had medical coverage. These findings underscore the critical role of Medicaid in providing essential mental health services to underserved populations.

Resources on Medicaid

There are many resources available to learn more about Medicaid and the impact of the changes being considered:

The Kaiser Family Foundation has extensive resources on Medicaid, marketplace plans, Medicare, and the health provisions in the reconciliation bill.

The Modern Medicaid Alliance created a dashboard with state and congressional district data on covered populations, including estimated Medicaid enrollees with behavioral health conditions.

The Georgetown University Center for Children and Families has in-depth analysis and research on child and maternal health, Medicaid, and related federal health care policies.

Moving Forward

APA Services will continue working closely with coalitions of other health care provider and consumer organizations to advocate against significant Medicaid funding reductions, reductions in health insurance coverage under marketplace plans, and other provisions in H.R. 1 that would end health insurance coverage and access to care for millions of Americans. As part of this work, we encourage psychologists to contact their Senators to ask them to vote against significant Medicaid cuts.

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APA and APA Services, Inc., are actively monitoring and responding to policy changes as they unfold. Due to the rapid nature of evolving policies, information provided here or in other communications may change quickly.

THE MAHA UNIVERSE

The Dizzying Rise of MAHA Warrior Calley Means, RFK Jr.'s Right-Hand Man

One of the primary architects of the Make America Healthy Again takeover of the federal health apparatus, Means has risen to power in part on the strength of his personal narrative: he was a Big Food and Big Pharma lobbyist who saw the light. Yet, a six-month Vanity Fair investigation raises questions about whether Means has embellished his personal story. "Calley Means is not a whistleblower. He is an opportunist, peddling junk science to make millions," says his former boss and mentor Steve Schmidt.



BY KATHERINE EBAN

MAY 30, 2025



ILLUSTRATION BY CELINA PEREIRA.

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"It Sounds Very Woo Woo"

ast March, Robert F. Kennedy Jr. crowded into a sweat lodge near Austin, Texas, with about 40 other people including a regenerative farming advocate and a nutritional

supplement entrepreneur.

"We were front to back, side to side, you couldn't move," Chase Iron Eyes, a Lakota legal activist, later recalled on a podcast. "I was like, man, I want to get out. I got to take a break. And then I was thinking, I'm the only Lakota in here…. My whole nation's riding on me over here." He stayed in.

The sweat lodge was the closing event of the American Wellness Summit, a one-day fundraiser for Kennedy's presidential campaign. Those in attendance had come in search of spiritual healing and cleansing renewal, yes, but also access to worldly power.

And indeed, one of the people perspiring inside that jam-packed lodge was struck by a vision that would prove to have seismic repercussions for the health of every American. "It sounds very woo woo," Calley Means, 39, told Joe Rogan six months later. "I just had this strong vision of [Kennedy] standing with Trump."

A former wedding-dress entrepreneur, Means had become a vocal proponent of ending chronic disease in America. Inspired by his epiphany inside the lodge, and convinced that it represented the best path to implementing Kennedy's radical health care agenda, Means enlisted Tucker Carlson to help arrange a meeting between the candidates. On the night of July 13, after the attempted assassination of Trump in Butler, Pennsylvania, Means and Carlson made the fateful introduction. "There's rare moments in history when the deck can change," Means told Rogan, adding that he felt "this could be a realignment of American politics."

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As Means described it, the bond between the Republican fast-food aficionado and the Democratic vaccine foe was emotional and instantaneous. They "had weeks of conversations, and there was not a discussion of polling" or the political horse race, Means said. "These were tear-filled conversations about why kids are getting so diabetic, about why we have such obese children in the United States, about why we have a fertility crisis." Leaked video of the two men talking by phone the day after the assassination attempt showed a less emotionally charged conversation. Trump could be heard wooing Kennedy and embracing his controversial theories. Riffing on an allegedly excessive childhood-vaccination shot, Trump said, "It looks like it's meant for a horse, not a 10-pound or 20-pound baby."

In short order, Trump became president, Kennedy was sworn in as the nation's health secretary, and Calley Means became RFK Jr.'s right hand as a White House special government employee. In May, Trump nominated Means's sister, Casey Means, MD, a onetime surgical resident whose rise in antiestablishment health circles has mirrored Calley's, to serve as surgeon general. The Make America Healthy Again (MAHA) movement had been catapulted from the left and right fringes to center stage, with the Means siblings positioned as its framers in chief.

Tall and wiry with a patrician air and often intense public demeanor, Calley Means paints a vivid portrait of endemic corruption plaguing the US health system: a poisoned food supply; doctors and scientists with undisclosed conflicts of interest; revolving-door bureaucrats; and out-of-control vaccine mandates. At the American Wellness Summit, he promised that the scourge of chronic diseases such as obesity and diabetes could be reversed "very quickly" once the corruption has been vanquished. And when the FDA announced a plan to phase out certain synthetic food dyes, Means was right there at the podium, extolling "a major win of grass roots forces against special interests" and declaring that "the cries" of MAHA moms are "ringing out across the country."

A wide array of medical experts have warned that the MAHA agenda, and its slipshod implementation, will potentially set the country's public health back years. Their plans, says Georges Benjamin, executive director of the American Public Health Association are "not in line with the evidence and science that we know works. As a result, people will be getting sicker, showing up for medical care at a later stage of disease, and at a higher cost."

Means betrays no doubts about the righteousness of his cause. Like many MAGA-adjacent influencers, he seems to delight in slamming his ideological enemies. At a Politico health care summit on April 2, journalist Dasha Burns asked him about mass firings at US health agencies. "It's insane for you to insinuate that the things standing between us and better health is more government bureaucrats," Means replied, before turning his wrath on the audience. "The lobbyists in this room [are] laughing, when we have the sickest children in the developed world."

Given Means's dizzying rise from relative obscurity to the summit of America's federal health apparatus, his hyperconfidence may well be justified. That climb has been propelled by the personal story he has shared often: that he was a food and pharmaceutical lobbyist who saw firsthand the collusion of both industries with medical groups and academia.

And yet, a six-month *Vanity Fair* investigation raises questions about whether Means has embellished his personal story. Nine of Means's former PR colleagues dispute some of his key biographical assertions. As well, his health care company, Truemed, which helps patients use tax-free dollars to buy wellness products, is poised to benefit from the radical health care overhaul he has been championing. *VF* interviewed more than 60 people for this account, and reviewed 24 of Means's public appearances since 2023, his social media accounts, and related federal and state legislation, tax, lobbying, and business records.

In May, *Vanity Fair* reached out to Means and presented him with an extensive list of questions for fact-checking and comment for this story. In response, Means said, "I

stand by everything I've said," adding that he was not surprised that anonymous sources were "spreading lies to *Vanity Fair*."

Means, who is a special government employee, is not listed on the White House website as having obtained an ethics waiver. "He's managed to avoid the scrutiny of a full-time government employee," says Virginia Canter, former associate counsel to President Obama and chief anti-corruption counsel at Democracy Defenders Fund, a nonprofit organization working to defend the rule of law. Given his financial stake in health policy issues, "I am not sure that an ethics official would have signed off on this in normal times."

"I Helped Funnel It"

MAHA's would-be reformers are not wrong about the dismal record of our profit-driven health care system. About one fourth of working-age Americans are underinsured and routinely skip unaffordable care or incur medical debt. Roughly 26 million people, about 8 percent of the population, have no health insurance at all. Prescription drugs cost almost three times as much here as they do in comparable countries. And life expectancy in the US is about four years shorter than in other wealthy nations. Americans are so fed up that, when a UnitedHealthcare executive was killed in cold blood on a Manhattan sidewalk last December, the mood in some corners of the internet was downright celebratory.

More Reporting by Katherine Eban

SHOTS IN THE DARK

Why Counterfeit Ozempic Is a Global-Growth Industry

BY KATHERINE EBAN

PUBLIC HEALTH

Inside the Bungled Bird Flu Response, Where Profits Collide With Public Health

BY KATHERINE EBAN

INVESTIGATION

"This Shouldn't Happen": Inside the Virus-Hunting Nonprofit at the Center of the Lab-Leak Controversy

BY KATHERINE EBAN

Now, the MAHA movement is in charge. Its tent is big enough to include Berkeley granola heads and anti-vaxxers, fitness junkies and right-wing tech bros, and even COVID-19 deniers, who allege the pandemic never occurred. A teeming marketplace of wellness grifters is along for the ride. While the movement's priorities range widely, from removing food dye from Froot Loops on one end to amending the Constitution to prohibit medical mandates including vaccinations on the other, they are all certain of one thing: You can't just tighten the cables of our existing health care system. You need to blow up the bridge.

In his three months in office, Kennedy has done just that. Hundreds of National Institutes of Health research studies—on everything from cancer risk factors to adolescent diabetes—have been axed. Gone are programs that tested milk for contaminants, shielded children from lead exposure, and decreased maternal mortality.

Amid a raging measles epidemic, which claimed the lives of two unvaccinated children in West Texas, Kennedy has offered only tepid support for the safe, effective, and long-studied MMR (measles, mumps, and rubella) vaccine, which he recently claimed falsely on a News Nation panel has "a lot of aborted fetus debris." Meanwhile, he has touted the healing benefits of vitamin A, the hype leading a number of Texas children to be hospitalized for toxic overexposure to the nutrient.

