Documents for the Record

Subcommittee on Health Hearing

Healthier America: Legislative Proposals to Improve Public Health

April 15, 2026

Majority:

1. April 15, 2026, statement by Eric A. Gehrie, MD, Deputy Chief Medical Officer, New York Blood Center Enterprises.
2. April 15, 2026, statement by Joanne Kurtzberg, M.D., Jerome Harris Distinguished Professor of Pediatrics, Professor of Pathology, Director, Marcus Center for Cellular Cures, Director, Pediatric Blood and Marrow Transplant Program Director, Director Carolinas Cord Blood Bank, Co-Director, Stem Cell Laboratory Duke University School of Medicine.
3. April 15, 2026, statement by the School-Based Health Alliance.
4. April 15, 2026, statement by the American College of Sports Medicine.
5. April 15, 2026, statement by the Physical Activity Alliance.
6. April 15, 2026, statement by the Health & Fitness Association.
7. April 15, 2026, statement by the American Cancer Society Cancer Action Network.
8. April 15, 2026, statement by Susan G. Komen.
9. April 15, 2026, statement by the Medical College of Wisconsin.
10. April 15, 2026, statement by Rep. Christopher H. Smith (NJ-04).

Minority:

1. June 13, 2025, letter to Reps. Balderson, LaHood, Barragán, and Tonko from Alzheimer's Impact Movement.
2. April 15, 2026, statement by ECRI.
3. April 14, 2026, letter to Chairman Griffith and Ranking Member DeGette from the Muscular Dystrophy Association.
4. April 8, 2026, statement by ALS Arizona, et al.
5. April 15, 2026, statement by the American Cancer Society Cancer Action Network.
6. April 14, 2026, letter to Representatives Guthrie and Griffith from the Center for Lyme Action.
7. April 15, 2026, statement by Susan G. Komen.
8. April 15, 2026, statement by the School-Based Health Alliance.

STATEMENT FOR THE RECORD

ERIC A. GEHRIE, MD

DEPUTY CHIEF MEDICAL OFFICER

NEW YORK BLOOD CENTER ENTERPRISES

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

"Healthier America: Legislative Proposals to Improve Public Health"

April 15, 2026

Chair Morgan Griffith, Ranking Member Diana DeGette, and Members of the Subcommittee:

On behalf of New York Blood Center Enterprises (NYBCe), I appreciate the opportunity to submit this statement for the record regarding the vital role of the C.W. Bill Young Cell Transplantation Program and opportunities to ensure its continued effectiveness in a rapidly evolving scientific and public health landscape.

NYBCe strongly supports the mission and success of the C.W. Bill Young Cell Transplantation Program. Historically, this bipartisan initiative had helped save and improve countless lives by expanding access to life-saving transplants, particularly for patients in need of bone marrow donors. As the program is set for reauthorization this year, there is an important opportunity to ensure that the program's policies and requirements remain aligned with current medical evidence, patient needs, and responsible stewardship of limited public health resources.

This statement highlights NYBCe's longstanding contributions to the program, the evolution of cord blood utilization, and the need for greater flexibility in the management of federally supported cord blood inventories.

I. About New York Blood Center

NYBCe is one of the nation's largest nonprofit blood and cellular therapy organizations, serving a population of approximately 75 million people across 16 states. Through a network of community-based blood centers, NYBCe provides a stable and reliable blood supply to more than 400 hospitals nationwide and distributes approximately one million blood products annually.

NYBCe's work extends beyond traditional blood banking. The organization supports over 200 research, academic, and biopharmaceutical partners through cellular therapies, specialty pharmacy services, and medical expertise. Our Lindsley F. Kimball Research Institute is internationally recognized for advancing innovation in hematology, transfusion medicine, immunology, and cell-based therapies.

NYBCe has also played a pioneering role in cord blood banking through our National Cord Blood Program, helping expand access to transplant options for patients who cannot find matched bone marrow donors.

II. Reauthorization and Improving the C.W. Bill Young Cell Transplantation Program

The C.W. Bill Young Cell Transplantation Program represents a model public-private partnership that has delivered measurable success with bipartisan support. Established to support patients who need a potentially life-saving bone marrow transplant or umbilical cord blood transplant, the program has played a critical role in connecting patients with suitable donors and expanding the diversity of the donor pool.

As part of this effort, Congress authorized the development of a National Cord Blood Inventory (NCBI) to supplement bone marrow donations and provide additional options for patients without matched donors. At the time, cord blood represented a promising and innovative therapeutic pathway.

However, since the inception of the NCBI program, significant advances in medical science have reshaped the landscape of stem cell transplantation. Newer approaches, including blood stem cell transplants and novel cell and gene therapies, have expanded treatment options for many blood cancers and disorders. These advances have significantly reduced reliance on cord blood transplants as life saving therapies.

NYBCe has fulfilled all obligations under our contracts with the Health Resources and Services Administration (HRSA), including the collection of more than 14,000 cord blood units. However, cord blood utilization has declined significantly over time. Since 1993, NYBCe has distributed a total of 6,585 cord blood units. More than 80% of these units (5,381) were distributed between 1996 and 2015. After years of steady decline, last year only 49 units were distributed. NYBCe is on track to distribute only 20 units in 2026 – and yet, to date, HRSA has required retention of nearly all of these units in perpetuity.

The requirements involved with comprehensive lifecycle management of the cord blood units include procurement, processing, testing, cryopreservation, storage, and distribution, as well as overhead costs such as IT systems, regulatory compliance, and program management. Maintaining these units requires costly, specialized storage at ultra-low temperatures (< -150°C) and continuous monitoring by highly trained personnel.

NYBCe maintains required testing protocols, including confirmatory typing, infectious disease testing, and annual stability testing and reporting, which further increase operational costs. Efforts to utilize cord blood units for research, clinical trials, and emerging therapies have resulted in limited demand. NYBCe has historically incurred approximately \$9.5 million annually in operating costs. Although the organization has taken drastic steps to reduce costs through outsourcing, still, in 2025, incurred approximately \$4.6 million in operating costs for its cord blood program. Overall, NYBCe has sustained cumulative losses exceeding \$60 million, diverting finite healthcare resources that could instead be better directed to improving the lives of patients and other public health priorities, including strengthening the nation's blood supply, supporting donor recruitment, and advancing innovative therapies.

The cost of maintaining the cord blood units – many of which have aged or are no longer desirable for use – without sufficient compensation is currently too great of a burden for the limited, or in some cases nonexistent, public health benefit. If there is a desire to keep them for an extended period of time, creation of a common, centralized bank for cord blood units could be one approach to mitigating the cost burden of ongoing storage for non-profits like NYBCe.

As with all government contracts, HRSA currently has the requisite authority to modify or terminate the NCBI contracts, and the statute even more explicitly provides that cord blood units should be made available "in perpetuity or for such time *as determined viable by the Secretary*"[1] (emphasis added). Indeed, during the COVID-19 pandemic, HRSA suspended the collection requirements in the NCBI contracts. Yet, to date, HRSA has not exercised its authority to modify or terminate the retention requirement of contracts like those with NYBCe.

As Congress considers reauthorization of the program, we urge you to tailor the existing statute in line with scientific advances since the program's inception. Specifically, we ask that you clarify that HHS and HRSA are required to modify or terminate legacy contractual storage requirements to allow for evidence-based inventory management by trusted partners like NYBCe, enabling them to reduce healthcare costs and better direct resources to benefit public health.

III. Conclusion

NYBCe remains deeply committed to the mission of the C.W. Bill Young Cell Transplantation Program and is proud of its longstanding partnership with HRSA. The program's success reflects its strong bipartisan support. Refining the statute regarding cord blood inventory management will help ensure resources are directed where they have the greatest impact for patients.

NYBCe appreciates the Subcommittee's leadership and continued support for this vital program and looks forward to working together to strengthen and modernize this important public-private partnership.

Submitted for your consideration,

ERIC A. GEHRIE, MD

DEPUTY CHIEF MEDICAL OFFICER

NEW YORK BLOOD CENTER ENTERPRISES

---

[1] Stem Cell Therapeutic and Research Act of 2005, Pub. L. No. 109-129, § 2(a), 119 Stat. 2550 (codified as amended at 42 U.S.C. § 274k note).

Statement of Joanne Kurtzberg, M.D.

Jerome Harris Distinguished Professor of Pediatrics, Professor of Pathology, Director, Marcus Center for Cellular Cures, Director, Pediatric Blood and Marrow Transplant Program Director, Director Carolinas Cord Blood Bank, Co-Director, Stem Cell Laboratory Duke University School of Medicine

Testimony Before the U.S. House of Representatives House Energy and Commerce Committee Health Subcommittee
“Healthier America: Legislative Proposals to Improve Public Health”
Statement in Support of H.R. 5160, the Stem Cell Therapeutic and Research Reauthorization Act

April 15, 2026

Introduction:

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee, I appreciate the opportunity to express my strong support for H.R. 5160, the Stem Cell Therapeutic and Research Reauthorization Act.

My name is Joanne Kurtzberg, and I am a pediatric hematologist/oncologist. My primary focus is on pediatric blood and marrow transplantation, umbilical cord blood banking and transplantation, and novel applications of cord blood and birthing tissues in the emerging fields of cellular therapies and regenerative medicine.

In addition, I serve in multiple roles at Duke University. I am a Distinguished Professor of Pediatrics and Professor of Pathology in the School of Medicine, and the Director of the Marcus Center for Cellular Cures, which is a joint Center of the School of Medicine and the Pratt School of Engineering. I also established and direct the Pediatric Blood and Marrow Transplant Program and am Co-Director of the Stem Cell Laboratory. Finally, I am the Director of the Carolinas Cord Blood Bank, which is an FDA licensed public cord blood bank and a member of the National Cord Blood Inventory (NCBI) of the C.W. Bill Young Cell Transplantation Program. I have dedicated my professional career to cord blood research, banking and transplantation.

I strongly support passage of the Stem Cell Therapeutic and Research Reauthorization Act and want to thank Congressman Chris Smith, Congresswoman Doris Matsui, and Congressman Gus Bilirakis for their leadership on the introduction of the legislation to reauthorize this important program. I also want to thank Subcommittee Chairman Morgan Griffith, Subcommittee Ranking Democratic Member Diana DeGette, Committee Chairman Brett Guthrie, and Ranking Democratic Member Frank Pallone for holding this hearing today.

I want to acknowledge this Committee’s unwavering bipartisan commitment to the creation and support of public cord blood banks, which began when the bill was first introduced in 2005. The original Stem Cell Therapeutic and Research Act of 2005 reflected a compromise between

Congress and the key stakeholder groups deeply interested in establishing cord blood banks for public use. This legislation not only reauthorized the National Marrow Donor Program (NMDP) but also created a national network of public cord blood banks. It also provides health care professionals the ability to search for unrelated bone marrow donors and cord blood units through a single electronic point of access, the "Be the Match" registry, which is operated by NMDP.

All of us involved in advancing the 2005 bill shared a common purpose: expanding patient access to the most effective therapies available. Through close collaboration, we worked together to have this legislation approved by Congress and ultimately secured its enactment into law by the President. The 2005, 2010, 2015, and 2021 reauthorization bills were approved by both the House and the Senate with overwhelming support.

In the U.S. House of Representatives, the late Congressman Bill Young, Congressman Chris Smith and Congresswoman Doris Matsui made significant contributions – without their leadership, our progress to date would not have been possible. All of us who have worked on this program over the last 21 years are grateful for your longstanding dedication and look forward to working with members of this Subcommittee to advance this important legislation.

The bill that we are discussing today reauthorizes both the NCBI Program and the C.W. Bill Young Cell Transplantation Program from Fiscal Year 2027 through Fiscal Year 2031. The NCBI would be reauthorized at $23 million each year and the C.W. Bill Young Cell Transplantation Program would be reauthorized at $33 million each year.

The National Cord Blood Inventory

The National Cord Blood Inventory (NCBI) was created in 2006 as part of the C.W. Bill Young Cell Transplantation Program after passage of the Stem Cell Therapeutic and Research Act of 2005. The C.W. Bill Young Program was designed to expand access to transplantation for patients without a suitable related donor by increasing the size of the donor pool, ultimately enabling more unrelated donor blood stem cell transplants to be performed each year. This goal was approached through a series of contracts from HRSA to the National Marrow Donor Program (NMDP) and to selected high-quality U.S. public cord blood banks. The NCBI was established to build a national network of cord blood banks, increase the availability of high-quality and diverse umbilical cord blood units, add at least 150,000 new units to the registry, and expand access to units for research. Additional priorities under the C.W. Bill Young Program included establishing the Cord Blood Coordinating Center (CBCC), which provides financial support to NCBI banks to help make units available more quickly. NCBI contracts are awarded and negotiated by the Health Resources and Services Administration (HRSA), while the CBCC contract is awarded through a competitive Request for Proposal process and has historically been held by the NMDP.

Cord blood, or the baby's blood remaining in the placenta can be collected after the birth of the baby without risk to the mother or baby. In fact, in the past, cord blood was routinely discarded as medical waste. With the discovery that cord blood contained important stem cells of the blood as well as other types of therapeutic cells, collection of cord blood for banking and later use in medical therapies is now common practice. Cord blood can be collected after a vaginal or cesarean section delivery. Generally, collections are performed within 10 minutes of the birth of the baby. After collection, cord blood is transported to a processing laboratory where it is qualified, volume and red blood cell-reduced, and frozen at ultra-cold temperatures for long-term storage. Today, we know that cord blood units can be stored for over 25 years and successfully used for transplantation of patients with blood cancers and certain genetic diseases. Each cord blood unit is tested to ensure that the proper numbers of cells were collected, that the cells are alive, sterile, and potent (capable of restoring the blood forming system in a patient whose system was destroyed by treatment and or disease). Mothers donating their babies' cord blood are screened to be sure they do not have any infectious or genetic diseases that can be transmitted through the blood. Public cord blood banks recruit and educate mothers to donate their babies' cord blood so that it can be distributed to patients in need of a donor for blood stem cell transplantation. Qualified cord blood units are listed on the NMDP "Be the Match" registry and distributed through the NMDP from banks to transplant centers for use in patients.

A goal of adding 150,000 high quality unrelated donor cord blood units to the national registry was established by the original legislation. This number was based on assumptions about HLA (Human Leukocyte Antigens) matching that would allow for 50% of patients to identify a 5/6 matched donor, and 90% to identify a 4/6 matched donor. To support accrual of cord blood units towards this goal, the NCBI was authorized to receive approximately $90 million during the first 5-year authorization cycle; however, the amount appropriated to this program has been woefully inadequate. It is my hope that the current and future congressional appropriations process will recognize the importance of fully investing in the NCBI program to ensure the collection of the largest and most diverse units.

Cord Blood Licensure

The original legislation also called for the establishment of guidelines for licensure of unrelated donor cord blood banks by the Food and Drug Administration (FDA). Multiple hearings occurred and draft guidance for licensure was issued and finalized. Today, seven of the original NCBI banks have been granted licenses from FDA and five continue to operate under the NCBI. The process of obtaining and maintaining licensure has been challenging for the public banks. Many existing regulations—originally designed for drug manufacturing—do not translate well to cord blood, where each unit effectively represents a single "batch." Requirements such as expiration dating, requalification of FDA-approved materials, and lengthy approval timelines for manufacturing changes can hinder innovation and slow progress. In addition, licensure has significantly increased the cost of public cord blood banking, diverting limited resources away from donor recruitment, collection, and the banking of new units.

Brief history of cord blood banking and transplantation

In the mid-1980s, Hal Broxmeyer and others showed that cord blood contained high numbers of young blood stem cells. In fact, cell for cell, cord blood was highly enriched for these blood forming stem cells as compared to bone marrow, the traditional source of these types of cells. Shortly after these observations were reported, a cord blood transplant was planned for a five-year-old boy with Fanconi Anemia (a genetic disease affecting the blood and leading to bone marrow failure, or leukemia, and death in the first decade of life) under my care at Duke. The boy's mother conceived a healthy child who was a full match to her brother. A team of physicians and scientists in New York City and at Duke arranged for the cord blood to be collected at the time of the sibling's birth and later, for the transplant to be performed by Dr. Eliane Gluckman at L'Hospital St. Louis, in Paris, France. The transplant, performed in 1988, was a success and laid the foundation for the field. The patient, named Matthew, is now 43 years of age, living a healthy, productive life. Importantly, he is fully engrafted with his younger sister's cord blood cells and is living proof that cord blood contains blood stem cells that can repopulate the bone marrow (blood factory) and immune system for life.

After that transplant, others were performed between siblings, confirming the findings of the first transplant. In addition, cord blood transplants are associated with significantly lower rates of graft-versus-host disease (GVHD), a serious complication in which donor cells attack the recipient and a major barrier to successful blood stem cell transplantation. This reduced risk led to the hypothesis that cord blood could be used more effectively in unrelated donor settings and may not require as close a match as bone marrow. This is especially important for patients who are unable to find a fully matched donor.

In 1992, Dr. Pablo Rubinstein established the first unrelated cord blood bank at the New York Blood Center with support from the National Heart, Lung, and Blood Institute (NHLBI) at the National Institutes of Health (NIH). I founded the pediatric blood and marrow transplant program at Duke in 1990 and collaborated with Dr. Rubinstein, agreeing to use cord blood units from his bank for transplantation.

In 1993, we performed the world's first unrelated donor cord blood transplant at Duke in a young child with refractory leukemia. The transplant successfully engrafted despite a partial match at only four of six key markers. In the years that followed, additional transplants at Duke and other centers demonstrated the effectiveness of cord blood in treating a range of conditions, including blood cancers, bone marrow failure, congenital immune deficiencies, inherited metabolic disorders, and hemoglobinopathies such as sickle cell disease and thalassemia. In 1996, Congress funded the NHLBI to expand public cord blood banking and study the use of cord blood in blood stem cell transplantation. Through the COBLT (Cord Blood Transplantation) Program, NHLBI issued Requests for Proposals to support the creation of three additional public cord blood banks in the United States and five multicenter prospective clinical trials evaluating cord blood for unrelated transplantation.

On behalf of Duke, I applied for and was awarded one of the banking contracts, leading to the establishment of the Carolinas Cord Blood Bank in 1997. I also served as a principal investigator for the COBLT clinical studies and as a member of the steering committee for both the banking and transplantation initiatives. This committee helped establish early standards for cord blood banking and initial guidelines for its use in transplantation.

Since then, the field has advanced significantly, with the development of innovative donation models, automated processing techniques, and improved assays to assess cord blood viability and potency. Early experience with cord blood transplantation revealed that many units did not contain a sufficient cell dose for a single adult recipient. This led to the establishment of minimum cell dose requirements based on patient weight for those undergoing myeloablative conditioning, which destroys the bone marrow and immune system. It also became clear that the volume of cord blood obtainable from a single placenta is inherently limited, leaving many collected units too small for larger children and adults.

In response, investigators at the University of Minnesota, Drs. John Wagner and Juliet Barker, pioneered the use of two cord blood units for a single transplant in adults in 2005. This approach proved successful and expanded access to transplantation for larger patients, though it also increased costs by requiring two units per procedure. Between 2005 and 2010, the double cord blood transplant approach was evaluated in a multicenter, Phase III trial in pediatric patients with acute leukemia conducted by the Blood and Marrow Transplant Clinical Trials Network (BMT CTN). Dr. John Wagner and I served as principal investigators. The study demonstrated that a single cord blood unit is sufficient for children when it contains an adequate cell dose; in fact, those receiving two units experienced higher rates of graft-versus-host disease (GVHD).

In adults, however, double cord blood transplantation remains in practice, despite its association with increased GVHD and higher costs. Strategies to increase the numbers of cells provided by a single cord blood unit are the subject of active and ongoing scientific investigation. Ex vivo expansion (or expanding stem cells in the laboratory) before infusion to the patient is showing great progress. At least five promising technologies are currently undergoing testing in the clinic under INDs from FDA. One of these technologies has been proven to accelerate engraftment of cord blood in a phase 3 registration trial and a BLA for this technology was approved for the product Omisirge (Gamida Cell, International). These modified cord blood products engraft (or grow back) more rapidly after transplant as compared to unmodified cord blood. For example, average times to engraftment after a standard cord blood transplant range from 20-27 days. With ex vivo expansion, engraftment times have decreased from 25-35 days to 7-15 days. Omisirge is approved as a donor for patients with leukemia and, more recently, severe aplastic anemia, under the same BLA. Additional technologies that improve homing of cord blood cells to the bone marrow are also being tested.

Today, cord blood is a well-established graft source for unrelated donor blood stem cell transplantation, expanding access for patients who lack a matched related or unrelated adult donor. It has been particularly important for patients of minority ancestry, who are less likely to find fully matched donors. Its lower risk of graft-versus-host disease (GVHD) is a key advantage, and more recent evidence demonstrates that cord blood transplantation is associated with lower relapse rates in adult and pediatric patients with high risk acute leukemias compared to other graft sources. In addition, cord blood remains an important option for pediatric patients needing rapid transplants who are diagnosed through newborn screening with metabolic, bone marrow failure and immunodeficiency disorders. It is also an important donor source for patients with sickle cell disease, for whom blood stem cell transplantation can be curative. However, there are challenges to the success of cord blood transplantation. While engraftment might occur more slowly than with bone marrow or peripheral blood, resulting in longer hospitalizations, and immune recovery—derived from a newborn source—may also be delayed. These limitations can be mitigated in part by using licensed and larger cord blood units. However, ensuring that these units represent a cross section of all Americans remains critical. Furthermore, the 150,000 unit target may be outdated today. Rather than targeting a specific number for the inventory, the largest and most diverse units should be targeted. As such, funding strategies should be readjusted to enable increased collections and banking of the largest, and most genetically diverse units.

The potential of cord blood in cellular therapies and regenerative medicine

Beyond its established role in treating malignant and genetic diseases, cord blood is demonstrating significant promise in the emerging fields of cellular therapy and regenerative medicine. Cord blood–derived allogeneic immunotherapies and vaccines targeting viruses and certain cancers are currently in development and early-phase clinical trials. In addition, cells manufactured from cord blood are being explored to accelerate immune recovery, reduce leukemic relapse, and treat life-threatening opportunistic infections in recently transplanted patients.

Regulatory T cells derived from cord blood are also under investigation in early clinical trials for their potential to modulate autoimmune diseases including Type I diabetes. In addition, cord blood is used as source material for manufacturing of immune effector cells, like CAR-T cells, CAR-NK cells, cytotoxic T cells, and others. We are also developing uses for cord blood to treat acquired brain disorders. Over the past eleven years, trials of autologous (the patient's own) and allogeneic (sibling and unrelated publicly banked cord blood units) cord blood in babies with birth asphyxia (hypoxic ischemic encephalopathy), cerebral palsy, hearing loss, and autism. These studies are showing promising results in conditions for which few treatments are available. We now realize that it will never be possible for all patients who might benefit from cord blood therapies to have access to their own cord blood. For this reason, we demonstrated that the use of donor cord blood was safe in adults with acute ischemic stroke. We then tested donor cord blood in children with autism and cerebral palsy and completed phase 2 studies describing efficacy in these diseases. Moreover, the infrastructure established by FDA-licensed public cord blood banks has enabled the procurement of GMP-compliant source material for the manufacture of cord tissue–derived mesenchymal stromal cells (MSCs) and other non-hematopoietic cell therapies. These products are being developed to treat a range of pro-inflammatory conditions, including graft-versus-host disease (GVHD) and complications associated with acute hypoxic brain injury.

Summary

In summary, cord blood has demonstrated enormous potential as a donor source for blood stem cell transplantation, expanding access for patients who lack a fully matched related or unrelated adult donor. In addition, cord blood and cord tissue–derived cells are playing an increasingly important role in the emerging fields of cellular therapy and regenerative medicine. Successful use depends on careful collection practices that ensure sterility, minimize disease transmission, and maximize cell yield. While banking techniques are well established, continued efforts to improve cell recovery and expansion are critical. Advances in expansion technologies are particularly promising, with the potential to reduce transplant risks and broaden access to patients with chronic but serious conditions such as sickle cell disease. Cord blood–derived therapies are also showing encouraging results in treating pediatric brain injuries and hold promise for adults with stroke and other debilitating conditions.

The NCBI program has established a robust inventory of high-quality, genetically diverse cord blood units for patients in need of transplantation. Continued support and reauthorization are essential to expand both the number of banked units with high cell doses. As new therapeutic applications emerge, the NCBI will play a vital role in ensuring patient access to these life-saving and life-enhancing treatments.

Conclusion

On behalf of patients across the country and around the world, I urge Congress to reauthorize both the NCBI and the C.W. Bill Young Cell Transplantation Program by approving H.R. 5160, the Stem Cell Therapeutic and Research Reauthorization Act. I look forward to working with Subcommittee members and key stakeholders of the cord blood banking community—patients, physicians, transplanters, cellular therapists, researchers and cord blood banks—to ensure that this important bill is signed into law this year.

Chairman Griffith, Ranking Democratic Member DeGette, and members of the Subcommittee, thank you for the opportunity to share my support for H.R. 5160, the Stem Cell Therapeutic and Research Reauthorization Act.

SCHOOL-BASED
HEALTH ALLIANCE
The National Voice for School-Based Health Care

Written Statement of the School-Based Health Alliance

Submitted to the United States House Energy and Commerce Committee
Subcommittee on Health in regard to the
Healthier America: Legislative Proposals To Improve Public Health Hearing
April 15, 2026
10:15 a.m. 2132 Rayburn House Office Building

Adriane Van Zwoll, PhD, LCSW, LMSW
Vice President
School-Based Health Alliance
1032 15th Street, NW; Suite 365
Washington, D.C. 20005

Introduction

Chairman Griffith, Ranking Member DeGette, and members of the House Energy and Commerce Committee Subcommittee on Health, thank you for the opportunity to submit this statement on behalf of the School-Based Health Alliance (SBHA) for the subcommittee's hearing "Healthier America: Legislative Proposals To Improve Public Health." I am excited to share with you all the impact school-based health centers (SBHCs) have on student health care.

SBHCs provide the nation's vulnerable students and youth with access to primary care, behavioral health, oral health, and vision care, where they spend most of their time – at school. SBHCs operate through partnerships with health care organizations, school communities, community-based organizations, families, and youth. This collaboration, care coordination, and youth engagement improve students' health literacy and outcomes, as well as those of their families, school staff, and the community, and contribute to positive educational outcomes, including reduced absenteeism, fewer disciplinary actions, and improved graduation rates.

Today, the subcommittee will consider several bills that address fundamental issues in student well-being and educational success. Food security, mental health, and behavioral health supports are not optional—they are essential to ensuring that students can learn, thrive, and succeed. SBHCs play a critical role in meeting these needs, serving as trusted, accessible providers for thousands of students and families across the country. However, SBHCs can only fulfill this role when they are equipped with adequate resources and sustained support. Continued federal investment, including the support proposed in H.R. 8209, is vital to strengthening SBHCs and ensuring they can continue delivering essential services to students, families, and the communities they serve.

About the School-Based Health Alliance

Since 1995, the School-Based Health Alliance, a 501(c)(3) nonprofit corporation, has supported and advocated for high-quality healthcare in schools for the nation's most vulnerable children. Working at the intersection of healthcare and education, the School-Based Health Alliance is a recognized leader in the field and a source for information on best practices for philanthropic, federal, state, and local partners and policymakers.

At the School-Based Health Alliance, we've worked for over 30 years to:

- Advance national policy and legislative priorities for the field
- Advocate for greater support and funding
- Promote high-quality clinical practices and standards
- Support data collection and reporting, evaluation, and research
- Provide training, technical assistance, and consultation

National Landscape of School-Based Health Centers

At present, approximately 4,000 school-based health centers across the nation provide primary, behavioral, dental, and vision care, as well as other support services, to students in poor and underserved urban, rural, and suburban communities at school. Most of the 4,000 centers delivering this evidence-based model are in Title I schools. However, there are nearly 60,000 Title I schools nationwide, and the majority of them do not currently have a school-based health center to address students' critical needs. With only 6.5% of the nation's approximately 60,000 Title I schools served by SBHCs, students in more than 56,000 schools remain without access to the health care they need to learn, grow, and thrive, representing a significant opportunity to expand student-centered care.

Nationwide, Federally Qualified Health Centers (FQHCs) sponsor more than half of all SBHCs. The remaining centers are sponsored by hospital systems, public health agencies, nonprofits, and some school districts directly. FQHC sponsors are financially advantaged compared to other sponsor types because they benefit from the Prospective Payment System (PPS) rate for Medicaid reimbursement, which is often significantly higher than that for other Medicaid providers. In addition, FQHCs benefit from robust federal funding through the Section 330 Health Centers Program. The funds being discussed today in H.R. 8209 provide FQHCs within the 330 Health Centers Program access to important resources dedicated to expanding SBHCs.

Importance of Investment in SBHCs

By providing services at school as part of a public-private partnership, SBHCs are a convenient and efficient access point to health care in a setting that families are familiar with and trust. In many rural schools, the SBHC is the nearest community health provider for miles, providing critical access to students and families, school staff, and community members. This convenience means less time taken off work for parents and school staff to travel to medical appointments, as well as increased seat time for students who can return to class after receiving health care services. SBHCs regularly provide patient-centered care that is responsive to the needs of local communities, including parents, and providers actively engage parents and promote parental involvement while obtaining parental consent for their child to receive care.

For decades, SBHCs have demonstrated their positive impact on students, schools, communities, and the health care system. Students who use SBHCs are less likely to visit the emergency room or be hospitalized, particularly for asthma. Academically, SBHCs help increase attendance, improve school climate, and support student achievement. SBHCs sometimes also respond to injuries and illnesses on school grounds, provide critical early intervention and prevention services, and help students with chronic conditions manage their health. Additionally, by facilitating positive, early interactions with health care providers, SBHCs promote lifelong health literacy and exposure to careers in health care for young people – all of which are critical to securing a healthy and prosperous future for our nation.

SBHCs are funded by third-party sponsors and aim to sustain their operations through billing and third-party revenue. The costs of startup and expansion can often be a significant barrier for sponsoring organizations running SBHCs as they seek to meet their communities' needs. Federal appropriations directed to SBHCs in the Health Center Program have helped fill some of these gaps in services expansion and startup costs. The need is still significant, and one that the federal government should continue to provide to federally qualified health centers interested in opening or expanding SBHCs.

SBHCs received $5 million in 2020 from the federal government, marking the first federal appropriation directed at establishing and supporting SBHC expansion. The appropriation increased annually from $5 million at inception up to $55 million in FY24, where it has remained. Appropriations support for SBHCs has drawn bipartisan support each year. H.R. 8209 ensures that federally qualified health centers interested in operating SBHCs will continue to receive these critical federal investments through fiscal year 2031. These funds play an integral role in the growth of SBHCs across the nation, improving access for our nation's most at-risk students and their families.