At every step, Means has been cheerleading. In late March, when Kennedy's team forced out the FDA's top vaccine regulator, Peter Marks, MD, Means wrote on X that Marks was a "mediocre scientist" whose "main expertise appears to be public relations and having lunch with pharmaceutical executives." When Kevin Hall, PhD, a top

nutrition scientist at NIH, resigned in late April, Means—who has no formal medical, public health, scientific, or nutritional credentials—wrote on X, "Good riddance Kevin."

Means—who has claimed falsely that COVID-19 was a foodborne illness that did not kill metabolically healthy people—has faced criticism for his lack of traditional expertise. "The arrogance of these bros…these professional podcasters who stand in front of career scientists and say, 'What has science ever done?'" Representative Jake Auchincloss (D-Ma.) said at the Politico health care summit shortly after Means left the stage. "I don't know, science eradicated measles—until two months ago."

But Means has sought to shore up his credibility by leveraging a key credential: He says that as a former lobbyist, he witnessed, and even participated in, the corrupt backroom dealmaking between pharmaceutical interests, Big Food, and the medical establishment. In a March 2024 appearance on Kennedy's podcast, he spoke with apparent insider knowledge of how Coca-Cola had lavished money on the very medical societies that should have been speaking out against soda consumption. "You wouldn't even believe this," he said, "but the American Diabetes Association took millions of dollars from Coke. I helped funnel it."

That personal narrative of conversion contributed to vaulting the book he cowrote with his sister, Casey Means, *Good Energy: The Surprising Connection Between Metabolism and Limitless Health,* to the top of the bestseller list. Casey, a physician, runs a health technology company called Levels, which helps customers track their blood glucose levels using continuous glucose monitors. She does not have an active medical license.

With their Ivy League pedigrees and skyrocketing trajectories, the Means siblings have aroused suspicion among some of the MAHA faithful. Some fear that they may be part of a "controlled opposition," sent by the global elite to sabotage Kennedy's mission to smash the vaccine-industrial complex. Means confronted two such critics on a heated episode of the *Danny Jones* podcast, a show dedicated to bringing "fringe

cultures to a wide audience." Defending his MAHA street cred, Means said "seeing that darkness" of corrupt dealmaking has been "foundational to who I am and what my story is."

But former colleagues from his time at Mercury Public Affairs and Edelman, the two publicity firms that employed Means, say his work would not have put him in the meetings he's described. In some instances, the firms where he worked did not represent the clients whose meetings he says he staffed. His former mentor Steve Schmidt, a longtime Republican strategist who brought Means into Mercury and oversaw his work there, then helped him land the job at Edelman, says, "Calley Means is not a whistleblower. He is an opportunist, peddling junk science to make millions."

"I Saw Inside the Room"

On January 2, 2023, Calley Means made his social media debut as a Big Soda whistleblower. In a lengthy Twitter thread, he wrote, "Early in my career, I consulted for Coke to ensure sugar taxes failed and soda was included in food stamp funding. I say Coke's policies are evil because I saw inside the room." He went on to lay out the company's playbook: "Coke gave millions to the NAACP and the Hispanic Federation—both directly and through front groups like the American Beverage Association." The civil rights groups, he said, in turn denounced soda restrictions as racist.

He shared a 2013 *New York Times* article documenting the payments that flowed from the beverage industry to dozens of health advocacy and minority civil rights groups, enabling the defeat of soda regulations. He said the conversations he witnessed were "depressingly transactional." It was just the kind of urgent, insider stuff that breaks through the noise, and the tweet thread garnered 12.3 million views and 52,000 likes.

Means offered even more vivid details on a podcast hosted by Dhru Purohit, a Truemed investor. "I was sitting in a room with the NAACP and Coke executives," Means said. "It was very unsettling. It was Coke executives telling the most prominent civil rights group in the United States, 'We're going to pay you millions of dollars, and we need you to call our opponents racists to shut down the debate.'"

Means would later tell Joe Rogan that, on behalf of the pharmaceutical industry, he helped steer money to academia to downplay the opioid crisis.

> **"I tried to scratch my brain and made a few calls, to make sure I wasn't going crazy...Maybe there was a six-month window when we all blacked out, this client came in, and Calley became the whisperer behind the scenes, plotting a supposedly nefarious role with soda executives."**

Means explained to the fitness trainer Jillian Michaels, on her podcast *Keeping It Real,* that "the food and pharma industries were my two big clients. I was a lobbyist and consultant…one of my big accounts was the American Beverage Association, which is the front group for Coke." Michaels had introduced him as the "number one whistleblower in America."

"I was completely mesmerized by his ability to tell the truth about the health care industry," Vani Hari, a nutrition blogger known online as Food Babe, recalls. "I had never seen anyone like him before do that, in such a bold truth-telling fashion. I extremely admired that." Hari has become a staunch ally of Means's and a voluble proponent of the MAHA agenda, often appearing at Trump administration events.

As his stature grew, Means received relatively little pushback. In 2023, however, the journalist Helena Bottemiller Evich, who covers the food industry in her Food Fix newsletter, asked him which consulting firm he was referencing in his Big Soda thread. Means "declined to specify," she wrote.

Means is not a whistleblower in the legally recognized sense. He didn't notify the authorities of any corporate wrongdoing or risk a job to divulge sensitive information. Many of the dealings he described were real, but they had been documented in the press long before he spoke out about them.

In at least eight public appearances identified by *VF*, Means has said he had been a lobbyist. A review of US lobbying records show that he has never registered as one. In the two years since his viral tweet thread, he's been introduced as a "former food lobbyist" or "Coca-Cola whistleblower" in dozens of podcasts and presentations. Last August he appeared with his sister on Tucker Carlson's show. As Carlson said to him, "You were a lobbyist, okay?"

Means did not dispute the characterization and went on to describe how, as a junior employee, he attended a meeting where the food companies were "paying off, you know, nutrition researchers at Harvard and Stanford."

"So you saw that?" Carlson asked.

"My first week, you know, working for these industries," Means replied.

The episode became the most shared podcast of 2024, according to Apple rankings.

The bigger his audience, and the more Means spoke, the more bewildered his former colleagues at Mercury and Edelman say they became, as they recalled the largely administrative work Means had done at Mercury, and the more benign PR he'd been tasked with at Edelman.

"I tried to scratch my brain and made a few calls, to make sure I wasn't going crazy," says one former Mercury colleague. "Maybe there was a six-month window when we all blacked out, this client came in, and Calley became the whisperer behind the scenes, plotting a supposedly nefarious role with soda executives."

"Calley Means Business"

Means grew up "down the street from the White House," as he said in a 2023 biographical video. His father, Grady, worked as an aide to Richard Nixon's health secretary, then led the Food and Nutrition Task Force to reform America's food stamp program under Gerald Ford. He went on to run PricewaterhouseCoopers's government consulting business.

Means ran track and field at Georgetown Prep, then majored in political science at Stanford University, where he was president of the Kappa Sigma fraternity. He was drawn toward libertarianism, notably the idea that the free market should be protected from government intervention. As a rising junior in college, he interned at the Heritage Foundation and worked on a report whose language hews closely to his stance almost 20 years later. "Congress should not consider any health care legislation that does not expand personal control over health care dollars, expand consumer choice and competition, and reduce the already excessive level of health care regulation," the 2006 report stated.

His early résumé, obtained by *Vanity Fair,* displays a penchant for hyperbole. He describes a three-month White House internship at the offices of Presidential Scheduling and Correspondence, at age 19, as follows: "Acted as liaison between the President and American soldiers in Iraq by analyzing and referring letters, e-mails, and comments from soldiers directly to the President." A separate bullet point notes that he was "Youngest White House intern selected in 2005."

On the 2008 McCain campaign, he became part of a "pit crew," working to help resuscitate the sinking reputation of vice presidential candidate Sarah Palin. From there, he followed senior campaign adviser Steve Schmidt, who returned to Mercury Public Affairs where he was a partner.

In January 2009, at age 23, Means arrived at the company's Sacramento office. On LinkedIn, Means says he worked there as a "Director," and describes his responsibilities as follows: "Collaborated with team of lawyers and management

consultants to advise companies facing high-profile public strategy challenges. Clients in pharma, food, and energy spaces."

In reality, Schmidt and other former Mercury employees say, Means was his executive assistant. He was chiefly responsible for organizing Schmidt's travel, managing his schedule and expenses, and compiling his briefing notebooks. (Schmidt has become an outspoken critic of the Republican Party under Trump and cofounded The Lincoln Project. He resigned from the board in 2021 during a period of turmoil sparked by another cofounder's sexual harassment scandal.)

> **Means "definitely wanted to be in the strategic conversations, and that sometimes annoyed people," a former senior Mercury official recalls. "He wore his smartness on his sleeve, like someone who wanted to matter."**

Some colleagues recall him as a goofy frat boy, who drank to excess at after-hours work events and once bought his office mates wearable Snuggie blankets. Others found him aloof, with a "blue blood vibe," as one former colleague put it.