Mental and Behavioral Health Support at SBHCs

Today's students face a variety of stressors that negatively impact their mental health and ability to succeed. The Centers for Disease Control and Prevention’s (CDC) *Youth Risk Behavior Survey Data Summary & Trends Report: 2013 – 2023* found that 40% of students have persistent feelings of sadness or hopelessness. Furthermore, 20% of students seriously considered attempting suicide, and 9% attempted suicide, painting a distressing picture of the mental health of students. SBHCs are a proven, evidence-informed model for addressing the full spectrum of youth mental health and substance use needs, from prevention and early identification to treatment and care coordination. Located directly in schools, SBHCs reduce longstanding barriers to care such as transportation, cost, and stigma, ensuring students can access services where they already spend most of their time. More than 80% of SBHCs nationwide provide behavioral health services, delivered either in-person or via telehealth, making them one of the key access points for youth mental health care. SBHCs are uniquely positioned to identify concerns early through routine screenings, provide brief interventions, and deliver ongoing therapy, psychiatric care, including evaluation and medication management, and substance use services. This integrated, school-based approach increases utilization of mental health services among young people and supports improved academic outcomes, attendance, and overall well-being, while reducing reliance on emergency departments and crisis systems.

SBHCs operate through interdisciplinary staffing models that commonly include licensed mental health professionals such as social workers, psychologists, and counselors, alongside primary care providers and, in some cases, psychiatrists or other psychiatric providers and substance use specialists. This team-based structure allows SBHCs to deliver comprehensive, coordinated care that addresses both physical and behavioral health needs. Services may include universal prevention programming, mental health education, screening and assessment, individual and group therapy, psychiatric evaluation and medication management, substance use counseling, crisis intervention, and care coordination with families and community providers. SBHCs also support schools by providing effective alternatives to suspension through on-site behavioral health interventions that keep students engaged in learning while addressing underlying needs. In addition, SBHCs serve as a critical bridge to higher levels of care when needed, connecting students to specialty services such as intensive outpatient programs or inpatient treatment. By embedding clinical expertise within the school environment while maintaining strong partnerships with community health systems, SBHCs ensure continuity of care beyond the school day and across settings, creating a more responsive, efficient, and youth-centered behavioral health system.

Nutrition Education and Food Security Through SBHCs

School-Based Health Centers (SBHCs) also play an important role in promoting healthy nutrition and preventing diet-related conditions among children and adolescents through integrated, patient-centered services. Nutrition assessment, education, and counseling are routinely incorporated into well-child visits and ongoing care, consistent with established clinical guidelines and captured through Uniform Data System (UDS) reporting. SBHCs support students with individualized nutrition counseling as well as broader prevention efforts that promote healthy eating habits and overall wellness. Nutrition services are also integrated into the management of chronic conditions such as obesity, diabetes, and hypertension, ensuring that dietary counseling is part of comprehensive care. Many SBHCs utilize interdisciplinary models that may include primary care providers, registered dietitians, and community health workers, and prioritize culturally and linguistically appropriate education materials alongside ongoing provider training.

At the same time, SBHCs are uniquely positioned to address food insecurity as a key driver of health outcomes by integrating screening and resource connection into routine care. The School-Based Health Alliance's partnership with Share Our Strength's No Kid Hungry campaign demonstrates how SBHCs can operationalize this work at scale. Since 2022, this collaboration has supported SBHCs nationwide in embedding food security screening, referrals, and follow-up into clinical workflows, reinforcing their role as trusted community anchors at the intersection of health and education. In 2024, a national learning and dissemination effort, including webinars, technical assistance, and a comprehensive survey, found that 86% of SBHCs screen for food insecurity, 87% provide referrals to nutrition supports, and 69% track follow-up to some degree. These efforts help normalize conversations about food access, reduce stigma, and strengthen connections to critical programs such as school meals, SNAP, and local food resources. However, SBHCs continue to face barriers, including limited awareness among families, stigma, competing priorities, and a lack of sustainable funding, with 60% of respondents reporting no dedicated funding stream for food security work. Sustained federal investment in staffing, training, data systems, and cross-sector partnerships is needed to ensure SBHCs can continue to integrate nutrition care and food access supports, so that every student identified as needing assistance receives timely, meaningful support.

Conclusion

Every day, students come to school hungry, sick, and face challenges that keep them from being productive learners. School-based health care is part of the solution to keeping youth healthy and ready to learn. The simple fact is that healthy kids learn and grow better. By providing direct access to primary care, mental health, behavioral health, food security support, oral health, vision care, and more, SBHCs give students the opportunity to reach their full potential while relieving stress for families and bolstering communities. Thank you, Chairman Griffith and Ranking Member DeGette, for the opportunity to share this information with the committee.

AMERICAN COLLEGE OF SPORTS MEDICINE

Statement of the American College of Sports Medicine
Submitted to
House Committee on Energy and Commerce
Subcommittee on Health
Hearing on
Healthier America: Legislative Proposals to Improve Public Health.
April 15, 2026

About the American College of Sports Medicine

The American College of Sports Medicine (ACSM) is the largest sports medicine and exercise science organization in the world. With more than 50,000 members and certified professionals globally, ACSM is dedicated to educating and empowering professionals to advance the science and practice of health and human performance.

Our vision is to extend and enrich lives through the power of movement. As the founding organization and leader in the "Exercise is Medicine" initiative, ACSM works tirelessly to ensure that physical activity is considered a standard part of disease prevention and treatment in the United States healthcare system.

H.R. 6121, the Promoting Physical Activity for Americans Act

H.R. 6121, the Promoting Physical Activity for Americans Act, is a vital piece of bipartisan legislation designed to provide a permanent, stable framework for federal physical activity guidelines. Specifically, the bill:

- **Codifies Regular Updates:** Directs the Secretary of Health and Human Services (HHS) to publish a report every ten years titled "Physical Activity Recommendations for Americans" based on the latest scientific evidence.
- **Ensures Contemporary Relevance:** Requires a mid-decade "midcourse report" five years after each full set of recommendations to highlight best practices and address emerging issues or specific demographic needs.
- **Establishes Scientific Continuity:** Formalizes the process ensuring that physicians, educators, and lawmakers have access to reliable, updated

standards for all age groups and populations without relying on ad-hoc administrative action.

The Critical Importance of Physical Activity for Americans
The urgency of this bill cannot be overstated. Physical inactivity remains a leading driver of chronic disease and escalating healthcare costs in our nation. Consider the following:

- **Economic Impact:** Inactivity is linked to more than $100 billion in annual healthcare costs. Investing in preventive movement is a direct investment in the fiscal health of our national budget.
- **Chronic Disease Prevention:** Regular physical activity that is of a sufficient amount, intensity, and type can significantly reduce the risk of type 2 diabetes, cardiovascular disease, hypertension, many types of cancer (including breast and colon cancer), and can reduce the likelihood of developing obesity. These effects appear to be present across the lifespan and health span. In head-to-head comparative effectiveness trials, exercise has demonstrated larger effects in most cases when compared to pharmaceuticals.
- **Mental Health and Brain Function:** Movement is a proven tool for reducing anxiety and depression, improving sleep, and protecting the aging brain. Regular physical activity stimulates the brain's own waste-clearance system, reducing the buildup of proteins linked to Alzheimer's disease.
- **Military Readiness:** Data from a recent study show that 77% of American youth (16 to 24 years of age) aren't qualified for military service without waivers. The good health and human performance of armed forces personnel remain central to the defense of the United States and its allies.
- **Current Participation Gaps:** Recent data shows that only about 47% of U.S. adults meet federal guidelines for aerobic activity. Even more concerning, sedentary lifestyles among youth contribute to a nearly 20% obesity rate in children, threatening the long-term health of the next generation.

Conclusion

Physical activity is a fundamental pillar of public health. By passing H.R. 6121, Congress will ensure that our national health policy is guided by the best available science, providing every American with the roadmap they need to lead an active, healthy, and productive life. ACSM strongly urges the Committee to support this common-sense, life-saving legislation.

References and Sources

1. **Centers for Disease Control and Prevention (CDC).** (2024). *Health and Economic Benefits of Physical Activity.*
2. **U.S. Department of Health and Human Services (HHS).** *Physical Activity Guidelines for Americans, 2nd edition.*
3. **American College of Sports Medicine (ACSM).** *Exercise is Medicine® Initiative: Supporting Physical Activity in Clinical Care.*
4. **National Center for Health Statistics (NCHS).** *Percentage of Adults Meeting Physical Activity Guidelines: United States, 2020-2024.*
5. **The Lancet Public Health.** *The Global Economic Burden of Physical Inactivity: A Analysis of Healthcare Expenditure.*

PHYSICAL ACTIVITY ALLIANCE
MOVE WITH **US**

Statement for the Record

Physical Activity Alliance (PAA)
Submitted by Mike Stack, President
U.S. House Energy & Commerce Committee
Subcommittee on Health

Hearing on H.R. 6121 – Promoting Physical Activity for Americans Act

Submitted electronically, April 15, 2026

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

The Physical Activity Alliance (PAA) respectfully submits this statement for the record in strong support of H.R. 6121, the Promoting Physical Activity for Americans Act. PAA is a coalition of leading national organizations dedicated to advancing policies that increase physical activity and improve the health of all Americans. As President of the Alliance, I am pleased to provide this submission on behalf of our members and partners committed to elevating physical activity as a central pillar of preventive health in the United States.

This legislation represents a critical and timely step toward ensuring that physical activity is appropriately recognized, elevated, and consistently guides preventive health in the United States.

The United States continues to face an escalating crisis of chronic disease, driven in large part by physical inactivity. Physical inactivity costs the U.S. healthcare system an estimated **$192 billion every year**, 12.6% of total national health care spending.[1] It is one of the leading risk factors for heart disease, diabetes, depression, and premature death. Only about 25% of U.S. adults and 20% of youth currently meet federal physical activity guidelines.[2]

According to the Centers for Disease Control and Prevention (CDC), more than 40 percent of U.S. adults have obesity, significantly increasing their risk for heart disease, type 2 diabetes, certain cancers, and other serious health conditions.[3] Chronic diseases account for the overwhelming majority of healthcare spending in the United States, placing an unsustainable burden on families, employers, and federal programs.

---

[1] Matjasko, JL., Chen, Z., Whitfield, GP., Whitsel, LP., Rose, K., Roy, K. Inadequate aerobic physical activity and healthcare expenditures in the United States: An updated cost estimate. American Journal of Health Promotion. July 2025. https://doi.org/10.1177/08901171251357128

[2] U.S. Department of Health and Human Services. (2018) Physical Activity Guidelines for Americans, 2nd Edition. Retrieved from https://odphp.health.gov/paguidelines/second-edition/pdf/Physical_Activity_Guidelines_2nd_edition.pdf

[3] Emmerich SD, Fryar CD, Stierman B, Ogden CL. Obesity and severe obesity prevalence in adults: United States, August 2021–August 2023. NCHS Data Brief, no 508. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/159281

Physical activity must be understood not as an optional lifestyle choice, but as essential preventive health with supportive infrastructure and investment. As one of the few interventions that simultaneously improves physical health, mental well-being, and long-term healthcare costs, physical activity empowers individuals to engage in their health in ways that are accessible, adaptable, and personal, whether through structured exercise, community-based programs, or everyday movement. Ensuring Americans have clear, science-based guidance is fundamental to driving meaningful health outcomes at scale.

The Physical Activity Guidelines for Americans, last updated in 2018, serve as the nation's authoritative, evidence-based recommendations for physical activity. They inform clinical practice, public health initiatives, education systems, and community programs across the country. However, unlike other cornerstone federal health guidelines, there is currently no statutory requirement to ensure these guidelines are regularly reviewed and updated. As a result, updates remain subject to administrative discretion, creating uncertainty and risking misalignment with the latest science.

H.R. 6121 establishes a regular, at a minimum ten-year cycle for updating the Physical Activity Guidelines and grounding that process in statute. Codifying this process will ensure long-term continuity and credibility of federal guidance; keep federal guidance aligned with evolving science; strengthen integration of physical activity into healthcare and prevention strategies; support consistent implementation across states, health systems, and communities; and elevate physical activity as a national priority in addressing chronic disease and healthcare costs. It also sends a clear and necessary signal that physical activity is not secondary, but central to improving the health of the nation.

Since the release of the 2018 guidelines, the scientific understanding of physical activity has continued to evolve. One of the most important developments is the growing body of evidence supporting the critical role of muscle-strengthening activities. Strength training is now widely recognized as essential for improving metabolic health, supporting healthy body composition and weight management, enhancing insulin sensitivity, preserving bone density, and promoting functional independence and healthy aging. Despite this evidence, strength training remains underappreciated and often underemphasized in public health messaging. A structured and recurring scientific review process is necessary to ensure that future guidelines fully reflect these advancements and provide clear, actionable recommendations to the public.

H.R. 6121 is a commonsense, bipartisan solution that will modernize how the United States approaches physical activity and prevention. By codifying a regular update process for the Physical Activity Guidelines, Congress can ensure that everyone has access to the most current, evidence-based physical activity recommendations.

On behalf of the Physical Activity Alliance, I strongly urge Congress to advance this legislation. Doing so will elevate physical activity as a central pillar of preventive health and help equip Americans with the tools they need to lead healthier lives.

Thank you for your leadership and your commitment to improving the health of the nation.

Respectfully submitted,

Michael Stack

Michael Stack
President
Physical Activity Alliance (PAA)

HEALTH & FITNESS ASSOCIATION

Statement for the Record
Health & Fitness Association (HFA)
Submitted to the U.S. House Energy & Commerce Committee
Subcommittee on Health

Hearing on H.R. 6121 – Promoting Physical Activity for Americans Act

Submitted electronically, April 15, 2026

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

The Health & Fitness Association (HFA) respectfully submits this statement for the record in strong support of H.R. 6121, the Promoting Physical Activity for Americans Act.

HFA is the leading trade association representing the health and fitness industry, including thousands of fitness facilities, studios, and industry partners across the United States. Our members serve tens of millions of Americans each year, providing accessible, community-based environments that empower individuals to improve both their physical and mental health through regular physical activity. Across the country, the health and fitness industry functions as a national network of preventive health infrastructure, helping Americans translate intention into action through structured programs, professional guidance, and community engagement.

Physical activity is one of the most effective tools available to improve population health and reduce healthcare costs, yet it remains underutilized across the United States. Only about one in four Americans meets recommended physical activity levels, contributing to rising rates of chronic disease, increased healthcare spending, and preventable loss of life. In 2019, physical inactivity was linked to approximately $192 billion in U.S. healthcare costs, or approximately 12.6% of annual healthcare spending. As a major driver of conditions like heart disease, diabetes, obesity, and depression, physical inactivity contributes to premature mortality and diminished quality of life.[1] At the same time, physical activity is uniquely effective in that it improves both physical and mental health, supports healthy aging, and reduces long-term healthcare expenditures.

Meanwhile, more Americans are increasingly recognizing the value of physical activity as a core component of their preventive health. Today, more than 81 million Americans hold a fitness facility membership, the highest level ever recorded, with total participation exceeding 100 million individuals. This sustained growth reflects a clear and encouraging trend: each year,

---

[1] Matjasko JL, Chen Z, Whitfield GP, Whitsel LP, Rose K, Roy K. Inadequate Aerobic Physical Activity and Healthcare Expenditures in the United States: An Updated Cost Estimate. *American Journal of Health Promotion*. 2025;39(7):1085-1087. doi:10.1177/08901171251357128

more Americans are choosing to engage in structured physical activity and incorporate movement into their daily lives. This increase in participation reflects a growing understanding of the powerful role physical activity plays in preventing chronic disease and improving overall health, driven in part by federal efforts to communicate clear, evidence-based guidance. The Physical Activity Guidelines for Americans are central to that effort, and ensuring they are regularly updated and elevated in federal policy is essential to sustaining and accelerating this progress.