Schmidt recalls that he was once at a Starbucks at Ronald Reagan Airport, only to have his credit card declined. That led to his discovery that Means had failed to file more than $150,000 of Schmidt's expenses for reimbursement, says Schmidt: "That was his competency level as an assistant." Still, Schmidt recalls him as "thermonuclear smart," and a "bright young man in a hurry."

Means "definitely wanted to be in the strategic conversations, and that sometimes annoyed people," a former senior Mercury official recalls. "He wore his smartness on his sleeve, like someone who wanted to matter."

Though Mercury Public Affairs has registered lobbyists on its staff and is known to dabble in the "dark arts" of public persuasion, Means worked on the PR side, according to former coworkers. While he was there, Mercury represented a client that

was trying to forestall a plastic-bag ban in California. It did represent PhRMA, the pharmaceutical industry trade group, but mostly to help it gain access to the Obama White House so it could join negotiations over the Affordable Care Act, former Mercury officials say.

From 2009 to 2011, when Means worked at Mercury, the firm did not represent Coca-Cola or its trade group, the American Beverage Association, a Mercury spokesperson confirms. In 2010 the Coca-Cola Foundation did donate $135,000 to the NAACP. But at the time, Mercury was actually working the other side of the issue, representing the California Endowment in its support of an additional tax on soda as a way to fight obesity. "We ran a campaign for them to get poor communities to stop drinking soda," one former Mercury official tells *VF*. The effort was supported by California governor Arnold Schwarzenegger, another Mercury client.

In 2011 Schmidt helped Means land a job at Edelman in its Washington, DC, office. There, old press releases show, Means helped Harvard Business School promote a roundtable on improving US competitiveness and flacked for a company launching a "wearable tech" center in Silicon Valley.

On weekends when his parents were away, he threw memorable parties at their house. At the office, several colleagues recall his air of self-importance; He seemed to have bigger and better plans ahead, which didn't include them. "He walked around the office saying, 'Calley Means business,'" another former colleague recounts.

Means's two-year stint at Edelman ended in 2013. The Coca-Cola Foundation again gave the NAACP $130,000 in 2011 and another $150,000 in 2012, according to its tax filings. But Edelman represented Pepsi during this period and could not have represented its archrival, say two of Means's former colleagues at the firm, who do not recall him working closely on food and beverage issues. During Means's tenure there, a spokesperson for Edelman says, the company did not represent either the American Beverage Association or Coca-Cola in the US. A spokesperson for the American Beverage Association confirms it never employed Edelman. Coca-Cola was unable to

respond by deadline. The NAACP did not respond to a request for comment. (The American Beverage Association did fund a coalition that opposed soda restrictions during this time frame, but that group did not use Edelman to conduct PR, according to its tax filings and a former member of Edelman's leadership team who oversaw food and beverage accounts.)

The scenarios Means paints are "highly unrealistic" for another reason, says a former Edelman colleague. Had any money exchanged hands, the interactions would have included lawyers at each step and only "the highest-level folks" in the room. The former colleague adds, "A transaction [like that] at Edelman that would involve a junior associate is about as impossible or impractical an assertion that I could think of."

When reached for comment for this story, Means initially referred *Vanity Fair* to a former colleague he described as his lieutenant "to refute your bullshit smears." When contacted, the former colleague declined an interview, saying by text, "Calley shared the questions you sent over to him, and I did not work closely with him on those projects, so unfortunately can't provide any background."

"She Was Tearful About It"

After Edelman, Means went on to Harvard Business School, where he met Leslie Voorhees, who already had considerable business experience and had managed a Nike factory in Jakarta, Indonesia. They married in 2016 in Portland, Oregon, and that same year launched a wedding-dress start-up called Anomalie that gave brides an affordable way to custom-design their gowns. The dresses were made in China.

Means framed the company as a consequential disruptor of the status quo. "Fundamentally, the complete brokenness of the [wedding dress] industry has been an uncovered topic," he told a *Forbes* journalist in 2018, "and there's going to be a time this year when every reporter in the country is writing about it in anticipation of all these bankruptcies." That never happened, and the couple sold Anomalie to

David's Bridal for an undisclosed price in 2022. Their son was born that year and they named him Roark, after the conformity-busting protagonist of *The Fountainhead.*

The inciting incident of Means's MAHA conversion had come a year earlier. In January 2021, Calley and Casey's mother, Gayle Brown Means, was diagnosed with pancreatic cancer and died just a few weeks later. She was 71. It was a devastating loss, and it inspired them to take action, as Means told Joe Rogan last year. "Casey and I on her grave site literally hugged each other and said we want to write a book" to raise awareness about the missed warning signs of poor health that led their mother to be "chopped down by cancer."

Casey had already "embarked on a journey to understand the real reasons why people get sick," their book recounts. *Good Energy* presents a narrative of Casey Means's own journey from medical-establishment wunderkind to prominent critic. In 2018, just months before completing her five-year residency in ear, nose, and throat surgery at Oregon Health & Science University, "I walked into the chairman's office at OHSU and quit." The book describes her transformation from cog in a profit-driven sick-care system, with medical training that taught her nothing about the root causes of illness, to a physician freed to have "deep conversations" with her patients to help "restore and maintain good health."

Paul W. Flint, MD, who was chairman of the Department of Otolaryngology—Head and Neck Surgery at OHSU at the time, tells *VF* that when Means left the program, it was because she found the surgical work "too stressful" and was not able to continue in the residency, even after taking a paid leave.

Flint says that Means returned from leave saying, "'I still can't do this.' She was tearful about it." He adds that the other residents had to "cover for her, and we're a small department and all the calls fall on them."

Two former OHSU residents who served alongside Casey tell *VF* that they do not recognize the version of events laid out in the book. In their view, Casey

misrepresented her residency training and proclaimed a medical conspiracy against good health that simply didn't exist. They describe her as being anxious and fearful of harming patients. "It feels disingenuous, demonizing your practice. She didn't make it through," one of the former residents says. "By trying to question our entire field and sowing distrust in medicine, it's hard to ignore that she may benefit from that."

Another former resident says, "I did not witness a spiritual awakening. It felt more and more like she was preying on the less educated and using the MD she had to tout these pseudoscience things." (Casey Means declined to provide an on-the-record response. In a statement issued after her nomination, Stanford medical school reiterated that she graduated in 2014 and returned in 2022 to lecture on food and health. The school said: "We are proud that Casey Means, MD, has been nominated to serve as the United States Surgeon General.")

"Beware of Companies Misrepresenting Nutrition..."

In June 2022 Calley Means and Justin Mares, founder of the Kettle & Fire bone-broth brand, launched Truemed. The goal was to enable patients to use their health savings accounts to buy wellness products. Typically, HSAs allow patients with high-deductible health insurance policies to set aside pretax money to help pay for uncovered medical expenses. Using Truemed, customers could fill out an online survey, identify their symptoms, and quickly obtain a letter of medical necessity from a doctor or nurse practitioner. The letter, in turn, would allow them to use HSA dollars to "address the root cause" of chronic diseases, as Means puts it.

Truemed partners with companies that sell items ranging from supplements and red light therapy to smart mattresses that track sleep, and takes a percentage of the sales. One customer, seeking to purchase a Peloton bike through the website, filled out an online survey and in short order received a letter from a nurse practitioner citing an

anxiety diagnosis and recommending "the patient bike, row, tread through class membership for 150 minutes per week."

Truemed's initial vision was to rebrand partner companies, including the salad chain Sweetgreen and the meal-kit company Daily Harvest, as health care companies, according to early marketing materials obtained by *VF*. That would enable customers to use their tax-free HSA dollars to purchase food.

In December 2023 a *Washington Post* wellness column explained to readers that they could now use HSA dollars for certain healthy foods and gym memberships, and Means was quoted saying that the company planned to partner with more large food brands soon. Three months later, however, the IRS issued an alert that warned, "Beware of companies misrepresenting nutrition, wellness and general health expenses as medical care" for HSAs and similar types of accounts.

> **[Means] posted an advertisement on LinkedIn two days after the election for an opening at Truemed: a "Chief of Staff" to help manage the "intersecting worlds of Truemed and healthcare policy work."**

The same day, the *Washington Post* ran a follow-up, noting the IRS's warning and its caveat that "medical letters must result from face-to-face interactions with the patient, either in person or through telehealth visits. Getting a medical letter by filling out a questionnaire" was "not adequate," a potentially crushing blow to Truemed's business model.

On March 6, the day the *Washington Post* ran its follow-up, Means had his first sit-down with RFK Jr., as a guest on his podcast. In the episode, entitled "IRS: Pro-Pharma Anti-Health," which ran a week later, Means asserted a conspiracy. "Well, just to give some inside baseball, uh, a literal pharmaceutical lobbyist, uh, who was upset with what we were doing, tipped off the IRS and the IRS called the *Washington Post.*" The IRS was embracing policies, Means suggested, that were intended to get

Americans sick and onto a "pharmaceutical treadmill." By contrast, he described his company as "disruptive" and working against entrenched interests.