The health and fitness industry plays a central role in supporting this shift by providing accessible, scalable solutions at the community level. Fitness facilities serve as front-line access points for preventive health, offering structured environments that improve adherence to physical activity while fostering the social connection and accountability necessary for long-term behavior change. These facilities enable Americans to engage in physical activity in ways that are personal, flexible, and sustainable, reinforcing that access and environment are critical drivers of health outcomes.

Recent data from HFA's 2026 U.S. Health & Fitness Consumer Report further underscores the public health value of this infrastructure.[2] Fitness facility members are twice as likely to meet or exceed recommended physical activity guidelines as Americans who do not use fitness facilities. In addition, only 5% of members report no weekly physical activity, compared to 33% among non-users — a seven-fold difference. These findings demonstrate that individuals who engage with fitness facilities are significantly more likely to achieve meaningful health outcomes. Fitness facilities are not simply places of recreation; they are essential community-based access points that drive consistent, habitual physical activity across diverse populations.

The Physical Activity Guidelines for Americans serve as the federal government's authoritative, evidence-based resource on physical activity, fitness, and health, developed by the U.S. Department of Health and Human Services in coordination with leading federal health agencies. These guidelines inform clinical practice, shape public health initiatives, guide state and local programs, and provide the scientific foundation for national efforts to improve population health. They also serve as a global benchmark, influencing international standards and reinforcing the United States' leadership in evidence-based health policy.

The importance of regularly updating the Guidelines is further underscored by the rapidly evolving nature of science, medicine, and how Americans engage with their health across different stages of life. The Guidelines must reflect not only age-specific needs but also emerging trends in clinical care and population health. For example, when the current Guidelines were released in 2018, GLP-1–based medications were not being used anywhere near the scale they are today. These therapies are now reshaping how millions of Americans approach weight management and metabolic health. However, growing evidence shows that without sufficient physical activity—particularly resistance training—patients using these medications may experience significant loss of lean muscle mass, which can negatively impact long-term health, metabolism, and functional strength. A regular, science-driven update process for the Physical Activity Guidelines will ensure that federal recommendations keep pace with these developments, provide clear guidance to clinicians and patients, and fully reflect the

---

[2] Health & Fitness Association. *2026 U.S. Health & Fitness Consumer Report*. Washington, DC: Health & Fitness Association; 2026.

critical role of physical activity in modern preventive and therapeutic care.

Despite their importance, the Physical Activity Guidelines are not codified in statute and are not subject to a required update cycle. Their development and release remain dependent on administrative priorities rather than a consistent, science-driven process. This stands in contrast to the Dietary Guidelines for Americans, which are codified in statute and updated on a consistent five-year cycle, ensuring that nutrition guidance remains current, evidence-based, and fully integrated into federal health programs and policy decisions.

This disparity creates uncertainty, limits long-term planning, and risks misalignment with the evolving body of scientific evidence. It also sends the wrong signal about the role of physical activity in improving health outcomes. Physical activity is equally fundamental to health as nutrition. Both are primary drivers of chronic disease prevention, essential tools for clinicians and public health leaders, and critical to improving long-term health outcomes and controlling healthcare costs. Yet today, only one benefits from the certainty, consistency, and prioritization that comes with a statutory requirement.

H.R. 6121 addresses this gap by establishing a regular, science-driven process for reviewing and updating the Physical Activity Guidelines. Codifying this process will ensure alignment with the latest scientific evidence, provide consistency and predictability for federal, state, and private sector stakeholders, strengthen the integration of physical activity into healthcare and prevention strategies, and elevate physical activity as a national priority in addressing chronic disease.

The United States cannot effectively address its chronic disease crisis without fully leveraging the power of physical activity. The science is clear, the infrastructure exists, and the data show that when Americans have access to supportive environments like fitness facilities, they are far more likely to be active and healthy. The continued growth in participation demonstrates that Americans are increasingly embracing physical activity as a cornerstone of preventive health, and federal policy should reflect and support that reality.

On behalf of the Health & Fitness Association and the broader health and fitness industry, which represents a primary channel through which the Physical Activity Guidelines are translated into real-world action, we strongly urge Congress to advance H.R. 6121. Doing so will help ensure that Americans have access to clear, current, evidence-based guidance and the community-based infrastructure necessary to translate that guidance into action.

Thank you for your leadership and your commitment to improving the health of the nation.

Respectfully submitted,

Mike Goscinski
Chief of Staff

AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

STATEMENT FOR THE RECORD

FOR THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE,

SUBCOMMITTEE ON HEALTH

HEARING ON

HEALTHIER AMERICA: LEGISLATIVE PROPOSALS TO IMPROVE HEALTH

APRIL 15, 2026

The American Cancer Society Cancer Action Network expresses our strong support of the Young Women's Breast Health Education and Awareness Requires Learning Young Act, also called the EARLY Act, sponsored by U.S. Representatives Debbie Wasserman Schultz (D-FL), Mariannette Miller-Meeks (R-IA), Kathy Castor (D-FL), Brian Fitzpatrick (R-PA), Debbie Dingell (D-MI), and Diana Harshbarger (R-TN). Enactment of this bipartisan bill could have a critical impact on saving more women's lives from breast cancer and improving their survivorship.

As the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, our volunteers know all too well about the increase in breast cancer diagnoses in younger women. Women are navigating their treatment and survivorship in the prime of their lives. These are women who may be considering starting families or are already taking care of children at home; whose parents have reached an age where they need support; and who are navigating their careers and community responsibilities.

ACS CAN stands with our volunteers. We are working together to make cancer a top priority for public officials and candidates at all levels of government and advocate for evidence-based public policies to reduce the burden of cancer for everyone. Together, we want to ensure every woman diagnosed with breast cancer does not just survive breast cancer, but goes on to live happy, productive, and fulfilling lives.

Incidence and Mortality of Breast Cancer

Thanks to decades of cancer research discovery, innovation and implementation of proven clinical and public health strategies, cancer in general is becoming less of a death sentence and more of a treatable chronic disease, and in many cases preventable. This progress means that 7 in 10 people diagnosed with cancer can celebrate their 5-year survivorship anniversary compared to just 1 to 2 people 50 years ago.[1]

Despite these incredible gains, far too many people will be diagnosed with cancer this year, including 321,910 women who will hear the words "you have breast cancer."[2] Breast cancer is the leading cause of cancer incidence and second leading cause of cancer mortality in women.[3] This year alone, we will lose 42,140 women to this terrible disease.[4]

When we look at trends in breast cancer incidence rates specifically, we see deeply troubling increases since the mid 2000's, especially among women younger than 50 years old and among women of Asian American, Pacific Islander or Hispanic heritage:

- On average, breast cancer incidence increased by 1% per year over the past decade.[5]
- For women younger than 50, breast cancer incidence has increased at a steeper pace at 1.4% per year, compared to 0.7% per year for women over 50 years old.[6]

---

[1] American Cancer Society. Cancer Facts & Figures 2026. Atlanta: American Cancer Society; 2026.

[2] Cancer Facts & Figures 2026.

[3] Cancer Facts & Figures 2026.

[4] Cancer Facts & Figures 2026.

[5] Cancer Facts & Figures 2026.

[6] Siegel RL, Kratzer TB, Wagle NS, Sung H, Jemal A. Cancer statistics, 2026. CA Cancer J Clin. 2026;e70043. doi:10.3322/caac.70043.

- For Asian American, Native Hawaiian, or other Pacific Islander women, breast cancer incidence has increased by 2.7% per year and by 2.4% per year for women who are Hispanic.[7]

While incidence rates are increasing, when we look at trends in breast cancer mortality rates, we've seen a 44% overall decline over the last three decades.[8] This translates to 546,000 fewer breast cancer deaths. Contributing to this achievement is both advances in treatment and early detection through screening. But this progress has not been experienced by everyone.

- For American Indian and Alaska Native women, mortality rates have not improved at all during this time and Black women are 37% more likely to die from breast cancer than White women, even though they are diagnosed at lower rates.
- Also, Black women have a lower survival rate at every breast cancer stage than women of any other racial or ethnic group.[9]
- Among women younger than 50 years old, breast cancer is the leading cause of cancer death.[10]

Young women may have unique breast cancer risk factors, early detection, treatment and survivorship needs. For example:

---

[7] Cancer statistics, 2026.

[8] Cancer Facts & Figures 2026.

[9] Giaquinto AN, Sung H, Newman LA, et al. Breast cancer statistics 2024. CA Cancer J Clin. 2024;74(6):477-495. doi:10.3322/caac.21863.

[10] Siegel RL, Wagle NS, Jemal A. Leading Cancer Deaths in People Younger Than 50 Years. JAMA. 2026;335(7):632–634. doi:10.1001/jama.2025.25467.

- Aggressive breast cancers, like triple-negative breast cancer, are more common in younger women and in Black women.
- Women diagnosed with breast cancer at younger ages are more likely to be carriers for BRCA gene mutations, which increases breast cancer risk.
- Discussion of symptoms and diagnosis can be challenging for young women because providers are not expecting cancer in this age group.
- Treatment can greatly impact quality of life, including fertility and development of co-morbidities for women who live many years – hopefully decades – after their treatment.

While the reasons for the rising number of cases of breast cancer in young women are complex and multifactorial, it is important for women and their providers to be aware of the increased rates of breast cancer, understand their risks and how to mitigate them; and if diagnosed, have access to appropriate treatment and survivorship support .

Need to Reauthorize EARLY Act

The EARLY Act provides a 5-year reauthorization of the life-saving programming at the Centers for Disease Control and Prevention (the CDC) that provide the public awareness and provider training programs critically needed to address the unique needs of young women who have breast cancer and those at risk of breast cancer.

The EARLY Act supports the *Bring Your Brave* campaign which uplifts the stories of young women to raise public awareness of breast cancer in this younger population. As we at ACS CAN also know, peer-to-peer support and real stories backed with fact-based information are proven impactful in helping people understand their risk of cancer and to drive them to take action. This innovative campaign tailors its messages through social media, podcasts, and streaming platforms, and with content creators and other partnerships to best reach its distinct audience, which is women 18 to 44 years old. For example, the CDC consulted on a multi-season early onset breast cancer storyline on the tv show *Superman & Lois*, which resulted in a 33 percent increase in good searches for “breast cancer support groups” after Clark attended a support group, 1.3 million visits to the CDC’s breast cancer-related webpages, and resulted in a Sentinel Award for its depiction of breast cancer.[11] CDC develops resources, tools and programs specifically for young breast cancer survivors and their families through strategic partnerships.

The EARLY Act supports provider training and education in addition to public education and survivor support resources. Providers are often not considering the risk of breast cancer in young women given its relatively low numbers, despite increasing incidence rates. To support providers and improve breast cancer outcomes, the CDC develops and supports provider training and education, including continuing education courses[12], focusing on improving primary care skills and confidence in understanding and managing the risks of breast cancer in young women. In 2017 and 2020 alone, CDC launched continuing medical education (CME) opportunities on early onset breast cancer for health care providers and issued 7,000 CME

---

[11] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024 & Bring Your Brave Campaign Updates

[12] Centers for Disease Control and Prevention. *Bring Your Brave* Campaign. Accessed April 9, 2026. https://www.cdc.gov/bring-your-brave/hcp/education/index.html

certificates.[13] Additionally, through a collaboration with the American College of Obstetricians and Gynecologist (ACOG), two 7-credit e-modules on early onset breast cancer were extensively developed. As a result, more than 21,000 CME credits were awarded and 1,477 nursing continuing education unit credits were awarded.[14]

The EARLY Act established the Advisory Committee on Breast Cancer in Young Women, a federal advisory committee that provides expert guidance to the Secretary of Health and Human Services and CDC leadership in the development and implementation of age-appropriate and culturally responsive messaging, public education, survivor support, and provider education and training programs and resources for women under 40. The work of the Committee ensures that the unique risks, experiences, and needs of young women, including those at heightened or hereditary risk, are systematically integrated into national breast cancer prevention and early detection efforts. The Committee's work strengthens the scientific quality, relevance, and reach of CDC initiatives, helping translate research into life-saving actions.

The programs and resources provided in the EARLY Act are not only designed to contribute to the survivability of breast cancer for young women by increasing their and their providers' knowledge of risks and how to mitigate them but also inspire young women to serve as trusted messengers for other young women across the nation. Reauthorization of the EARLY Act is

---

[13] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024

[14] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024

essential to providing stability for its programs and the opportunity to deepen its impact at a time when breast cancer trends in young women are going in the wrong direction.

Without the EARLY Act, more young women and their providers may be left in the dark about their risk of breast cancer, and opportunities for life-saving interventions will be lost. Reauthorization of the EARLY Act is necessary to ensure continued timely access to fact-based information, training, and public awareness, which can help improve breast cancer outcomes among this younger population.

Thank you for the opportunity to submit this statement for the record in strong support for the EARLY Act. We urge you to pass the bill as quickly as possible to help us in the fight to end breast cancer as we know it, for everyone.

Statement for the record from Susan G. Komen on *Healthier America: Legislative Proposals to Improve Public Health.*
United States Committee on Energy and Commerce Health Subcommittee
April 15, 2026

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Health Subcommittee,

I write today on behalf of Susan G. Komen (Komen) to provide the following written comments in response to the April 15, 2026, U.S. House Committee on Energy and Commerce Health Subcommittee Hearing, *Healthier America: Legislative Proposals to Improve Public Health*. Specifically, we write in support of H.R. 4541, the EARLY Act Reauthorization of 2025.

Komen is the world's leading nonprofit breast cancer organization representing the millions of people who have been diagnosed with breast cancer. Komen has an unmatched, comprehensive 360-degree approach to fighting this disease across all fronts – we advocate for patients, drive research breakthroughs, improve access to high quality care, offer direct patient support and empower people with trustworthy information. Komen is committed to supporting those affected by breast cancer today, while tirelessly searching for tomorrow's cures. We advocate on behalf of the estimated 324,600 people in the United States who will be diagnosed with breast cancer and the 42,670 who will die from the disease in 2026 alone.

Breast Cancer in Young Women

Recent data points to increased breast cancer diagnoses in younger women. Between 2012-2022, the breast cancer incidence rate in women under 50 has risen faster than in women over 50. Additionally, women under 40 are nearly 40% more likely to die from breast cancer than women over 40.[1] Compared to breast cancers in older women, breast cancers in younger women are more likely to be fast growing, higher grade, and hormone receptor-negative – each of these factors makes breast cancer more aggressive and more likely to need chemotherapy.[2]

All of this supports the need for the reauthorization of the programs which have been created as a result of the EARLY Act.

EARLY Act Reauthorization of 2025

H.R. 4541, the EARLY Act Reauthorization of 2025, is bipartisan, bicameral legislation that would reauthorize and allow for the continued funding of the Breast Cancer Education and Awareness

---

[1] Breast Cancer Research Foundation. 5 Facts About Breast Cancer in Younger Women. Available at https://www.bcrf.org/about-breast-cancer/breast-cancer-young-women/.

[2] Susan G. Komen. Unique Issues for Women Under 40 with Breast Cancer. Available at https://www.komen.org/breast-cancer/treatment/by-diagnosis/young-women-and-breast-cancer/.

Requires Learning Young Act (EARLY Act), which requires the Department of Health and Human Services (HHS) to provide breast cancer education and support for young women. The EARLY Act first passed in 2010 and was reauthorized in 2014 and 2020. The authorization is set to expire at the end of this year, 2026.