Sherry Glied, the dean of NYU's Robert F. Wagner Graduate School of Public Service, is an economist who has studied HSAs. She says the accounts amount to a tax break for the wealthy and are "completely useless" for someone living paycheck to paycheck. "You want medical freedom?" she says. "Spend your own money. But why should I pay higher taxes because you want a Peloton bike?"

"Full-Metal-Jacket Crazy"

On February 13, 2025, RFK Jr. was sworn in as health secretary. Speaking from the Oval Office, the scion of America's most famous Catholic family cast his rise in religious terms. "For 20 years, I've gotten up every morning on my knees and prayed that God would put me in a position where I can end the childhood chronic disease epidemic in this country," he said. "On August 23 of last year, God sent me President Trump."

Five days later he told thousands of Health and Human Services employees that he intended to wage war on "the corrosive power of money as it infiltrates and captures institutions like ours." He vowed to remove conflicted members of advisory committees and shutter the revolving door to industry.

His own conflicts, and those of his closest allies, were another story. Incoming cabinet members are supposed to forfeit any financial interests that might compromise their official duties, but Kennedy tried to retain a 10 percent stake in personal-injury litigation targeting Merck over its Gardasil vaccine. Only after a public outcry did he transfer it to his son. As for Means, he posted an advertisement on LinkedIn two days after the election for an opening at Truemed: a "Chief of Staff" to help manage the "intersecting worlds of Truemed and healthcare policy work."

Canter of Democracy Defenders Fund says Means's post "seems to show an intent to develop policies, maybe in advance of entering government, to benefit his company."

By March, Means, now a special government employee assisting the MAHA commission, began flying from state to state and campaigning to ban sugary drinks from nutrition assistance programs. In response, MAGA lawmakers in red states have become unlikely advocates of a healthy-food movement. In late March, West Virginia's governor signed a bill removing seven different food dyes from school lunches.

To Vani Hari, the Food Babe, the GOP's embrace of MAHA is a welcome development. It's "so good for humanity, and so good for the country," says Hari, who was a two-time Obama delegate but says the Democrats never took up this issue as effectively, Michelle Obama's organic garden and Let's Move! efforts notwithstanding. "If the Democrats want to survive, they will have to try and out-MAHA the Republicans."

Yet others question whether MAHA is a movement at all. "It's an entity in which the branding has outstripped the content," says Peter Lurie, president and executive director of the Center for Science in the Public Interest. "There is a slogan and a certain amount of grift."

From the fringes of MAHA, medical-freedom hardliners began to take aim at Means, seeing his emphasis on food policy as a misdirection strategy aimed at diluting the attack on vaccines. In blog posts, they combed through his background, questioning his links to supposedly shadowy entities from the Rockefeller family to the Council on Foreign Relations.

Mary Talley Bowden, MD, who was suspended from Houston Methodist hospital in 2021 for promoting "dangerous misinformation which is not based in science," and has campaigned to get the COVID-19 mRNA vaccines pulled from the shelf, tells *VF* that Means sparked her suspicions when he "showed up out of nowhere as a

leader" of the MAHA movement, then shifted the focus from vaccines to food. "That was just a red flag for me," she says.

Others think Means has been subjected to "bad jacketing," a targeted effort to undermine him by spreading doubt about his true-believer bona fides. "If you're not buying into the full-metal-jacket crazy, then you're controlled opposition," says a physician and MAHA insider. "You're serving some cult master that is not disclosed, in some way."

Means has done his best to assuage the suspicions, in part by adopting the fire-and-brimstone language of the MAHA fringe. He recently told a far-right streaming platform that "demonic forces" are "profiting from children being in fear, being addicted, being sick."

He's also gone out of his way to directly attack vaccine scientists. On a CNN panel in February, he lit into fellow guest Paul Offit, a pediatrician who holds the Maurice R. Hilleman chair in vaccinology at the University of Pennsylvania's Perelman School of Medicine, which is endowed by the pharmaceutical company Merck. Comparing Offit to a "NASCAR driver wearing their sponsors," Means said, "I mean, that is just insane. Merck does not have children's interests at heart."

As Offit struggled to explain that the endowed chair came with no quid pro quo, and that Merck gives money to the medical school, not to him, Means laughed out loud and spoke over him. The segment rocketed around the internet.

"You're attacked in this fire hydrant way," says Offit, reflecting on the exchange, "for the purpose of creating a one-minute clip, to show he's taken me on and brought me down."

"One Big GNC Store"

In January 2024 Means arrived at the Renaissance Esmeralda Resort in Palm Springs, California, for the annual meeting of a philanthropy called Stand Together, founded by the libertarian billionaire Charles Koch. Koch-backed organizations have long sought to dismantle government-subsidized health insurance programs, from the Affordable Care Act and Medicaid to the Veterans Health Administration, and replace them with tax credits to purchase private insurance. Nothing about the exclusive event was posted online, and the organizers held the guest list close. Means was seeking funding to launch a nonprofit whose purpose was to end chronic disease, in part by lobbying the federal government to allow Americans to buy wellness items with HSA dollars—the very purchases offered by his company Truemed.

Not everyone was happy to see him. One former Stand Together employee who was there viewed an alliance with him as "reputationally a third rail," citing Means's lack of medical credentials and the shakiness of his public-health claims.

Regardless, in June 2024, Stand Together's health care director, J.C. Hernandez, became the executive director of End Chronic Disease, Means's nonprofit lobbying group. He has since changed his title to "co-founder" on his LinkedIn account. According to his page on the social media site, he overlapped at both organizations for six months. Previously, Hernandez had worked as a registered lobbyist for another Koch organization, Americans for Prosperity. (Neither Hernandez nor Stand Together responded to requests for comment.)

> **"They are out there using tax-preferential dollars for wealthy people to buy saunas, and they are going to turn our entire health care system into one big GNC store."**

The press release announcing the launch of End Chronic Disease listed 20 members of its coalition including Means and his Truemed partner, Mares. It made no mention of specific donors, referring only to "funding through a bi-partisan group of

leaders," and its website includes no financial disclosures. The nonprofit's registered address leads to the same office complex in Arlington, Virginia, where Stand Together, Americans for Prosperity, and the Charles Koch Foundation are headquartered. Of the original 20 coalition members, 12 had either invested in or partnered with Truemed. Today, the coalition has grown to 28, including boldface names in the wellness space, from functional medicine doctor Mark Hyman to Jillian Michaels. Both sell their products on the site, and Hyman was an investor.

The End Chronic Disease website until recently directed patients to contact their legislators, urging them to support the HOPE Act (Health Out-of-Pocket Expense Act), which would allow HSA dollars to be used more expansively. In May, House Republicans passed their reconciliation tax bill, which in addition to preserving tax cuts for the wealthiest Americans and gutting Medicaid, contained a number of provisions that could expand HSA use significantly. Even without that expansion, one report estimates that by the end of 2026, HSA accounts will hold more than $175 billion in assets.

Many of the End Chronic Disease coalition members are selling products that would potentially benefit from such legislation: infrared saunas and cold plunges, herbal medicines and protein powders, and ketone drinks. Some are available through Truemed's platform.

Speaking with *Vanity Fair,* Representative Jake Auchincloss says of the MAHA takeover of HHS: "Their self-designation as oracles of health care gives them license for corruption…. They are out there using tax-preferential dollars for wealthy people to buy saunas, and they are going to turn our entire health care system into one big GNC store."

On May 22, Donald Trump and Robert F. Kennedy Jr. sat shoulder to shoulder at the White House to deliver a report from the MAHA Commission, "Make Our Children Healthy Again." Over 72 pages, the paper, which Means helped to coordinate, calls out the scourge of ultraprocessed foods, antidepressants, toxic

pesticides, and the "possible role" of childhood vaccines in making our children "the sickest generation in American history," as Kennedy put it. (The MAHA Commission is scheduled to deliver its follow-up strategy paper in mid-August.)

The press event was in many ways the apotheosis of Means's whirlwind rise, with the two men he'd connected less than a year earlier driving a splashy news cycle.

Means was in the audience, sitting dead center, absorbing it all. In little more than a week, it would emerge that the report cited a number of studies that didn't actually exist. A White House press secretary said that "formatting issues" were to blame. Means took to X to argue that special interests were "quibbling with footnotes" while the report had fearlessly tackled "taboo subjects."

Additional reporting and research by Liz Rosenberg.

This story has been updated.

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KATHERINE EBAN

Katherine Eban is a special correspondent at *Vanity Fair*, covering medical and scientific mayhem. An award-winning investigative journalist, she is the best-selling author of *Bottle of Lies: The Inside Story of the Generic Drug Boom*. You can follow her on Twitter. . . . Read More

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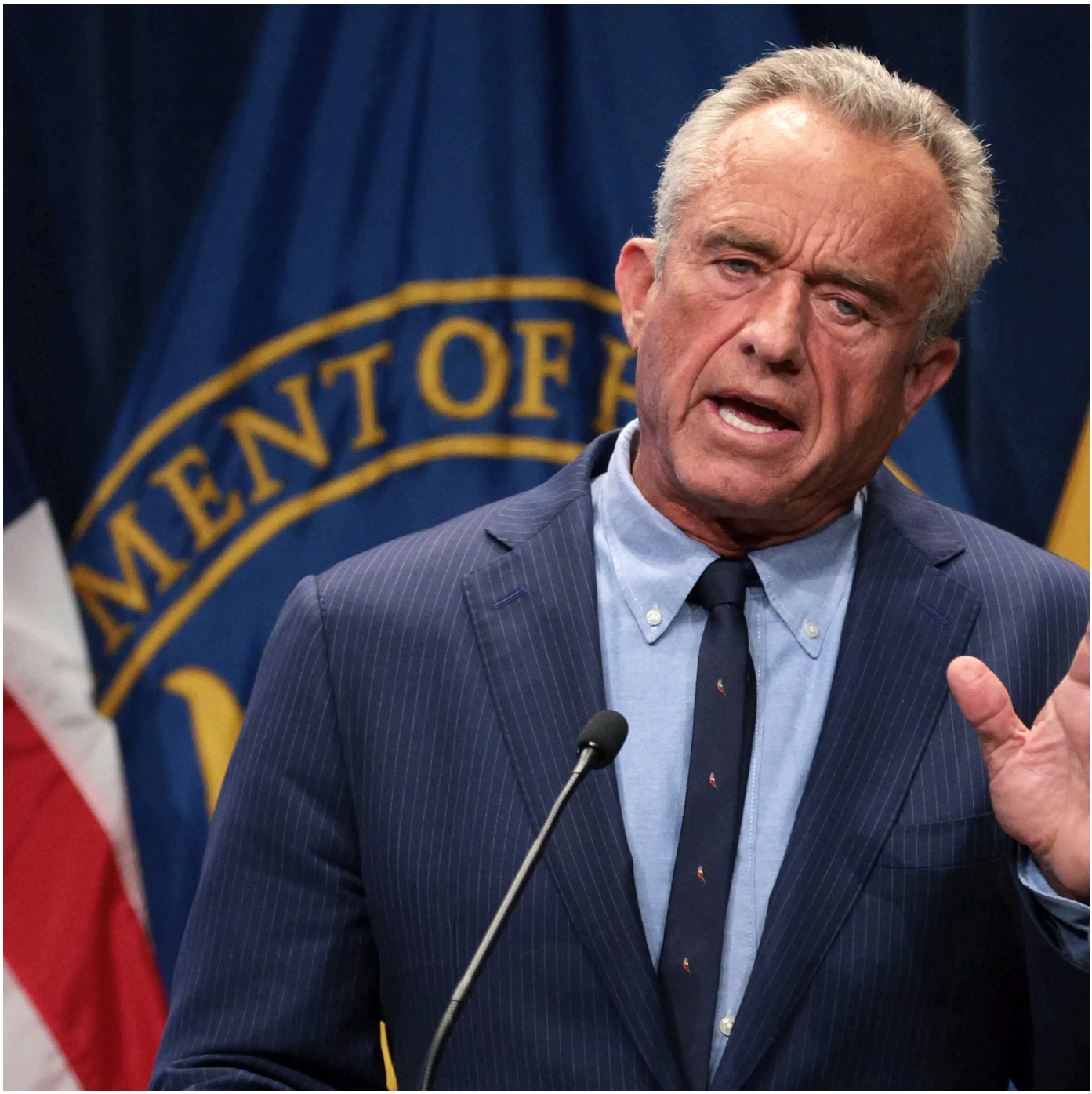


NEWS

RFK Jr. Hires Vaccine Skeptics for Vaccine Panel, Because Modern Medicine Is for Suckers

The new group includes one person who believes vaccines cause autism and another who has claimed the Texas measles outbreak might have been caused by MMR shots.

BY BESS LEVIN

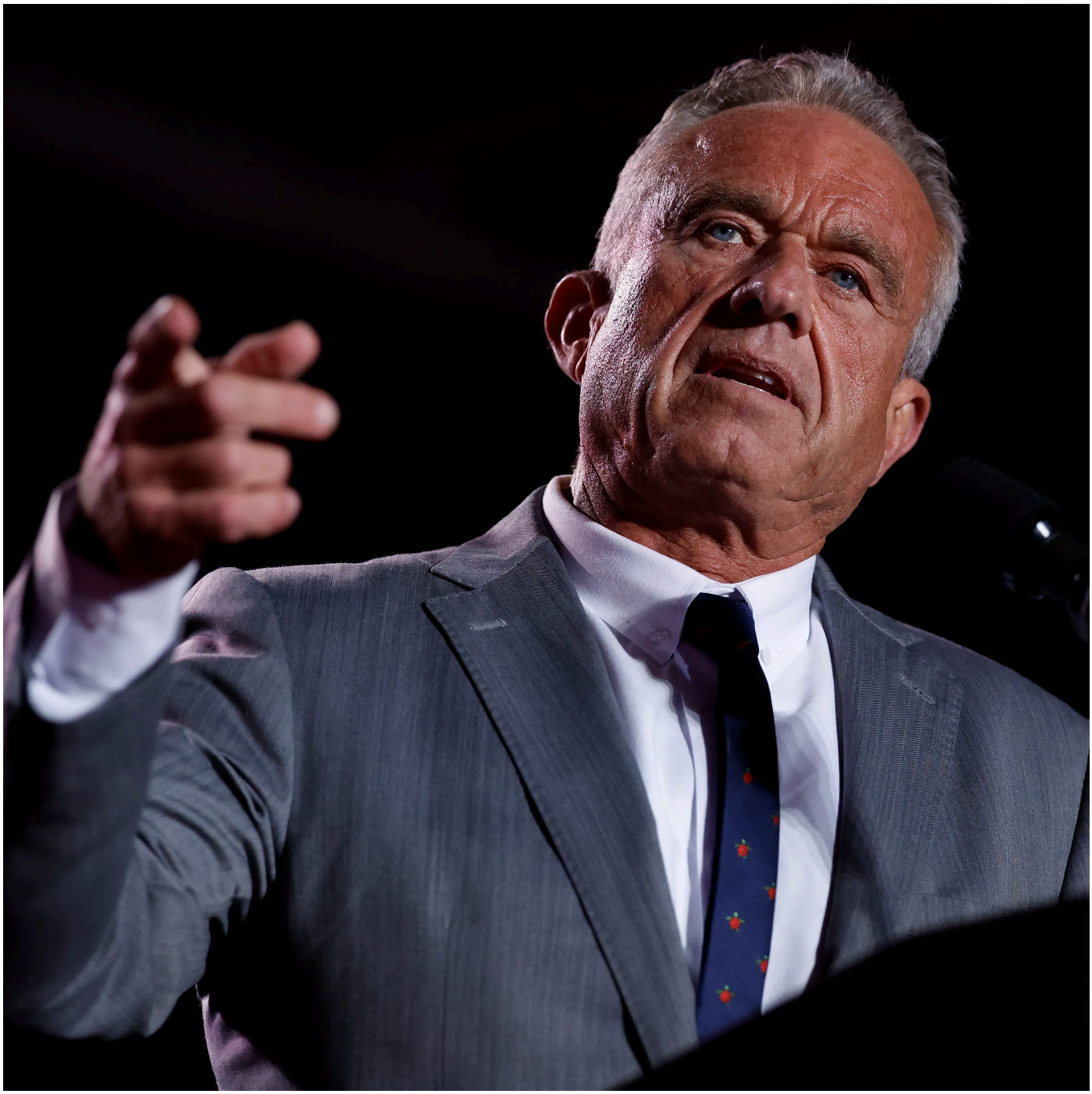


POLITICS

Get Ready to Die of a Preventable Disease: RFK Jr. Fires Every Vaccine Expert on CDC Panel

"This will not restore trust in vaccines, and is not designed to do so."

BY BESS LEVIN



POLITICS

RFK Jr. and the Worm That Ate His Brain Threaten to Ban Government Scientists From Publishing in Top Medical Journals

Do you feel healthier already?

BY BESS LEVIN

POLITICS

Trump Administration Cuts $258M Program Crucial To Discovering HIV Vaccines

The lack of funding is expected to set back decades' worth of progress against HIV, according to public health experts.

BY KATIE HERCHENROEDER

POLITICS

How Elon Musk's Reported Drug Use Aligns With RFK Jr.'s Vision for Mental Health

Kennedy believes you should skip your SSRIs and consider some Special K. Has Musk told him about the "bladder issues" that can come along with it?

BY KASE WICKMAN

POLITICS

"Pro-Life" Admin Nixes Policy Requiring Hospitals to Perform Lifesaving Abortions

Sorry, pregnant people.

BY BESS LEVIN

POLITICS

Turns Out That RFK Jr.'s Plan to Make America Healthy Again Doesn't Include Most Pregnant Women or Children

In response, the president of the American College of Obstetricians and Gynecologists said, "The science has not changed. It is very clear that COVID infection during pregnancy can be catastrophic and lead to major disability."

BY BESS LEVIN

BUSINESS

"We've Been Sold a Story That Isn't Remotely True": How Private-Equity Billionaires Killed the American Dream

In her new book, *Bad Company*, journalist Megan Greenwell shows how the secretive industry has insinuated itself into average Americans' lives.