Komen strongly supports H.R. 4541, which would reauthorize the EARLY Act for an additional five years. Specifically, it would reauthorize three programs administered by the Centers for Disease Control and Prevention (CDC), *Bring Your Brave*, Young Breast Cancer Survivors Program, and continuing medical education courses for health care providers about breast cancer. Between 2019 and 2023, EARLY Act programs reached over 48.8 million young breast cancer survivors, metastatic breast cancer patients, caregivers, and family members providing almost 36.5 million resources and tools.

The *Bring Your Brave* Campaign, which launched in 2015, is a web-based campaign to educate young women at risk of or living with breast cancer.[3] The Campaign, housed on the CDC's website, includes stories about young women whose lives have been affected by breast cancer, facts and statistics related to breast cancer in young women, information about risk factors, and tips on what someone can do to lower their breast cancer risk. As of March 2025, the *Bring Your Brave* Campaign has resulted in 231 million impressions across social media, blogs, search engines, digital display, and earned media; nearly 12.4 million video views, nearly 2 million social media engagements and nearly 2.9 million visits to *Bring Your Brave* web pages.

The Young Breast Cancer Survivors Program, housed in the CDC's National Comprehensive Cancer Control Program, focuses on supporting young breast cancer survivors and people living with metastatic breast cancer. Most recently, in 2024, under this program, CDC funding allowed for structured support services and resources for this community through partnership with community organizations.[4] Thanks to our investment in finding improved early-detection and treatment methods, the number of cancer survivors is steadily increasing. But being a breast cancer survivor comes with a unique set of needs, including managing effects of breast cancer treatment (e.g. bone health, declining cognitive function, lymphedema) and the fear of and risk of breast cancer recurrence, including understanding and taking action related to needed follow-up and screenings.[5] Young breast cancer survivors often must also contend with additional challenges including career disruption and potential impacts on fertility. Living with metastatic breast cancer (MBC) – also known as stage 4 or advanced breast cancer that has

---

[3] U.S. Centers for Disease Control and Prevention. *Bring Your Brave* Campaign. Available at https://www.cdc.gov/bring-your-brave/index.html.

[4] U.S. Centers for Disease Control and Prevention. (2024 November 12). Young Breast Cancer Survivors Program. Available at https://www.cdc.gov/comprehensive-cancer-control/related-programs/young-breast-cancer-survivors.html.

[5] Susan G. Komen. Breast Cancer Survivorship. Available at https://www.komen.org/breast-cancer/survivorship/.

spread beyond the breast to affect other parts of the body – is likewise extremely complex. An estimated 170,000 individuals are living with MBC in the US.[6] While MBC cannot be cured, thanks to treatment advances, MBC is now considered to be a livable disease, but again, this community faces its own challenges. The average five-year survival rate for those diagnosed with MBC is only 30% and most of the nearly 43,000 people who will die from breast cancer in 2026 will die from MBC.

Lastly, the EARLY Act has helped provide for continuing medical education (CME) for health care providers related to young women and breast cancer. The *Bring Your Brave* Campaign is home to a provider education component, providing free content for health care providers related to early onset breast cancer. Based on data from February 2020 – February 2022, the *Bring Your Brave* Campaign CME component, which operates in partnership with Medscape, resulted in 29,007 learners, 11,654 test-takers, 10,050 CMS certificates issued, and 20,0430 CME credits.[7] Additionally, in 2020, the CDC partnered with a professional organization to develop a free online course series, Understanding Early Onset Breast Cancer.[8] These CME courses are available to women's health care clinicians, including obstetrician-gynecologists, family physicians, nurses, nurse practitioners, physician assistants, and genetic counselors. Healthcare providers have completed more than 6,000 courses since the online learning platform was launched in 2020.[9]

Conclusion

Komen thanks the Subcommittee for including H.R. 4541, the EARLY Act Reauthorization, in this hearing and urges the Committee to advance this important legislation. Please consider Komen to be a resource on anything related to breast cancer. Please reach out to Valerie Nelson, Komen's Manager of Federal Policy and Advocacy, at VNelson@komen.org, with any questions or for additional information.

Sincerely,

Molly L. Guthrie

Molly Guthrie

---

[6] Susan G. Komen. Treatments for Metastatic Breast Cancer. Available at https://www.komen.org/breast-cancer/metastatic/metastatic/.

[7] U.S. Centers for Disease Control and Prevention. (2022 August 23). Update from CDC: Public health's response to early onset breast cancer. Available at https://www.cdc.gov/cancer/breast/pdf/acbcyw-melillo-08232022-508.pdf

[8] American College of Obstetricians & Gynecologists. Early Onset Breast Cancer (EOBC) Education. Available at https://www.acog.org/education-and-events/courses/early-onset-breast-cancer-education

[9] U.S. Centers for Disease Control and Prevention Stacks. (2024 March 18). Centers for Disease Control and Prevention Justification of Estimates for Appropriation Committees Fiscal Year 2025. Available at https://stacks.cdc.gov/view/cdc/177367.

Vice President, Policy & Advocacy
Susan G. Komen

MEDICAL
COLLEGE
OF WISCONSIN

TO: **The Honorable Members of the House Committee on Energy and Commerce, Subcommittee on Health**

FROM: **Bronwen Shaw, MD, PhD**
Chief Scientific Director, CIBMTR MCW
Research Director for the SCTOD
Co-PI of the CIBMTR Data Resource U24 grant
Professor of Medicine, Medical College of Wisconsin

J. Douglas Rizzo, MD, MS
Senior Scientific Director, CIBMTR MCW
Principal Investigator of the SCTO,
Professor of Medicine at MCW
Associate Director of Clinical Operations for the Froedtert and MCW Cancer Center

DATE: **April 15, 2026**

RE: **Support for H.R. 5160 (119th Congress), to Reauthorize the Stem Cell Therapeutic and Research Act of 2005**

The Medical College of Wisconsin (MCW) applauds Representatives Smith and Matsui for authoring this critical legislation, and Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Griffith, Vice Chair Harshbarger, Ranking Member DeGette, and Members of the Subcommittee for hearing testimony on H.R. 5160, to reauthorize the C.W. Bill Young Cell Transplantation Program (the Program), ensuring Americans who need hematopoietic cell transplants (HCT) can find a donor *and* trust the outcomes.

The current federal infrastructure is a tremendous success story; Facilitating seamless, lifesaving access and long-term support for patients in vital need of urgent care.

The Center for International Blood and Marrow Transplant Research (CIBMTR) contracts with HRSA through its MCW campus to operate the Stem Cell Therapeutic Outcomes Database (SCTOD). CIBMTR provides critical functions within this contract to serve as a comprehensive national resource that enables ongoing research, accountability, and continuous improvement in patient outcomes. CIBMTR is charged with:

- Collecting data and analyzing every allogeneic transplant performed nationally; Including procedures performed globally using U.S. products
- Publishing center-specific one-year survival analyses providing patients, providers, and payers transparent decision-making ability
- Providing data and quality reports to support US cord blood bank quality and regulatory reporting, research and other initiatives

- Making nearly 150 de-identified datasets available for secondary research, and fulfilling 100+ time-sensitive analyses annually via the CIBMTR's Information Request Service,

The CIBMTR (supporting essential functions like the SCTOD) plays a critical role in refining transplantation practices and expanding access to life-saving therapies. By systematically capturing real-world data, it informs clinical decision-making, supports regulatory and payor coverage policies, and accelerates innovation that allows more patients to live longer, healthier lives. Studies completed by the CIBMTR in the last several years using the Database have led to changes in transplant procedures that expanded use partially matched related and unrelated donors. A very tangible national benefit of this research is the availability of a suitable donor option for nearly all patients with common blood cancers - creating nearly universal access (or availability)

Continued innovation is improving outcomes, and the SCTOD is critically important to continue these advances.

The CIBMTR collaborates closely with the NMDP (formerly *Be the Match)* to seamlessly operate several components of the CWBYCTP like a single system. NMDP manages the national registry (donor recruitment, search coordination, cell collections and distribution, and patient support), and the CIBMTR provides mandated accountability. Running these functions in parallel ensures the CWBYCTP is safe and effective.

The CIBMTR's infrastructure and research program serves more than the CWBYCTP. Its reach includes:

- **320+** transplant center partners nationwide
- **750,000+** patients with outcomes data held since inception
- **~35,000** new patients registered annually
- **2,000+** peer-reviewed publications, establishing CIBMTR as the field's primary source of real-world evidence and quality benchmarking

Additionally, CIBMTR data and infrastructure is used to support other important federally funded research and policy objectives; providing enhanced value to the federal government's contract with CIBMTR. For example, CIBMTR supports CMS Coverage-with-Evidence Development efforts; collaborates with CMS to support the CGT Access Model data requirements; collects data to meet FDA required 15-year follow up for patients receiving CAR-T cells and gene therapy; and other critical activities. MCW co-manages the NIH-funded Blood and Marrow Transplant Clinical Trials Network Data and Coordinating Center (with NMDP and Emmes).

CIBMTR is proud of its track record delivering on-time, on-budget performance over two decades. CIBMTR has maintained continuous authorization to operate IT systems supporting the CWBYCTP; sustained uninterrupted public reporting; and progressively modernized a system that also connects NIH trials infrastructure, CMS policy initiatives, and 320+ reporting centers.

Thank you for your consideration of H.R. 5160. MCW respectfully requests your support for this legislation. For more information, please contact Nathan Berken, MCW Vice President of Government Relations at 414.955.8588, or nberken@mcw.edu.

04/15/2026

Healthier America: Legislative Proposals to Improve Public Health

Statement from Rep. Christopher H. Smith, NJ-04

Thank you Chairman Griffith, Vice Chair Harshbarger, and Ranking Member DeGette for holding this hearing on proposals to improve public health and giving me the opportunity to submit a statement in support of two bills, HR 4348, to reauthorize the Kay Hagan Tick Act, and HR 5160, the Stem Cell Therapeutic and Research Reauthorization Act of 2025.

As you know, cases of Lyme disease have skyrocketed across the country. In 2023, the CDC recorded 476,000 cases of Lyme nationwide, including over 7,200 in my home state of New Jersey, a 22% increase from the previous year. Although our federal response has markedly improved since I first became involved with the issue in 1991, there is an urgent need to build on existing successes and ensure sustained investment in research and prevention efforts on both the state and federal level.

Notably, ticks that transmit Lyme are now found in all of the 48 contiguous U.S. states and in 50% of U.S. counties. It is critical that Congress support nationwide efforts to train public health officials to identify Lyme and monitor potential outbreaks in new regions. To that end, I urge my colleagues to take prompt action to reauthorize the Kay Hagan Tick Act.

The original Kay Hagan Tick Act, an effort I led in 2019 with my then-Lyme Caucus co-chair Collin Peterson in the House and Susan Collins, Agnus King, and Tina Smith in the Senate, created the largest whole-of-government national strategy to combat Lyme and other tick-borne diseases. What ultimately resulted was the 2024 National Strategy to Prevent and Control Vector-Borne Diseases in People, a groundbreaking plan to track and mitigate vector-borne disease outbreaks and diagnose and treat the pathogens they spread. The National Strategy also identified concrete public health goals, including reducing the number of Lyme cases 25% from 2022 to 2035. In order to make progress on these goals, continued collaboration and federal support are crucial.

The Kay Hagan Act also authorizes $10 million in funding for five years for regional centers of excellence, which coordinate with academia and local public health agencies to conduct research on Lyme outbreaks in their areas and train public health professionals to identify and treat Lyme. These centers of excellence have trained thousands of professionals and students on vector control and authored research on suppression of ticks and their associated pathogens. Sustained funding will ensure that these centers can provide guidance to local agencies and organizations and provide greater insights into both successes and challenges of containing Lyme within their respective regions.

Finally, the Kay Hagan Act authorizes $20 million for grants for states and localities at high risk of Lyme to identify and respond to tick outbreaks. These grants allow state public health departments to bolster their data collection and public awareness efforts, ultimately building a robust public health infrastructure that can respond quickly to outbreaks and provide quality information and care to patients.

Chairman Griffith and I recently joined Secretary Kennedy and Administrator Oz at a Lyme Disease roundtable at HHS, where the Secretary maintained the Trump Administration's commitment to ongoing federal support for Lyme research, with the ultimate aim of developing better diagnostics and therapeutics. The Secretary announced the full renewal of the LymeX Innovation Accelerator, a groundbreaking public-private partnership between HHS and the Steven & Alexandra Cohen Foundation focused on the development of diagnostics, reaffirming the President's commitment to fighting chronic illnesses and boosting innovation. Congress must reauthorize the Kay Hagan Tick Act to ensure that our public health apparatus is adequately equipped to monitor, treat, and prevent Lyme.

I thank my Lyme and Tick-Borne Disease Caucus Co-Chair Lloyd Doggett as well as original cosponsors Mr. Kean and Mr. Tonko for their continued efforts. I thank the Committee for your consideration and ask that you promptly move this critical legislation.

The C.W. Bill Young Cell Transplantation Program, operated by NMDP, provides a single point of access for patients needing lifesaving transplants, allowing them to search an integrated nationwide network of bone marrow donors and cord blood stem cells. Through the registry, Americans have access to more than 42 million potential adult donors worldwide and760,000 cord blood units. NMDP has facilitated nearly 150,000 lifesaving transplants.[1]

NCBI contracts with cord blood banks to collect umbilical cord blood units donated after mothers give birth. It has currently banked nearly 119,000 units. The C.W. Bill Young Cell Transplantation Program then makes these umbilical cord blood units available.

God, in His wisdom, created a placenta and umbilical cord that not only nurtures an unborn child but leaves behind something very special: umbilical cord blood that is rich with lifesaving stem cells.

---

[1] NMDP. Accessed March 9, 2026. https://www.nmdp.org/

Breathtaking scientific breakthroughs have shown that the stem cells within umbilical cord blood are valuable for research, regenerative medicine, and transplantation. They have been used to treat over 75 diseases—including leukemia, lymphoma, and sickle cell disease—and hold significant promise for research into future research and cures.[2]

Today's bill is the fourth reauthorization of the Stem Cell Therapeutic and Research Act of 2005, a law that I sponsored joined by Artur Davis of Alabama. It expanded on the excellent work of Bill Young of Florida to facilitate bone marrow transplants and create a new national umbilical cord blood donation and transplantation program.

As we consider reauthorization, I want to thank the Americans who have given the gift of life to others through bone marrow or peripheral blood stem cells, as well as mothers who have donated umbilical cord blood. You are at the heart of the success of these programs.

H.R. 5160 authorizes $33 million for each of fiscal years 2027 through 2031 to ensure that thousands of present-day and future patients benefit from the exciting field of regenerative medicine.

I want to thank Chairman Guthrie for bringing this bill forward today. I am also deeply grateful to original cosponsors Ms. Matsui, Mr. Bilirakis, Ms. Pingree, Ms. Tenney, and Mr. Mfume for their important contributions.

---

[2] National Marrow Donor Program. "The Cord Blood Donation Process and FAQs." Accessed February 26, 2025. https://www.nmdp.org/getinvolved/join-the-registry/donate-cord-blood/cord-blood-donation-process

ALZHEIMER'S IMPACT MOVEMENT
ALZHEIMER'S ASSOCIATION

The Honorable Troy Balderson
United States House of Representatives
2429 Rayburn House Office Building
Washington, D.C. 20515

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

The Honorable Darin LaHood
United States House of Representatives
503 Cannon House Office Building
Washington, D.C. 20515

The Honorable Paul Tonko
United States House of Representatives
2269 Rayburn House Office Building
Washington, D.C. 20515

June 13, 2025

Dear Representatives Balderson, Barragán, LaHood and Tonko:

On behalf of the Alzheimer's Association and the Alzheimer's Impact Movement (AIM), including our nationwide network of advocates, thank you for your continued leadership on issues and legislation important to Americans living with Alzheimer's and other dementia, and to their caregivers. The Alzheimer's Association and AIM write today to strongly support the Accelerating Access to Dementia & Alzheimer's Provider Training (AADAPT) Act, H.R. 3747, which will empower primary care providers to better diagnose Alzheimer's and other dementia and deliver high-quality, person-centered care in community-based settings.

Over 7 million Americans are living with Alzheimer's, and by 2050, this number is expected to rise to nearly 13 million. Alzheimer's is one of the costliest conditions in the United States. In 2024, total payments for all individuals with Alzheimer's or other dementia are estimated at $360 billion (not including unpaid caregiving). By 2050, these costs are projected to rise to nearly $1 trillion. Only half of those living with Alzheimer's disease are diagnosed, and of those, only half are told of their diagnosis. An early and accurate diagnosis cannot be ignored; it can significantly improve an individual's treatment and enhance quality of life.

Primary care providers are often the first point of contact for many people concerned with their cognitive abilities. With specialists often backlogged when accessible at all, primary care must be better equipped to detect and diagnose causes of dementia directly. In 85 percent of cases, the initial diagnosis of Alzheimer's disease is made by clinicians who are not dementia specialists, usually primary care providers. Recent studies show that half of primary care physicians do not feel adequately prepared to care for individuals living with Alzheimer's and other dementia. Quality care delivered by trained providers leads to better health outcomes for individuals and caregivers and puts less strain on health systems. Yet, too often, overburdened primary care providers are unable to access the latest patient-centered dementia training.

The AADAPT Act would provide grants to providers participating in structured Alzheimer's and dementia education and support programs, expanding access for people in rural, frontier, and medically underserved areas to receive the diagnosis, care, and support they need from providers they already know. These grants aim to address the knowledge gaps and workforce capacity issues faced by primary care providers as they see an increasing population living with Alzheimer's disease and other dementia.

The Alzheimer's Association and AIM deeply appreciate your continued leadership on behalf of all Americans living with Alzheimer's and other dementia. If you have any questions about this or any other legislation, please contact Jennifer Pollack, Director of Access Policy, at jpollack@alz-aim.org or at 202.638.7032.

Sincerely,

Rachel M. Conant

Rachel Conant
Senior Vice President, Public Policy, Alzheimer’s Association
Executive Director, Alzheimer’s Impact Movement

ECRI | The Most Trusted Voice in Healthcare

STATEMENT FOR THE RECORD

Submitted by ECRI

Hearing on “Healthier America: Legislative Proposals to Improve Public Health”

Subcommittee on Health | Committee on Energy and Commerce

U.S. House of Representatives

April 15, 2026

Executive Summary

The following position statement captures ECRI's insights and recommendations regarding the Digital Health Screeners Act of 2026, part of the legislative hearing to be held on April 15, 2026: "Healthier America: Legislative Proposals to Improve Public Health."

Why ECRI’s Perspective was Requested

ECRI is a global nonprofit organization dedicated to preventing harm in healthcare and advancing evidence-based medicine. ECRI evaluates health technologies for safety, efficacy, and innovation; investigates adverse events and near-misses in clinical settings; and provides evidence-based guidance to hospitals, health systems, and policymakers. That investigative and analytical experience informs the safety concerns raised here.

Patient Safety Concerns

ECRI submits this position statement to draw the legislative committee's attention to interrelated patient safety concerns emerging from the current digital health regulatory environment:

- **Patient Confusion & Clinical Reliance:** The reduced oversight framework for general wellness devices creates significant consumer confusion and false clinical reliance risk when applied to devices capable of acquiring and/or estimating physiologic data such as blood pressure, oxygen saturation, electrocardiogram recordings, and blood glucose.
- **Lack of Wellness Device Problem Reporting:** Wellness devices are not subject to mandatory reporting requirements like their medical device counterparts. Recent FDA recalls of wearable devices highlight the potential for errant physiologic data acquisition and patient harm. How can the public ensure that these errors will not be pervasive in wellness products? The public does not have a reliable means to monitor similar hazards with wellness devices other than through voluntary consumer product reporting programs, or learning about wellness device recalls from the manufacturer, legal actions, or other means.
- **Lack of Enforceable Transparency:** While the FDA's updated Clinical Decision Support (CDS) guidance appropriately defines the boundary between regulated and non-regulated software, its nonbinding nature leaves existing hospital-deployed CDS tools without enforceable transparency requirements, allowing automation bias to persist unchecked in clinical settings. ECRI urges Congress to act on mandatory algorithmic transparency standards that enable clinicians to exercise genuine independent judgment as the guidance intends.

Summary of ECRI's Recommendations

- Require that FDA's criteria-setting process under Section 3(4) be paired with a public-facing classification mechanism enabling consumers and providers to distinguish clinically validated devices from unvalidated wellness products, which may market unsupported claims.
- Call for expansion of Consumer Products Safety Commission (CPSC) oversight to include oversight of errant physiologic data acquisition in addition to the current physical and electrical hazard requirements.
- Do not expand the Non-Device CDS exemption to single-recommendation tools without accompanying mandatory transparency requirements for algorithmic logic, training data, and demographic performance. Establish enforceable algorithmic transparency standards for all CDS tools used in clinical care, regardless of device classification status.
- Require demographic validation across racial, ethnic, and body composition subgroups as a condition of the general wellness product exclusion for any device acquiring physiological data.

Wearables and General Wellness Devices

The FDA's January 2026 updated General Wellness guidance represents a meaningful step in clarifying regulatory boundaries. However, as supported by a history of patient adverse events on these types of devices, tracked by ECRI and FDA, ECRI is concerned that reduced oversight of devices capable of generating clinically relevant physiologic outputs, such as blood pressure estimates, oxygen saturation readings, fibrillation detection, and blood glucose trends, creates patient risk.

The guidance permits non-invasive wearables to remain outside the device definition even when they output values that clinicians and patients may interpret in a clinical context, provided such products avoid explicit disease-related claims and include validated measurements. In practice, this distinction is invisible to most consumers: a wrist-worn device displaying a blood pressure reading looks and functions identically regardless of whether it carries FDA clearance.

Section 3 of the Digital Health Screeners Act codifies FDA's January 2026 General Wellness guidance into statute, formally excluding general wellness products from the device definition even when they measure and display physiologic parameters such as blood pressure estimates, oxygen saturation readings, ECG recordings, and blood glucose trends. ECRI acknowledges that the Act includes a labeling requirement and directs FDA to establish product criteria within 180 days of enactment. These are meaningful procedural steps. However, they do not resolve the most pressing patient safety concern in this space.

As Congress considers the Digital Health Screeners Act of 2026, we urge that any codification of the general wellness product exclusion be paired with a clear, accessible mechanism, whether a registry, a uniform labeling standard, or a public classification tool, that enables consumers and providers to meaningfully distinguish devices that have been validated for clinical accuracy from those that have not.

We urge analysis of a regulatory gap regarding errant acquisition of blood pressure, oxygen saturation, heart rate, blood glucose, and other physiologic parameters. The current CPSC authority over wearable wellness devices includes physical and electrical hazards. For example, the CPSC recalled the Fitbit Ionic in 2022 for battery overheating. The CPSC does not require premarket accuracy testing or post-market clinical harm, and post-market reporting is voluntary, so with further expansion of unregulated wellness devices we anticipate not learning about hazards until, unfortunately, after patient harm.

Clinical Decision Support Software

ECRI likewise views the FDA's January 2026 CDS guidance as a necessary clarification of the regulatory landscape, but one that does not resolve the most pressing patient safety concern: the absence of enforceable transparency requirements for CDS tools currently deployed in hospital systems nationwide.

Section 2 of the Digital Health Screeners Act amends the Non-Device CDS exemption under Section 520(o)(1)(E) of the Federal Food, Drug, and Cosmetic Act to cover single-recommendation CDS tools, which present only one clinically appropriate option, in addition to multi-option recommendation tools. This expansion introduces no transparency or disclosure requirements for the tools it shields from regulation. Additional clarification on what constitutes a 'single option' and what supporting evidence is required.

The existing Non-Device CDS framework rests on the premise that clinicians can exercise independent judgment by reviewing the basis of a tool's recommendations. A single-option recommendation forecloses that choice by design and yet Section 2 would extend less regulatory scrutiny to precisely those tools. Vendors of single-recommendation CDS tools would not be required to disclose training data, training data distribution characteristics, algorithmic logic, or performance limitations, nor would existing deployed systems be required to come into conformance with any transparency standard.

ECRI views this as a patient safety concern. From ECRI's perspective, this creates a fundamental trust problem: clinicians cannot exercise the independent judgment the guidance envisions if they lack access to information about where the recommendations come from, what patient populations the algorithm was validated on, or how it performs across demographic subgroups. The risk is compounded with automation bias, particularly in high-volume clinical environments where time pressure is constant. ECRI strongly supports legislative or regulatory action to require that CDS tools used in clinical care, regardless of their device classification status, provide plain-language transparency documentation sufficient for the clinicians relying on them to understand and critically evaluate the basis for those recommendations.

Health Equity Implications

The Digital Health Screeners Act raises patient safety concerns that fall disproportionately on medically underserved communities. Wearable devices acquiring physiologic parameters have well-documented performance gaps across demographic groups. Pulse oximeters, for example, were shown during COVID-19 to systematically overestimate oxygen saturation in patients with darker skin tones. When such devices are excluded from the device definition, there is no mechanism requiring manufacturers to validate accuracy across gender, racial, ethnic, or body composition subgroups. This risk is greatest in rural and low-income communities, where wearables increasingly substitute for in-person care, meaning the populations least able to absorb the consequences of a false reading are the most exposed.

CDS algorithms present the same equity risk: without mandatory transparency requirements, clinicians cannot assess whether the tools they rely on were validated on populations representative of the communities they serve. ECRI urges the Committee to require demographic validation as a condition of the general wellness exclusion under Section 3(4), and to mandate subgroup performance documentation in any future CDS transparency legislation.

Contact

Dr. Scott Lucas, Vice President for Device Safety, ECRI, SLucas@ecri.org

Yvonne Rhodes, Director of Strategic Communications & Operations, ECRI, YRhodes@ECRI.org

References

1. U.S. Food and Drug Administration. *General Wellness: Policy for Low Risk Devices.* Guidance for Industry and FDA Staff. January 6, 2026. (Supersedes September 27, 2019 guidance.)
2. U.S. Food and Drug Administration. *Clinical Decision Support Software.* Guidance for Industry and FDA Staff. January 29, 2026. (Supersedes January 6, 2026 version.)
3. H.R. ___, 119th Congress, 2nd Session. *Digital Health Screeners Act of 2026.* Introduced by Rep. Balderson. April 7, 2026.
4. CPSC. *Safety Concerns Associated with Wearable Technology Products.* Staff Report. April 2020.
5. Cummings, M.L. "Automation Bias in Intelligent Time Critical Decision Support Systems." AIAA 1st Intelligent Systems Technical Conference, Vol. 2, 2004, pp. 557–562. (As cited in FDA CDS Guidance, January 2026.)

Muscular Dystrophy Association

April 14, 2026

The Honorable Morgan Griffith, Chairman House Committee on Energy and Commerce Subcommittee on Health 2110 Rayburn House Office Building Washington, DC 20515	The Honorable Diana DeGette, Ranking Member House Committee on Energy and Commerce Subcommittee on Health 2111 Rayburn House Office Building Washington, DC 20515

Re: Energy and Commerce Subcommittee on Health Hearing on the ACT for ALS Reauthorization Act (H.R.8205)

Dear Chairman Griffith and Ranking Member DeGette:

In service of the neuromuscular disease (NMD) patient community, including those living with amyotrophic lateral sclerosis (ALS) and other rare neurodegenerative diseases, the Muscular Dystrophy Association (MDA) thanks the Energy and Commerce Subcommittee on Health (the Subcommittee) for convening tomorrow's hearing. In particular, we are incredibly grateful for the Subcommittee's consideration of the ACT for ALS Reauthorization Act of 2026 (H.R.8205), legislation that will renew and refresh critical ALS and other rare neurodegenerative disease research and drug development initiatives. We ask that you express your support for this legislation during tomorrow's hearing and support its progression to a markup.

MDA is the #1 voluntary health organization in the United States for people living with muscular dystrophy, ALS, and related neuromuscular diseases. For over 75 years, MDA has led the way in accelerating research, advancing care, and advocating for the support of our community. MDA's mission is to empower the people we serve to live longer, more independent lives.

ALS remains an unrelenting disease. While progress has been achieved over the past five years, the experience of someone newly diagnosed with ALS today remains far too similar to the experience from five years ago. This is why the ACT for ALS's programs are critical for maintaining the hope and possibility of a life-changing, maybe even life-saving, treatment reaching the ALS and rare neurodegenerative disease community.

The ACT for ALS, enacted in December 2021, has successfully expanded access to investigational therapies for those with ALS. According to the Government Accountability Office (GAO), approximately 750 people with ALS have received an investigational therapy due to ACT for ALS funding, individuals who were otherwise ineligible to participate in clinical trials and other available treatments were inadequate to alter the progression of their disease. The law also has funded groundbreaking natural history data collection and analysis through the Access for All in ALS (ALL ALS) Consortium, a crucial endeavor for better understanding the risk factors, etiology, and progression of the disease.

The ACT for ALS also created and continues to fund the Accelerating Medicines Partnership for Amyotrophic Lateral Sclerosis (AMP ALS) as well as the Critical Path for Rare Neurodegenerative Diseases, two key facets of the HHS Public Private Partnership for Rare Neurodegenerative Diseases created under the law. Both programs seek to speed therapeutic development in ALS and other rare neurodegenerative diseases by accelerating the creation of drug development tools and other approaches to bringing new treatments through clinical trials and to our community.

Finally, the ACT for ALS commissioned the ALS and other Rare Neurodegenerative Disease Action Plan. This plan, published in the summer of 2022, outlined the steps and initiatives the Food and Drug Administration (FDA) would take to accelerate therapeutic development in ALS. The law also created the FDA Rare Neurodegenerative Disease Grants Program, an effort that has funded over $20 million in drug development projects in ALS, Huntington's disease, myotonic dystrophy, ataxias, and more.

The ACT for ALS Reauthorization Act will reauthorize each of these programs while refining and improving upon the original law's approach. This bill will better target the investigational therapies available to the ALS community under the law's expanded access program, will renew FDA's Action Plan while requiring updates on the progress achieved under the original plan, and will commission a GAO report to evaluate the impacts of the reauthorization.

We appreciate this opportunity to provide the Subcommittee with the perspectives of the ALS and rare neurodegenerative disease communities. For questions regarding MDA or the above comments, please contact Paul Melmeyer, Executive Vice President, Public Policy and Advocacy, at pmelmeyer@mdausa.org,

Sincerely,

Paul Melmeyer, MPP
Executive Vice President, Public Policy and Advocacy
Muscular Dystrophy Association

Leading ALS Organizations Celebrate Introduction of ACT for ALS Reauthorization Act: Call for Swift Congressional Passage

Washington, D.C., April 8, 2026 – In support of this week's introduction of the *ACT for ALS Reauthorization Act of 2026* (H.R.8205), leading ALS advocacy organizations released the following statement calling for swift passage of the legislation:

"This week's introduction of the *ACT for ALS Reauthorization Act of 2026* is a meaningful milestone in our unified efforts to reauthorize the *ACT* prior to the September 30, 2026, deadline. We are incredibly grateful to Congressmen Quigley and Calvert for their leadership in introducing this bill. Congress must act swiftly to enact this critical legislation.