BY ISSIE LAPOWSKY

POLITICS

"Butthurt" Elon Musk Has Billions of Reasons to Hate the GOP Spending Bill

The Tesla CEO says he's angry about America's ballooning debt. White House sources say it's personal.

BY ISSIE LAPOWSKY

POLITICS

Elon Musk Continues to Insist He Is Not on Drugs, Now With Screenshot of Drug Test

It's come to this.

BY BESS LEVIN

POLITICS

Biden's Health Secretary Is Taking On RFK Jr.—and, Maybe, Kamala Harris

Xavier Becerra, the former HHS head vying to succeed Gavin Newsom in the Golden State, tells *VF* that, with his experience, he matches up "better than any of the folks who are running, or thinking of running, for governor."

BY ISSIE LAPOWSKY

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June 16, 2025

Calley Means
Co-Founder
True Medicine Inc.
1800 E 4th Street, Unit 101
Austin, TX 78702

Dear Mr. Means,

I write to request information regarding your role as a "special government employee" (SGE) at the Department of Health and Human Services (HHS) and your coinciding leadership at True Medicine Inc. (TrueMed). You have not been required to disclose your financial details or where they intersect with the policies you are advancing.[1] Therefore, your responses will provide clarity regarding the insulation of HHS from any potential conflicts of interest given your co-occurring work in the public and private sectors.

You have been appointed as a White House advisor[2] and serve as a Special Government Employee to HHS Secretary Robert F. Kennedy Jr. As a leading policy-maker behind the Trump Administration's "Make America Healthy Again" (MAHA) initiative, you have significant influence in both regulation and legislation while your business stands to benefit from changes to that regulation and legislation. Given the pattern of self-dealing and conflicts of interest throughout this administration,[3] [4] [5] [6] [7] the public deserves to know whether you and your business,

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[1] Perrone, Matthew. "Takeaways from AP's Report on Financial Interests of RFK Jr. Adviser Who Runs Wellness Platform." *AP News*, AP News, 10 June 2025, apnews.com/article/calley-means-rfk-maha-wellness-ethics-8bbe34cb952f31bb8b6002144bb2b975

[2] Reuters, et al. "White House Names Kennedy Ally Means as Health Adviser, Source Says." Edited by Alan Barona et al., *Reuters*, 18 Mar. 2025, www.reuters.com/world/us/white-house-hires-calley-means-special-government-adviser-bloomberg-news-reports-2025-03-18/.

[3] Dunleavy, Kevin. "RFK Jr.'s Referral Fees in Litigation over Merck's Gardasil Raise Conflict-of-Interest Questions: Reports." *Fierce Pharma*, 23 Jan. 2025, www.fiercepharma.com/pharma/rfk-jrs-referral-fees-raise-conflict-interest-concerns-nyt.

[4] Backman, Maurie, and Ellen B Kennedy. "Will Dr. Oz Push Medicare Advantage Plans Now That He's Confirmed?" *Kiplinger*, Kiplinger, 27 Feb. 2025, www.kiplinger.com/retirement/medicare/will-dr-oz-push-medicare-advantage-plans-if-confirmed.

[5] Perrone, Matthew. "Takeaways from AP's Report on Financial Interests of RFK Jr. Adviser Who Runs Wellness Platform." *AP News*, AP News, 10 June 2025, apnews.com/article/calley-means-rfk-maha-wellness-ethics-8bbe34cb952f31bb8b6002144bb2b975.

[6] Rascoe, Ayesha, and Will Stone. "Dr. Casey Means, Trump's Pick for Surgeon General, Faces Criticism across the Spectrum." *NPR*, 11 May 2025, www.npr.org/2025/05/11/nx-s1-5393721/dr-casey-means-trumps-pick-for-surgeon-general-faces-criticism-across-the-spectrum.

[7] Karlin-Smith, Sarah. "US FDA Commissioner's Office Plans Involvement in Many Approvals in Potential Major Change." *Citeline News and Insights*, 30 Apr. 2025,

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TrueMed, are operating ethically.

I request your response to the following questions regarding the steps that you, the Administration, and TrueMed have taken to ensure an ethical and legal separation of interests and proprietary information no later than **Friday, June 27, 2025**.

1. **Policy Decisions Regarding the Legislative Process:** TrueMed creates partnerships with businesses to sell health and wellness products, many of which are not regulated or FDA approved.[8] Offered as a service are "letters of medical necessity" (LMNs) that enable patients to use pre-tax dollars from their Health Savings Account (HSA) or Flexible Spending Account (FSA) to purchase these products. In fact, you have publicly stated that the role of TrueMed is to route federal funds out of providing for government programs and into expanding HSAs.[9] Most recently, the Republican reconciliation package (*One Big Beautiful Bill Act*) contained many provisions to expand HSA use significantly, benefitting TrueMed's business model.[10]
    a. Can you please explain the extent to which you were involved in the drafting, revising, reviewing, or provision of feedback regarding the *One Big Beautiful Bill Act*?
    b. Please provide any communication between TrueMed and yourself related to this legislation, including but not limited to emails, chat or text messages, board meeting agendas and minutes, and memoranda.

2. **Engagement in Drafting of Executive Orders:** The Trump Administration issued an Executive Order on February 13, 2025, entitled, *Establishing the President's Make America Healthy Again Commission.*[11] The EO includes a provision that health agencies must focus on reversing chronic disease by ensuring "the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention," ultimately suggesting increased revenue for companies like TrueMed.
    a. Can you please explain to what extent you were involved in the drafting, revising, reviewing, or otherwise providing feedback regarding the Executive Order, *Establishing the President's Make America Healthy Again Commission*?
    b. Please provide any communications between yourself and representatives and/or employees of TrueMed related to this policy issue, including but not limited to emails, chat or text messages, board meeting agendas and minutes, and memoranda.

3. **Ethical Concerns Regarding Leveraging Your Government Appointment:** A supplements company filed an official complaint with the Office of Special Counsel,

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insights.citeline.com/pink-sheet/agency-leadership/us-fda/us-fda-commissioners-office-plans-involvement-in-many-approvals-in-potential-major-change-JFPWOQ2VF5D2JAFKXKGK54REZU/.

[8] Perrone, Matthew. "Takeaways from AP's Report on Financial Interests of RFK Jr. Adviser Who Runs Wellness Platform." *AP News*, AP News, 10 June 2025, apnews.com/article/calley-means-rfk-maha-wellness-ethics-8bbe34cb952f31bb8b6002144bb2b975

[9] Ibid.

[10] Eban, Katherine. "The Dizzying Rise of Maha Warrior Calley Means, RFK Jr.'s Right-Hand Man." *Vanity Fair*, 30 May 2025, www.vanityfair.com/news/story/calley-means-rfk-jrs-maha-rise.

[11] Executive Order. No. 14212, 2025.

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HHS Office of Civil Rights; HHS Office of Inspector General; and the Federal Trade Commission, on May 12, 2025.[12] This competing company alleged that you used your government position to pressure them into transacting with TrueMed. Specifically, the allegations state that you threatened the involvement of National Institutes of Health (NIH) Director Jay Bhattacharya and Secretary Kennedy during negotiations.

a. Have you recused yourself from any of TrueMed's governance activities, such as soliciting business partnerships?
b. In your role as an SGE, have you signed an Executive Branch Personnel Public Financial Disclosure Report (OGE Form 278e) and/or a supplemental Periodic Transaction Report (OGE Form 278-T)?[13]
c. What was the nature of your and/or your Board's involvement with the transaction negotiations with The Wellness Company?

Ensuring health care accountability includes guaranteeing that all these conflicts of interest have, in fact, been resolved. If you have any questions or concerns, please do not hesitate to contact my staff, Nikita Varman, at nikita.varman@mail.house.gov or at 202-225-5934.

Thank you for your attention and prompt response.

Sincerely,



Jake Auchincloss

CC: Robert F. Kennedy, Jr., Secretary of the U.S. Department of Health and Human Services

[12] Barnes, Daniel. "Wellness CEO Files Ethics Complaint against Top RFK Jr. Adviser." *Politico*, 12 May 2025, www.politico.com/news/2025/05/12/calley-means-wellness-ethics-complaint-hhs-00342230.
[13] U.S. Office of Government Ethics. "Public Financial Disclosure Guide | Introduction." *USOGE | Introduction*, Nov. 2024, www.oge.gov/web/278eGuide.nsf/Introduction.

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June 16, 2025

Bennett Graham and Board of Directors
Main Street Health LLC
1001 Hawkins Street
Nashville, TN 37203

Dear Mr. Graham and the Board of Directors of Main Street Health,

I write to request information regarding Main Street Health's conflict of interest policies. As Brad Smith, founder of Main Street Health, provided his service to the current Administration, it is critical that the American people have confidence in the integrity of his work and the company's prevention of conflicts of interest.

Based on public reporting, Mr. Smith served as the Department of Government Efficiency (DOGE) lead at the Department of Health and Human Services (HHS)[1] until his reported departure on May 29, 2025.[2] In this role, he was reportedly primarily responsible for planning and executing the sweeping reduction in force (RIF) at HHS. Given the lack of transparency in the manner with which Mr. Smith was hired, and because conflict-of-interest and/or disclosure notices are not publicly available, this request for information will provide clarity regarding his former position in the Administration and how Main Street Health addressed potential or actual conflicts of interest.