The *ACT for ALS Act*, enacted in December 2021, has resulted in meaningful and potentially life-changing impacts for the ALS and rare neurodegenerative disease communities. The National Institutes of Health (NIH) ALS Expanded Access program has funded approximately 750 community members with ALS receiving investigational new treatments and has equipped clinics across the United States with the ability to participate in ALS research. The Access for ALL in ALS Consortium (ALL ALS), funded by the NIH through the *ACT for ALS*, is one of the largest and most important efforts to understand and evaluate the natural history of ALS. The Public-Private Partnerships on rare neurogenerative diseases (Accelerating Medicines Partnership ® in Amyotrophic Lateral Sclerosis [AMP® ALS] Program and the Critical Path for Rare Neurodegenerative Diseases Program [C-Path RND]) have made meaningful strides in accelerating data integration, digital biomarkers, and therapeutic development, particularly for ALS, and the FDA's Rare Neurodegenerative

Disease Grants Program has funded over $20 million in research accelerating therapeutic development across the spectrum of rare neurodegenerative diseases.

The legislation also makes refinements to *ACT for ALS* programs in response to report findings to ensure their continued success in the years ahead. All these important advancements may cease to exist unless Congress passes the *ACT for ALS Reauthorization Act*.

Congress must act quickly; the ALS community cannot wait."

Signed:

ALS Arizona
ALS Association
ALS Hope Foundation
ALS One
ALS Network
ALS of Nevada
ALS New Mexico
ALS Northwest
ALS United
ALS United Connecticut
ALS United of Georgia
ALS United Greater New York
ALS United Illinois, Indiana, & Missouri
ALS United Mid-Atlantic
ALS United North Carolina
ALS United Ohio
ALS United Orange County
ALS United Rhode Island
ALS United Rocky Mountain
Answer ALS
Compassionate Care ALS
Hop on a Cure
I AM ALS
Les Turner ALS Foundation
Muscular Dystrophy Association
Project ALS
Target ALS

AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

STATEMENT FOR THE RECORD

FOR THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE,

SUBCOMMITTEE ON HEALTH

HEARING ON

HEALTHIER AMERICA: LEGISLATIVE PROPOSALS TO IMPROVE HEALTH

APRIL 15, 2026

The American Cancer Society Cancer Action Network expresses our strong support of the Young Women's Breast Health Education and Awareness Requires Learning Young Act, also called the EARLY Act, sponsored by U.S. Representatives Debbie Wasserman Schultz (D-FL), Mariannette Miller-Meeks (R-IA), Kathy Castor (D-FL), Brian Fitzpatrick (R-PA), Debbie Dingell (D-MI), and Diana Harshbarger (R-TN). Enactment of this bipartisan bill could have a critical impact on saving more women's lives from breast cancer and improving their survivorship.

As the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, our volunteers know all too well about the increase in breast cancer diagnoses in younger women. Women are navigating their treatment and survivorship in the prime of their lives. These are women who may be considering starting families or are already taking care of children at home; whose parents have reached an age where they need support; and who are navigating their careers and community responsibilities.

ACS CAN stands with our volunteers. We are working together to make cancer a top priority for public officials and candidates at all levels of government and advocate for evidence-based public policies to reduce the burden of cancer for everyone. Together, we want to ensure every woman diagnosed with breast cancer does not just survive breast cancer, but goes on to live happy, productive, and fulfilling lives.

Incidence and Mortality of Breast Cancer

Thanks to decades of cancer research discovery, innovation and implementation of proven clinical and public health strategies, cancer in general is becoming less of a death sentence and more of a treatable chronic disease, and in many cases preventable. This progress means that 7 in 10 people diagnosed with cancer can celebrate their 5-year survivorship anniversary compared to just 1 to 2 people 50 years ago.[1]

Despite these incredible gains, far too many people will be diagnosed with cancer this year, including 321,910 women who will hear the words "you have breast cancer."[2] Breast cancer is the leading cause of cancer incidence and second leading cause of cancer mortality in women.[3] This year alone, we will lose 42,140 women to this terrible disease.[4]

When we look at trends in breast cancer incidence rates specifically, we see deeply troubling increases since the mid 2000's, especially among women younger than 50 years old and among women of Asian American, Pacific Islander or Hispanic heritage:

- On average, breast cancer incidence increased by 1% per year over the past decade.[5]
- For women younger than 50, breast cancer incidence has increased at a steeper pace at 1.4% per year, compared to 0.7% per year for women over 50 years old.[6]

---

[1] American Cancer Society. Cancer Facts & Figures 2026. Atlanta: American Cancer Society; 2026.

[2] Cancer Facts & Figures 2026.

[3] Cancer Facts & Figures 2026.

[4] Cancer Facts & Figures 2026.

[5] Cancer Facts & Figures 2026.

[6] Siegel RL, Kratzer TB, Wagle NS, Sung H, Jemal A. Cancer statistics, 2026. CA Cancer J Clin. 2026;e70043. doi:10.3322/caac.70043.

- For Asian American, Native Hawaiian, or other Pacific Islander women, breast cancer incidence has increased by 2.7% per year and by 2.4% per year for women who are Hispanic.[7]

While incidence rates are increasing, when we look at trends in breast cancer mortality rates, we've seen a 44% overall decline over the last three decades.[8] This translates to 546,000 fewer breast cancer deaths. Contributing to this achievement is both advances in treatment and early detection through screening. But this progress has not been experienced by everyone.

- For American Indian and Alaska Native women, mortality rates have not improved at all during this time and Black women are 37% more likely to die from breast cancer than White women, even though they are diagnosed at lower rates.
- Also, Black women have a lower survival rate at every breast cancer stage than women of any other racial or ethnic group.[9]
- Among women younger than 50 years old, breast cancer is the leading cause of cancer death.[10]

Young women may have unique breast cancer risk factors, early detection, treatment and survivorship needs. For example:

---

[7] Cancer statistics, 2026.
[8] Cancer Facts & Figures 2026.
[9] Giaquinto AN, Sung H, Newman LA, et al. Breast cancer statistics 2024. CA Cancer J Clin. 2024;74(6):477-495. doi:10.3322/caac.21863.
[10] Siegel RL, Wagle NS, Jemal A. Leading Cancer Deaths in People Younger Than 50 Years. JAMA. 2026;335(7):632–634. doi:10.1001/jama.2025.25467.

- Aggressive breast cancers, like triple-negative breast cancer, are more common in younger women and in Black women.
- Women diagnosed with breast cancer at younger ages are more likely to be carriers for BRCA gene mutations, which increases breast cancer risk.
- Discussion of symptoms and diagnosis can be challenging for young women because providers are not expecting cancer in this age group.
- Treatment can greatly impact quality of life, including fertility and development of co-morbidities for women who live many years – hopefully decades – after their treatment.

While the reasons for the rising number of cases of breast cancer in young women are complex and multifactorial, it is important for women and their providers to be aware of the increased rates of breast cancer, understand their risks and how to mitigate them; and if diagnosed, have access to appropriate treatment and survivorship support .

Need to Reauthorize EARLY Act

The EARLY Act provides a 5-year reauthorization of the life-saving programming at the Centers for Disease Control and Prevention (the CDC) that provide the public awareness and provider training programs critically needed to address the unique needs of young women who have breast cancer and those at risk of breast cancer.

The EARLY Act supports the *Bring Your Brave* campaign which uplifts the stories of young women to raise public awareness of breast cancer in this younger population. As we at ACS CAN also know, peer-to-peer support and real stories backed with fact-based information are proven impactful in helping people understand their risk of cancer and to drive them to take action. This innovative campaign tailors its messages through social media, podcasts, and streaming platforms, and with content creators and other partnerships to best reach its distinct audience, which is women 18 to 44 years old. For example, the CDC consulted on a multi-season early onset breast cancer storyline on the tv show *Superman & Lois*, which resulted in a 33 percent increase in good searches for "breast cancer support groups" after Clark attended a support group, 1.3 million visits to the CDC's breast cancer-related webpages, and resulted in a Sentinel Award for its depiction of breast cancer.[11] CDC develops resources, tools and programs specifically for young breast cancer survivors and their families through strategic partnerships.

The EARLY Act supports provider training and education in addition to public education and survivor support resources. Providers are often not considering the risk of breast cancer in young women given its relatively low numbers, despite increasing incidence rates. To support providers and improve breast cancer outcomes, the CDC develops and supports provider training and education, including continuing education courses[12], focusing on improving primary care skills and confidence in understanding and managing the risks of breast cancer in young women. In 2017 and 2020 alone, CDC launched continuing medical education (CME) opportunities on early onset breast cancer for health care providers and issued 7,000 CME

---

[11] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024 & Bring Your Brave Campaign Updates

[12] Centers for Disease Control and Prevention. *Bring Your Brave* Campaign. Accessed April 9, 2026. https://www.cdc.gov/bring-your-brave/hcp/education/index.html

certificates.[13] Additionally, through a collaboration with the American College of Obstetricians and Gynecologist (ACOG), two 7-credit e-modules on early onset breast cancer were extensively developed. As a result, more than 21,000 CME credits were awarded and 1,477 nursing continuing education unit credits were awarded.[14]

The EARLY Act established the Advisory Committee on Breast Cancer in Young Women, a federal advisory committee that provides expert guidance to the Secretary of Health and Human Services and CDC leadership in the development and implementation of age-appropriate and culturally responsive messaging, public education, survivor support, and provider education and training programs and resources for women under 40. The work of the Committee ensures that the unique risks, experiences, and needs of young women, including those at heightened or hereditary risk, are systematically integrated into national breast cancer prevention and early detection efforts. The Committee's work strengthens the scientific quality, relevance, and reach of CDC initiatives, helping translate research into life-saving actions.

The programs and resources provided in the EARLY Act are not only designed to contribute to the survivability of breast cancer for young women by increasing their and their providers' knowledge of risks and how to mitigate them but also inspire young women to serve as trusted messengers for other young women across the nation. Reauthorization of the EARLY Act is

---

[13] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024

[14] U.S. Centers for Disease Control and Prevention. (2024, September 13). *Advisory Committee on Breast Cancer in Young Women Hybrid Meeting* [Record of the Proceedings]. Record of the Proceedings of the Advisory Committee on Breast Cancer in Young Women Meeting on September 13, 2024

essential to providing stability for its programs and the opportunity to deepen its impact at a time when breast cancer trends in young women are going in the wrong direction.

Without the EARLY Act, more young women and their providers may be left in the dark about their risk of breast cancer, and opportunities for life-saving interventions will be lost. Reauthorization of the EARLY Act is necessary to ensure continued timely access to fact-based information, training, and public awareness, which can help improve breast cancer outcomes among this younger population.

Thank you for the opportunity to submit this statement for the record in strong support for the EARLY Act. We urge you to pass the bill as quickly as possible to help us in the fight to end breast cancer as we know it, for everyone.

Center for Lyme Action

April 14, 2026

Honorable Brett Guthrie, Chair, House Energy and Commerce Committee
Honorable Morgan Griffith, Chair, Health Subcommittee

Dear Representatives Guthrie and Griffith:

Center for Lyme Action is pleased to submit this statement for the record of the hearing entitled, “Healthier America: Legislative Proposals to Improve Public Health.” Center for Lyme Action is grateful that the U.S. House Committee of Energy and Commerce, Subcommittee on Health has provided the opportunity to express our strong support for the reauthorization of the Kay Hagan Tick Act and to commend the bipartisan leadership in advancing solutions to the growing threat of Lyme and other tick-borne diseases across the United States.

Center for Lyme Action is the leading advocacy organization dedicated to growing federal funding and advancing policy solutions for Lyme and tick-borne diseases. Our network of nearly 10,000 advocates and 40+ community organizations from all 50 States, DC, and Puerto Rico reflects the widespread and rapidly growing impact of this public health crisis. Our mission is to ensure the federal government prioritizes funding for prevention, diagnostic innovation, improved therapeutics, and long-term care for the millions of Americans impacted by these debilitating diseases.

Tick-borne illnesses are no longer a regional issue—they are a fast-growing national epidemic. The Centers for Disease Control and Prevention (CDC) estimates that nearly 500,000 Americans are diagnosed and treated for Lyme disease each year, and cases continue to rise at an alarming rate. At the same time, emerging threats such as Alpha-gal syndrome, Rocky Mountain Spotted Fever, and Powassan virus are straining public health infrastructure and leaving patients without answers or adequate care.

The Kay Hagan Tick Act has played a foundational role in addressing this crisis by strengthening federal coordination across 17 agencies and departments through the development and implementation of the National Public Health Strategy to Prevent and Control Vector-Borne Diseases in Humans, and investing in research, prevention, and education efforts. This has been critical to building the federal framework necessary for our nation to detect, respond to, and ultimately prevent these devastating diseases.

This is a pivotal moment and we now must implement this ambitious strategy. Reauthorization of the Kay Hagan Tick Act represents a renewed commitment to protecting American families, improving patient outcomes, and responding to an evolving vector-borne disease landscape with the urgency it demands.

Thank you again for your leadership and dedication to addressing this critical public health crisis. We stand ready to support these efforts and urge swift action from the committee on the Kay Hagan Tick Act’s reauthorization.

Sincerely,

Meghan Bradshaw, MPH
Executive Director
Center for Lyme Action

Statement for the record from Susan G. Komen on *Healthier America: Legislative Proposals to Improve Public Health.*
United States Committee on Energy and Commerce Health Subcommittee
April 15, 2026

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Health Subcommittee,

I write today on behalf of Susan G. Komen (Komen) to provide the following written comments in response to the April 15, 2026, U.S. House Committee on Energy and Commerce Health Subcommittee Hearing, *Healthier America: Legislative Proposals to Improve Public Health*. Specifically, we write in support of H.R. 4541, the EARLY Act Reauthorization of 2025.

Komen is the world's leading nonprofit breast cancer organization representing the millions of people who have been diagnosed with breast cancer. Komen has an unmatched, comprehensive 360-degree approach to fighting this disease across all fronts – we advocate for patients, drive research breakthroughs, improve access to high quality care, offer direct patient support and empower people with trustworthy information. Komen is committed to supporting those affected by breast cancer today, while tirelessly searching for tomorrow's cures. We advocate on behalf of the estimated 324,600 people in the United States who will be diagnosed with breast cancer and the 42,670 who will die from the disease in 2026 alone.

Breast Cancer in Young Women

Recent data points to increased breast cancer diagnoses in younger women. Between 2012-2022, the breast cancer incidence rate in women under 50 has risen faster than in women over 50. Additionally, women under 40 are nearly 40% more likely to die from breast cancer than women over 40.[1] Compared to breast cancers in older women, breast cancers in younger women are more likely to be fast growing, higher grade, and hormone receptor-negative – each of these factors makes breast cancer more aggressive and more likely to need chemotherapy.[2]

All of this supports the need for the reauthorization of the programs which have been created as a result of the EARLY Act.

EARLY Act Reauthorization of 2025

H.R. 4541, the EARLY Act Reauthorization of 2025, is bipartisan, bicameral legislation that would reauthorize and allow for the continued funding of the Breast Cancer Education and Awareness

---

[1] Breast Cancer Research Foundation. 5 Facts About Breast Cancer in Younger Women. Available at https://www.bcrf.org/about-breast-cancer/breast-cancer-young-women/.

[2] Susan G. Komen. Unique Issues for Women Under 40 with Breast Cancer. Available at https://www.komen.org/breast-cancer/treatment/by-diagnosis/young-women-and-breast-cancer/.

Requires Learning Young Act (EARLY Act), which requires the Department of Health and Human Services (HHS) to provide breast cancer education and support for young women. The EARLY Act first passed in 2010 and was reauthorized in 2014 and 2020. The authorization is set to expire at the end of this year, 2026.

Komen strongly supports H.R. 4541, which would reauthorize the EARLY Act for an additional five years. Specifically, it would reauthorize three programs administered by the Centers for Disease Control and Prevention (CDC), *Bring Your Brave*, Young Breast Cancer Survivors Program, and continuing medical education courses for health care providers about breast cancer. Between 2019 and 2023, EARLY Act programs reached over 48.8 million young breast cancer survivors, metastatic breast cancer patients, caregivers, and family members providing almost 36.5 million resources and tools.

The *Bring Your Brave* Campaign, which launched in 2015, is a web-based campaign to educate young women at risk of or living with breast cancer.[3] The Campaign, housed on the CDC's website, includes stories about young women whose lives have been affected by breast cancer, facts and statistics related to breast cancer in young women, information about risk factors, and tips on what someone can do to lower their breast cancer risk. As of March 2025, the *Bring Your Brave* Campaign has resulted in 231 million impressions across social media, blogs, search engines, digital display, and earned media; nearly 12.4 million video views, nearly 2 million social media engagements and nearly 2.9 million visits to *Bring Your Brave* web pages.

The Young Breast Cancer Survivors Program, housed in the CDC's National Comprehensive Cancer Control Program, focuses on supporting young breast cancer survivors and people living with metastatic breast cancer. Most recently, in 2024, under this program, CDC funding allowed for structured support services and resources for this community through partnership with community organizations.[4] Thanks to our investment in finding improved early-detection and treatment methods, the number of cancer survivors is steadily increasing. But being a breast cancer survivor comes with a unique set of needs, including managing effects of breast cancer treatment (e.g. bone health, declining cognitive function, lymphedema) and the fear of and risk of breast cancer recurrence, including understanding and taking action related to needed follow-up and screenings.[5] Young breast cancer survivors often must also contend with additional challenges including career disruption and potential impacts on fertility. Living with metastatic breast cancer (MBC) – also known as stage 4 or advanced breast cancer that has

---

[3] U.S. Centers for Disease Control and Prevention. *Bring Your Brave* Campaign. Available at https://www.cdc.gov/bring-your-brave/index.html.

[4] U.S. Centers for Disease Control and Prevention. (2024 November 12). Young Breast Cancer Survivors Program. Available at https://www.cdc.gov/comprehensive-cancer-control/related-programs/young-breast-cancer-survivors.html.

[5] Susan G. Komen. Breast Cancer Survivorship. Available at https://www.komen.org/breast-cancer/survivorship/.

spread beyond the breast to affect other parts of the body – is likewise extremely complex. An estimated 170,000 individuals are living with MBC in the US.[6] While MBC cannot be cured, thanks to treatment advances, MBC is now considered to be a livable disease, but again, this community faces its own challenges. The average five-year survival rate for those diagnosed with MBC is only 30% and most of the nearly 43,000 people who will die from breast cancer in 2026 will die from MBC.

Lastly, the EARLY Act has helped provide for continuing medical education (CME) for health care providers related to young women and breast cancer. The *Bring Your Brave* Campaign is home to a provider education component, providing free content for health care providers related to early onset breast cancer. Based on data from February 2020 – February 2022, the *Bring Your Brave* Campaign CME component, which operates in partnership with Medscape, resulted in 29,007 learners, 11,654 test-takers, 10,050 CMS certificates issued, and 20,0430 CME credits.[7] Additionally, in 2020, the CDC partnered with a professional organization to develop a free online course series, Understanding Early Onset Breast Cancer.[8] These CME courses are available to women's health care clinicians, including obstetrician-gynecologists, family physicians, nurses, nurse practitioners, physician assistants, and genetic counselors. Healthcare providers have completed more than 6,000 courses since the online learning platform was launched in 2020.[9]

Conclusion

Komen thanks the Subcommittee for including H.R. 4541, the EARLY Act Reauthorization, in this hearing and urges the Committee to advance this important legislation. Please consider Komen to be a resource on anything related to breast cancer. Please reach out to Valerie Nelson, Komen's Manager of Federal Policy and Advocacy, at VNelson@komen.org, with any questions or for additional information.

Sincerely,

Molly L. Guthrie

Molly Guthrie

---

[6] Susan G. Komen. Treatments for Metastatic Breast Cancer. Available at https://www.komen.org/breast-cancer/metastatic/metastatic/.

[7] U.S. Centers for Disease Control and Prevention. (2022 August 23). Update from CDC: Public health's response to early onset breast cancer. Available at https://www.cdc.gov/cancer/breast/pdf/acbcyw-melillo-08232022-508.pdf

[8] American College of Obstetricians & Gynecologists. Early Onset Breast Cancer (EOBC) Education. Available at https://www.acog.org/education-and-events/courses/early-onset-breast-cancer-education

[9] U.S. Centers for Disease Control and Prevention Stacks. (2024 March 18). Centers for Disease Control and Prevention Justification of Estimates for Appropriation Committees Fiscal Year 2025. Available at https://stacks.cdc.gov/view/cdc/177367.

Vice President, Policy & Advocacy
Susan G. Komen

Written Testimony of the School-Based Health Alliance

Submitted to the United States House Energy and Commerce Committee
Subcommittee on Health in regard to the
Healthier America: Legislative Proposals To Improve Public Health Hearing
April 15, 2026
10:15 a.m. 2132 Rayburn House Office Building

Adriane Van Zwoll, PhD, LCSW, LMSW
Vice President
School-Based Health Alliance
1032 15th Street, NW; Suite 365
Washington, D.C. 20005

Introduction

Chairman Griffith, Ranking Member DeGette, and members of the House Energy and Commerce Committee Subcommittee on Health, thank you for the opportunity to submit written testimony on behalf of the School-Based Health Alliance (SBHA) for the subcommittee's hearing "Healthier America: Legislative Proposals To Improve Public Health." I am excited to share with you all the impact school-based health centers (SBHCs) have on student health care.

SBHCs provide the nation's vulnerable students and youth with access to primary care, behavioral health, oral health, and vision care, where they spend most of their time – at school. SBHCs operate through partnerships with health care organizations, school communities, community-based organizations, families, and youth. This collaboration, care coordination, and youth engagement improve students' health literacy and outcomes, as well as those of their families, school staff, and the community, and contribute to positive educational outcomes, including reduced absenteeism, fewer disciplinary actions, and improved graduation rates.

Today, the subcommittee will consider several bills that address fundamental issues in student well-being and educational success. Food security, mental health, and behavioral health supports are not optional—they are essential to ensuring that students can learn, thrive, and succeed. SBHCs play a critical role in meeting these needs, serving as trusted, accessible providers for thousands of students and families across the country. However, SBHCs can only fulfill this role when they are equipped with adequate resources and sustained support. Continued federal investment, including the support proposed in H.R. 8209, is vital to strengthening SBHCs and ensuring they can continue delivering essential services to students, families, and the communities they serve.

About the School-Based Health Alliance

Since 1995, the School-Based Health Alliance, a 501(c)(3) nonprofit corporation, has supported and advocated for high-quality healthcare in schools for the nation's most vulnerable children. Working at the intersection of healthcare and education, the School-Based Health Alliance is a recognized leader in the field and a source for information on best practices for philanthropic, federal, state, and local partners and policymakers.

At the School-Based Health Alliance, we've worked for over 30 years to:

- Advance national policy and legislative priorities for the field
- Advocate for greater support and funding
- Promote high-quality clinical practices and standards
- Support data collection and reporting, evaluation, and research
- Provide training, technical assistance, and consultation

National Landscape of School-Based Health Centers

At present, approximately 4,000 school-based health centers across the nation provide primary, behavioral, dental, and vision care, as well as other support services, to students in poor and underserved urban, rural, and suburban communities at school. Most of the 4,000 centers delivering this evidence-based model are in Title I schools. However, there are nearly 60,000 Title I schools nationwide, and the majority of them do not currently have a school-based health center to address students' critical needs. With only 6.5% of the nation's approximately 60,000 Title I schools served by SBHCs, students in more than 56,000 schools remain without access to the health care they need to learn, grow, and thrive, representing a significant opportunity to expand student-centered care.

Nationwide, Federally Qualified Health Centers (FQHCs) sponsor more than half of all SBHCs. The remaining centers are sponsored by hospital systems, public health agencies, nonprofits, and some school districts directly. FQHC sponsors are financially advantaged compared to other sponsor types because they benefit from the Prospective Payment System (PPS) rate for Medicaid reimbursement, which is often significantly higher than that for other Medicaid providers. In addition, FQHCs benefit from robust federal funding through the Section 330 Health Centers Program. The funds being discussed today in H.R. 8209 provide FQHCs within the 330 Health Centers Program access to important resources dedicated to expanding SBHCs.

Importance of Investment in SBHCs

By providing services at school as part of a public-private partnership, SBHCs are a convenient and efficient access point to health care in a setting that families are familiar with and trust. In many rural schools, the SBHC is the nearest community health provider for miles, providing critical access to students and families, school staff, and community members. This convenience means less time taken off work for parents and school staff to travel to medical appointments, as well as increased seat time for students who can return to class after receiving health care services. SBHCs regularly provide patient-centered care that is responsive to the needs of local communities, including parents, and providers actively engage parents and promote parental involvement while obtaining parental consent for their child to receive care.

For decades, SBHCs have demonstrated their positive impact on students, schools, communities, and the health care system. Students who use SBHCs are less likely to visit the emergency room or be hospitalized, particularly for asthma. Academically, SBHCs help increase attendance, improve school climate, and support student achievement. SBHCs sometimes also respond to injuries and illnesses on school grounds, provide critical early intervention and prevention services, and help students with chronic conditions manage their health. Additionally, by facilitating positive, early interactions with health care providers, SBHCs promote lifelong health literacy and exposure to careers in health care for young people – all of which are critical to securing a healthy and prosperous future for our nation.

SBHCs are funded by third-party sponsors and aim to sustain their operations through billing and third-party revenue. The costs of startup and expansion can often be a significant barrier for sponsoring organizations running SBHCs as they seek to meet their communities' needs. Federal appropriations directed to SBHCs in the Health Center Program have helped fill some of these gaps in services expansion and startup costs. The need is still significant, and one that the federal government should continue to provide to federally qualified health centers interested in opening or expanding SBHCs.

SBHCs received $5 million in 2020 from the federal government, marking the first federal appropriation directed at establishing and supporting SBHC expansion. The appropriation increased annually from $5 million at inception up to $55 million in FY24, where it has remained. Appropriations support for SBHCs has drawn bipartisan support each year. H.R. 8209 ensures that federally qualified health centers interested in operating SBHCs will continue to receive these critical federal investments through fiscal year 2031. These funds play an integral role in the growth of SBHCs across the nation, improving access for our nation's most at-risk students and their families.

Mental and Behavioral Health Support at SBHCs

Today's students face a variety of stressors that negatively impact their mental health and ability to succeed. The Centers for Disease Control and Prevention's (CDC) *Youth Risk Behavior Survey Data Summary & Trends Report: 2013 – 2023* found that 40% of students have persistent feelings of sadness or hopelessness. Furthermore, 20% of students seriously considered attempting suicide, and 9% attempted suicide, painting a distressing picture of the mental health of students. SBHCs are a proven, evidence-informed model for addressing the full spectrum of youth mental health and substance use needs, from prevention and early identification to treatment and care coordination. Located directly in schools, SBHCs reduce longstanding barriers to care such as transportation, cost, and stigma, ensuring students can access services where they already spend most of their time. More than 80% of SBHCs nationwide provide behavioral health services, delivered either in-person or via telehealth, making them one of the key access points for youth mental health care. SBHCs are uniquely positioned to identify concerns early through routine screenings, provide brief interventions, and deliver ongoing therapy, psychiatric care, including evaluation and medication management, and substance use services. This integrated, school-based approach increases utilization of mental health services among young people and supports improved academic outcomes, attendance, and overall well-being, while reducing reliance on emergency departments and crisis systems.

SBHCs operate through interdisciplinary staffing models that commonly include licensed mental health professionals such as social workers, psychologists, and counselors, alongside primary care providers and, in some cases, psychiatrists or other psychiatric providers and substance use specialists. This team-based structure allows SBHCs to deliver comprehensive, coordinated care that addresses both physical and behavioral health needs. Services may include universal prevention programming, mental health education, screening and assessment, individual and group therapy, psychiatric evaluation and medication management, substance use counseling, crisis intervention, and care coordination with families and community providers. SBHCs also support schools by providing effective alternatives to suspension through on-site behavioral health interventions that keep students engaged in learning while addressing underlying needs. In addition, SBHCs serve as a critical bridge to higher levels of care when needed, connecting students to specialty services such as intensive outpatient programs or inpatient treatment. By embedding clinical expertise within the school environment while maintaining strong partnerships with community health systems, SBHCs ensure continuity of care beyond the school day and across settings, creating a more responsive, efficient, and youth-centered behavioral health system.

Nutrition Education and Food Security Through SBHCs

School-Based Health Centers (SBHCs) also play an important role in promoting healthy nutrition and preventing diet-related conditions among children and adolescents through integrated, patient-centered services. Nutrition assessment, education, and counseling are routinely incorporated into well-child visits and ongoing care, consistent with established clinical guidelines and captured through Uniform Data System (UDS) reporting. SBHCs support students with individualized nutrition counseling as well as broader prevention efforts that promote healthy eating habits and overall wellness. Nutrition services are also integrated into the management of chronic conditions such as obesity, diabetes, and hypertension, ensuring that dietary counseling is part of comprehensive care. Many SBHCs utilize interdisciplinary models that may include primary care providers, registered dietitians, and community health workers, and prioritize culturally and linguistically appropriate education materials alongside ongoing provider training.

At the same time, SBHCs are uniquely positioned to address food insecurity as a key driver of health outcomes by integrating screening and resource connection into routine care. The School-Based Health Alliance's partnership with Share Our Strength's No Kid Hungry campaign demonstrates how SBHCs can operationalize this work at scale. Since 2022, this collaboration has supported SBHCs nationwide in embedding food security screening, referrals, and follow-up into clinical workflows, reinforcing their role as trusted community anchors at the intersection of health and education. In 2024, a national learning and dissemination effort, including webinars, technical assistance, and a comprehensive survey, found that 86% of SBHCs screen for food insecurity, 87% provide referrals to nutrition supports, and 69% track follow-up to some degree. These efforts help normalize conversations about food access, reduce stigma, and strengthen connections to critical programs such as school meals, SNAP, and local food resources. However, SBHCs continue to face barriers, including limited awareness among families, stigma, competing priorities, and a lack of sustainable funding, with 60% of respondents reporting no dedicated funding stream for food security work. Sustained federal investment in staffing, training, data systems, and cross-sector partnerships is needed to ensure SBHCs can continue to integrate nutrition care and food access supports, so that every student identified as needing assistance receives timely, meaningful support.

Conclusion

Every day, students come to school hungry, sick, and face challenges that keep them from being productive learners. School-based health care is part of the solution to keeping youth healthy and ready to learn. The simple fact is that healthy kids learn and grow better. By providing direct access to primary care, mental health, behavioral health, food security support, oral health, vision care, and more, SBHCs give students the opportunity to reach their full potential while relieving stress for families and bolstering communities. Thank you, Chairman Griffith and Ranking Member DeGette, for the opportunity to share this information with the committee.