For example, the Biden Administration issued a proposed rule, *Contract Year (CY) 2026 Policy and Technical Changes to the Medicare Advantage (MA) Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly* (CMS-4208-P), on November 26, 2024.[3] The Biden Administration's proposed rule included several provisions that were not incorporated in the Trump Administration's final rule published on April 4, 2025.[4] Omissions include the requirement for Medicare Advantage Organizations (MAOs) to conduct annual analyses of utilization management policies, reform of

[1] Cai, Sophia, et al. "Mass Firings Hit Speed Bump at HHS." *Politico*, 31 Mar. 2025, www.politico.com/newsletters/west-wing-playbook-remaking-government/2025/03/31/mass-firings-hit-speedbump-at-hhs-00261614.
[2] Ramachandran, Shalini, and Josh Dawsey. "Elon Musk's Chief Lieutenant at DOGE Leaves Agency." *MSN*, 29 May 2025, www.msn.com/en-us/technology/tech-companies/elon-musk-s-chief-lieutenant-at-doge-leaves-agency/ar-AA1FIU8g?ocid=BingNewsSerp.
[3] 2025. Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)
[4] 2025. Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F)

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MA marketing practices, and the implementation of artificial intelligence guardrails.[5]

The final rule also makes additions, including increased capitated rates for MAOs. The policies included in the final rule are projected to increase payments to MAOs in CY 2026 by $25 billion (5.06 percent on average) compared to CY 2025, resulting in a $21 billion increase in the proposed rule.

In sum, MAOs benefited from the Administration's removal of regulation and enhancement of reimbursement.

Additionally, whistleblowers at HHS have raised important questions regarding transparency and conflicts of interest in the RIF process.[6] One whistleblower stated that Mr. Smith worked closely with senior officials at the Centers for Medicare and Medicaid (CMS) in crafting the RIF plan to reduce the overall impact on CMS — a stark contrast from the RIF's impact on other HHS operating divisions.[7] As you know, he was responsible for cutting 10,000 HHS employees, only 300 of whom were at CMS.

Main Street Health's biggest investors are regulated by or transact with CMS, including some of the largest MAOs: UnitedHealthcare, Centene, CVS Health Ventures, Elevance, and Humana.[8] [9] These MAOs, and Main Street Health investors, benefited not just from the Administration's final rule, but also from Mr. Smith's ability to win favor with CMS by protecting personnel from RIFs.

I write to define for the public interest whether Mr. Smith's role at HHS benefited his business, Main Street Health. Please provide responses to the following questions no later than **Friday, June 27, 2025**.

1. What policies does the Board of Main Street Health have in place to evaluate and avoid ethical concerns and potential conflicts of interest, how long have they been in place, and how are they enforced?

2. Did Mr. Smith recuse himself from Board activities or decisions that may be conflicts of interest while he was involved in the Trump Administration?

3. Was Main Street Health's Board informed if Mr. Smith had or had not signed an Executive Branch Personnel Public Financial Disclosure Report (OGE Form 278e) and/or

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[5] Clements, Christine M, et al. "CMS Issues CY 2026 Medicare Advantage and Part D Final Rule." *National Law Review*, 17 Apr. 2025, natlawreview.com/article/cms-issues-cy-2026-medicare-advantage-and-part-d-final-rule.
[6] Cai, Sophia, et al. "Mass Firings Hit Speed Bump at HHS." *Politico*, 31 Mar. 2025, www.politico.com/newsletters/west-wing-playbook-remaking-government/2025/03/31/mass-firings-hit-speedbump-at-hhs-00261614.
[7] Ibid.
[8] Main Street Health. "Main Street Health Announces $315M Financing Round to Expand into 26 States." *PR Newswire*, 8 Oct. 2023, www.prnewswire.com/news-releases/main-street-health-announces-315m-financing-round-to-expand-into-26-states-301950238 html.
[9] PitchBook. "Main Street Health 2025 Company Profile: Valuation, Funding & Investors." *Main Street Health*, 2025, pitchbook.com/profiles/company/454308-58.

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a supplemental Periodic Transaction Report (OGE Form 278-T)?[10]

4. Did Mr. Smith proactively communicate to the Board about any instance wherein he had recused himself from any decisions at HHS that posed a conflict of interest with his work at Main Street?

5. Did the Board evaluate whether Mr. Smith's role at HHS created a potential conflict of interest or legal liability for Main Street? If so, please provide documentation of that analysis and any conclusions reached.

6. Please describe the nature of your communications with Mr. Smith while he was at HHS. If any of your communications were related to ongoing federal policy issues, particularly the RIFs of HHS, or agency rulemaking, please provide those communications, including but not limited to emails, chat or text messages, board meeting agendas and minutes, and memoranda.

7. Is the Board aware of any involvement by Mr. Smith in the final rule issued April 4, 2025, *Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly* (CMS-4208-F)?

Ensuring health care accountability includes guaranteeing that all these conflicts of interest have, in fact, been resolved. Thank you for your attention and prompt response. If you have any questions or concerns, please do not hesitate to contact my staff, Nikita Varman, at nikita.varman@mail.house.gov or at 202-225-5934.

Sincerely,



Jake Auchincloss

[10] U.S. Office of Government Ethics. "Public Financial Disclosure Guide | Introduction." *USOGE | Introduction*, Nov. 2024, www.oge.gov/web/278eGuide.nsf/Introduction.

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JAKE AUCHINCLOSS
4TH DISTRICT, MASSACHUSETTS

HOUSE COMMITTEE ON
ENERGY AND COMMERCE

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SUBCOMMITTEE ON ENERGY
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June 16, 2025

Justin Mares and Board of Directors
True Medicine Inc.
1800 E 4th Street, Unit 101
Austin, TX 78702

Dear Mr. Mares and the Board of Directors of True Medicine,

I write to request information regarding True Medicine Inc.'s (TrueMed) Board of Directors' conflict of interest policies. As Calley Means, co-founder of TrueMed, continues his service at the Department of Health and Human Services (HHS), it is critical that the American people have confidence in the integrity of his work and your company's prevention of conflicts of interest with the Agency.

Mr. Means was appointed as a White House advisor in March 2025.[1] In this capacity, he serves as "special government employee" (SGE) to HHS Secretary Robert F. Kennedy Jr. and is a leading policy-maker behind the Trump Administration's "Make America Healthy Again," or MAHA initiative.

While Mr. Means' role as an SGE means that he is able to serve in a temporary capacity without having to step away from his personal business or officially obtaining an ethics waiver,[2] it is notable that TrueMed's value has increased nearly three-fold since January 2024. It is not the increasing valuation of TrueMed that raises concerns but its concurrent rise alongside Mr. Means' appointment.[3] Your business stands to benefit from changes to regulation and legislation that your co-founder, Mr. Means, helps guide. In fact, Mr. Means has publicly stated that the role of TrueMed is to route federal funds out of providing for government programs and into expanding HSAs.[4] Given the pattern of self-dealing and conflicts of interest throughout this

[1] Reuters, et al. "White House Names Kennedy Ally Means as Health Adviser, Source Says." Edited by Alan Barona et al., *Reuters*, 18 Mar. 2025, www.reuters.com/world/us/white-house-hires-calley-means-special-government-adviser-bloomberg-news-reports-2025-03-18/.
[2] The White House. "Public Disclosures." *WH.Gov*, 2025, www.whitehouse.gov/disclosures/.
[3] Peterson, Kristina, and Corrie Driebusch. "How RFK Jr. Is Boosting 'Food Babe' and Other MAHA Acolytes." *Wall Street Journal*, 9 May 2025, www.wsj.com/politics/policy/rfk-jr-maha-allies-benefit-3d1a963d.
[4] Ibid.

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administration, [5] [6] [7] [8] [9] the public deserves to know whether TrueMed is operating ethically.

For example, the Republican reconciliation package that recently passed the House (*One Big Beautiful Bill Act*) contained many provisions to significantly expand Health Savings Accounts (HSAs), in line with the services TrueMed offers.[10] Additionally, Executive Order 14212, *Establishing the President's Make America Healthy Again Commission,*[11] included a provision that health agencies must focus on reversing chronic disease by ensuring "the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention," ultimately suggesting increased revenue for companies like TrueMed.

There is also speculation of Mr. Means' conflicts of interest from within the MAHA movement itself. One of TrueMed's competitors has filed an official complaint with the Office of Special Counsel, HHS Office of Civil Rights; HHS Office of Inspector General; and the Federal Trade Commission, on May 12, 2025.[12] This company alleges that Mr. Means used his government position to pressure them into transacting with TrueMed, threatening them with the involvement of National Institutes of Health (NIH) Director Jay Bhattacharya and Secretary Kennedy in negotiations.

Therefore, I write to define for the public interest TrueMed's ongoing relationship with Mr. Means and its conflict of interest policies. Please provide responses to the following questions no later than **Friday, June 27, 2025**.

1. What policies does the Board of TrueMed have in place to evaluate and avoid ethical concerns and potential conflicts of interest, how long have they been in place, and how are they enforced?

2. Can you please describe the nature of your current communications with Mr. Means? If

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[5] Dunleavy, Kevin. "RFK Jr.'s Referral Fees in Litigation over Merck's Gardasil Raise Conflict-of-Interest Questions: Reports." *Fierce Pharma*, 23 Jan. 2025, www.fiercepharma.com/pharma/rfk-jrs-referral-fees-raise-conflict-interest-concerns-nyt.
[6] Backman, Maurie, and Ellen B Kennedy. "Will Dr. Oz Push Medicare Advantage Plans Now That He's Confirmed?" *Kiplinger*, Kiplinger, 27 Feb. 2025, www.kiplinger.com/retirement/medicare/will-dr-oz-push-medicare-advantage-plans-if-confirmed.
[7] Perrone, Matthew. "Takeaways from AP's Report on Financial Interests of RFK Jr. Adviser Who Runs Wellness Platform." *AP News*, AP News, 10 June 2025, apnews.com/article/calley-means-rfk-maha-wellness-ethics-8bbe34cb952f31bb8b6002144bb2b975.
[8] Rascoe, Ayesha, and Will Stone. "Dr. Casey Means, Trump's Pick for Surgeon General, Faces Criticism across the Spectrum." *NPR*, 11 May 2025, www.npr.org/2025/05/11/nx-s1-5393721/dr-casey-means-trumps-pick-for-surgeon-general-faces-criticism-across-the-spectrum.
[9] Karlin-Smith, Sarah. "US FDA Commissioner's Office Plans Involvement in Many Approvals in Potential Major Change." *Citeline News and Insights*, 30 Apr. 2025, insights.citeline.com/pink-sheet/agency-leadership/us-fda/us-fda-commissioners-office-plans-involvement-in-many-approvals-in-potential-major-change-JFPWOQ2VF5D2JAFKXKGK54REZU/.
[10] Eban, Katherine. "The Dizzying Rise of Maha Warrior Calley Means, RFK Jr.'s Right-Hand Man." *Vanity Fair*, 30 May 2025, www.vanityfair.com/news/story/calley-means-rfk-jrs-maha-rise.
[11] Executive Order. No. 14212, 2025.
[12] Barnes, Daniel. "Wellness CEO Files Ethics Complaint against Top RFK Jr. Adviser." *Politico*, 12 May 2025, www.politico.com/news/2025/05/12/calley-means-wellness-ethics-complaint-hhs-00342230.

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any of your communications are or have been related to ongoing federal policy issues or agency rulemaking, please provide those communications, including but not limited to emails, chat or text messages, board meeting agendas and minutes, and memoranda.
    a. These materials would include any discussion of the drafting of the MAHA report and/or the Wellness Company's complaint filed with the Office of Special Counsel, HHS Office of Civil Rights, HHS Office of Inspector General, and the Federal Trade Commission.

3. Did the Board evaluate whether Mr. Means' role at HHS created a potential conflict of interest or legal liability for TrueMed?

4. Is TrueMed aware of whether Mr. Means has or has not signed an Executive Branch Personnel Public Financial Disclosure Report (OGE Form 278e) and/or a supplemental Periodic Transaction Report (OGE Form 278-T)?[13]

5. Has Mr. Means recused himself from any of your organization's governance activities since his appointment as an SGE in the Trump Administration?

6. Has the Board provided feedback or analysis to Mr. Means throughout the drafting, revising, reviewing, or other engagement regarding the Trump Administration's Executive Order entitled, *Establishing the President's Make America Healthy Again Commission* or the *One Big Beautiful Bill Act*?

Ensuring health care accountability includes guaranteeing that all conflicts of interest have, in fact, been resolved. If you have any questions or concerns, please do not hesitate to contact my staff, Nikita Varman, at nikita.varman@mail.house.gov or at 202-225-5934.

Thank you for your attention and prompt response.

Sincerely,



Jake Auchincloss
Member of Congress

[13] U.S. Office of Government Ethics. "Public Financial Disclosure Guide | Introduction." *USOGE | Introduction*, Nov. 2024, www.oge.gov/web/278eGuide.nsf/Introduction.

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Congress of the United States

Washington, DC 20515

April 23, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary, Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Kennedy:

We are writing regarding the Department of Health and Human Services' (HHS) and Department of Government Efficiency's (DOGE) so-called Defend the Spend initiative. We are deeply concerned that this initiative and its abrupt implementation will lead to massive amounts of inefficient bureaucratic red tape.

As reported in the *Washington Post* on April 17, 2025, Defend the Spend is a new layer of bureaucratic review on grants that have already been determined to be meritorious and awarded.[1] Grantees across the country have reached out to me and to my colleagues confused about why requested drawdowns have not paid out. Many received no communication at all about Defend the Spend and thus were unable to comply with new processes for which there was no robust communications strategy or public input. In addition, the *Post* reports that as of April 17, 2025, some HHS agencies have implemented this new process but have not designated individuals to carry out the process, leading to delays in payments.

Furthermore, it is clear that HHS is aware that it is misleading grantees about the current status of drawdown requests. As reported in the *Washington Post* article dated April 17, a National Institutes of Health official was quoted as saying "all funding is on hold" in a meeting that concerned grants. The official went on to be quoted as stating, "the bottom line is no one is getting any money right now. But they don't know they're not getting any money because it just says that it's 'in transit.'"

As of April 21, there was no mention of Defend the Spend on HHS' website. Some grantees have reported receiving emails from defendthespend@hhs.gov with brief instructions; however, instructions have been piecemeal and lacking in detail. The only public communications about Defend the Spend appear to be a pair of tweets from DOGE.[2]

This new and unwarranted imposition of red tape does not appear to provide any meaningful benefit to the government, grantees, or the public. Instead, it requires public servants and grantee institutions to waste time justifying expenditures that have already gone through a rigorous review process.

Please provide answers to the following questions regarding Defend the Spend no later than May 7, 2025:

1. Did HHS identify specific instances of improper payments prior to adding new burdensome steps to the drawdown process? Please detail those improper payments.
2. Did HHS conduct an analysis of the cost and time burden both for the government and for grantees prior to imposing Defend the Spend? If so, what were the findings of this analysis?
3. How has HHS communicated the current status of drawdown requests to grantee institutions? Has HHS clarified to all affected grantees that some drawdowns that appear to be in transit are being held up by Defend the Spend? Please provide copies of all emails, notices, or any other guidance.

[1] https://www.washingtonpost.com/politics/2025/04/17/doge-trump-grants-hhs-nih-backlog/
[2] https://x.com/DOGE/status/1911208855066849712, https://x.com/DOGE/status/1898957551330533797

4. What guidance has HHS provided to grantee institutions about how to make their draws? Please provide copies of all emails, notices, or any other guidance.
5. Who is ultimately responsible for approving drawdowns with respect to grants made by each Operating Division?
6. What factors are considered in whether to approve or deny a drawdown in this new layer of the drawdown approval process? Please provide copies of all emails, notices, or any other guidance detailing the decision making for the new approval process.
7. Are political appointees within HHS, HHS Staff or Operating Divisions, or entities external to HHS (such as DOGE) involved in this process? If so, who and what is their role?
8. Is there an appeals process in place for draws that are improperly denied due to this new process? Please provide copies of all emails, notices, or any other guidance detailing the appeals process.

Furthermore, we reiterate that it is necessary for you to testify in front of Congress immediately. You must answer for the unstudied, unjustified, and often illegal actions that HHS has taken since your confirmation. Congress's oversight authority and your duty to the American people demand no less.

We look forward to your prompt response.

Sincerely,

Diana DeGette
Member of Congress

Debbie Dingell
Member of Congress

Kelly Morrison
Member of Congress

Eleanor Holmes Norton
Member of Congress

Jason Crow
Member of Congress

Robin L. Kelly
Member of Congress

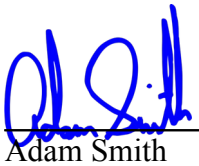
Greg Landsman
Member of Congress



Cleo Fields
Member of Congress



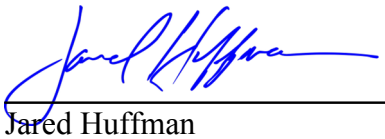
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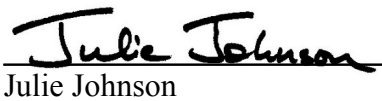
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Rashida Tlaib
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Julie Johnson
Member of Congress



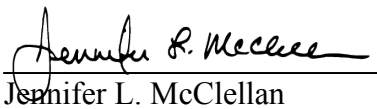
Darren Soto
Member of Congress



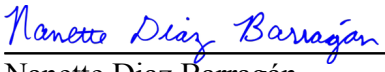
Seth Moulton
Member of Congress



Angie Craig
Member of Congress



Jennifer L. McClellan
Member of Congress



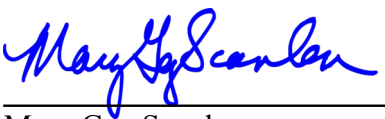
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Member of Congress



Seth Magaziner
Member of Congress



Maxine Dexter
Member of Congress



Mary Gay Scanlon
Member of Congress



Sarah McBride
Member of Congress