James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

May 20, 2025

The Honorable Mike Johnson
Speaker
United States House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
House Democratic Leader
United States House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson and Leader Jeffries:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our comments on numerous parts of the combined legislation accompanying the Concurrent Resolution on the Budget for Fiscal Year 2025, specifically House Concurrent Resolution 14. Since the House of Representatives is considering this comprehensive piece of legislation under a condensed legislative calendar, this letter intentionally focuses on the policy issues that are central to the AMA's advocacy platform. More specifically, my colleagues and I are pleased to offer our expertise and perspective on provisions within the legislative proposal pertaining to Medicare physician payment, Pharmacy Benefit Manager (PBM) transparency, Medicaid and the Children's Health Insurance Program (CHIP), artificial intelligence (AI), the Affordable Care Act (ACA) marketplaces, and federal support of medical student loans.

Medicare

The AMA strongly supports section 44304 which provides a positive modification to the conversion factor under the Medicare physician fee schedule. Since 2001, Medicare physician payment updates have fallen 33 percent below inflation in the costs of running a medical practice as measured by the Medicare Economic Index (MEI), severely straining practice sustainability. Congress has adopted several temporary physician payment updates to help address steep cuts that took effect starting in 2021, but each of these updates led to a severe cliff as the payment update expired and reverted to the reduced payment rate as if there had been no legislative provision at all. Section 44304 provides the first Medicare physician payment update that is permanently built into baseline Medicare rates since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.

As recommended by the Medicare Payment Advisory Commission, section 44304 links the Medicare update to the MEI. The proposed 2026 update, 75 percent of the MEI, currently estimated to provide a 2026 payment update of 2.25 percent, is significantly higher than any of the annual physician payment updates in MACRA. It has been decades since Medicare physician payment updates were linked to inflation and the AMA strongly supports it. Importantly, this payment increase will be permanently built into the rates that Medicare pays for patient care delivered by medical practices instead of expiring at the end of the year like so many previous temporary updates. As a result, the AMA estimates that the cumulative growth in Medicare payment updates for physician practices from 2025 to 2035 will be 4.3 percent under section 44304 compared to 2.5 percent under current law, reflecting a nearly two percentage point increase.

Under current law, reductions in the conversion factor over the last five years to account for budget neutrality adjustments have led to payment rates falling to levels that make private practice unsustainable for many physicians. It is absolutely vital that this issue be addressed. It should come as no surprise that physician ownership of their practices has decreased dramatically over the past quarter century. In 2001, 61 percent of physicians were owners. By 2016, fewer than half of physicians had ownership stakes in their practices, and since 2018 more physicians are employees than owners. Physicians should not be forced to leave community-based practice because it is not financially sustainable, and addressing this erosion is essential to strengthening the Medicare program and protecting patient access to care.

We further view these provisions as a foundational step toward comprehensive Medicare physician payment reform in the 119th Congress. Ensuring regular, adequate payment updates is vital to maintaining practice stability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries, particularly in rural and underserved communities. Medical practices in the most rural locations treat four times as many Medicare patients as metropolitan practices. The AMA remains committed to working with Congress to achieve lasting reforms that give patients and physicians the Medicare program they need and deserve.

PBM Transparency

The AMA is also pleased to see the inclusion of language requiring additional levels of transparency from PBMs, as well as efforts to constrain PBM compensation practices that serve to increase costs to patients. The AMA has consistently expressed concern regarding the opaque way PBMs operate and the impact PBM business practices have on access to medically necessary drugs for patients. We have also been deeply concerned about the impact of the business practices of both prescription drug manufacturers and PBMs on costs to both patients and the health care system at large. As such, we strongly support efforts to mandate greater transparency regarding the business practices of PBMs. This lack of transparency has made it difficult to understand exactly how PBMs operate and the nature of their contracting with manufacturers and health plans and in turn has made it difficult to determine appropriate legislative or regulatory action to limit their continued ability to manipulate the system for their own financial gain.

Medicaid and CHIP

The AMA would also like to share our views on proposed changes to the Medicaid and CHIP programs included in the reconciliation legislation. As physicians, we know that Medicaid is a vital component of America's health care infrastructure, providing health insurance coverage to millions of patients and serving as a critical safety net for children, pregnant and postpartum women, seniors, and people with disabilities and serious health conditions. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes, fewer hospitalizations, better educational outcomes, and greater financial security.[1] Medicaid is an indispensable source of coverage for maternal health services, covering over 40 percent of all births in the United States, including almost 50 percent of births in rural areas.[2] In many communities Medicaid is a major source of health insurance coverage or, in

[1] Benjamin D. Sommers, Katherine Baicker & Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions." 367 NEJM 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight in the Evidence" (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, "Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid" (Jul. 2015).
[2] https://www.aha.org/fact-sheets/2025-02-07-fact-sheet-medicaid.

some cases, the primary payer.[3] For the physician practices and other health care providers who serve these communities, Medicaid payments are a crucial source of funding without which they might be unable to continue to operate, jeopardizing access to care in those communities and in rural areas in particular. For all these reasons, the AMA has a strong interest in ensuring that Medicaid remains a reliable source of health insurance coverage for low-income Americans and other vulnerable patients.

The AMA commends the inclusion in the Energy and Commerce title of section 44302, which streamlines the enrollment process for eligible out-of-state providers under Medicaid and CHIP and will increase the ability of children enrolled in Medicaid and CHIP to receive the care they need from the appropriate providers, even if those providers are located in a different state. However, after reviewing the proposed changes to the Medicaid and CHIP programs, we note the potential for unintended consequences that could affect patients, rural and underserved communities, and the providers who serve them. Like any large health insurance program, Medicaid and CHIP lose money to waste, fraud, and abuse.[4] The AMA is supportive of legislative efforts to address these program integrity issues in a targeted fashion. However, changes that would result in reductions in Medicaid and CHIP funding, procedural changes that may lead to coverage disruptions for otherwise eligible patients, or new obstacles to physicians and other providers participating in Medicaid and CHIP would go against the long-standing policy of the AMA that Medicaid reforms should avoid jeopardizing patient access to health care.

Regarding changes that could result in the denial or loss of coverage under Medicaid or CHIP for eligible patients, the AMA is particularly concerned with sections 44101, 44102, 44108, and 44141. These provisions could create additional administrative burdens for patients. The AMA understands that robust processes are necessary for program integrity, but we recommend minimizing administrative complexity to help eligible patients enroll and maintain coverage under Medicaid and CHIP. Administrative hurdles in these two safety net programs are a proven barrier to eligible individuals enrolling for coverage, especially given that of the estimated 25.3 million uninsured Americans in 2023, 6.3 million were eligible for Medicaid or CHIP but not enrolled, often due to administrative barriers.[5] The proposed changes may increase the risk of wrongful denials or disenrollments, disrupting patients' access to care and potentially affecting the continuity of care physicians strive to provide. To limit patient churn and help ensure continuity of care, the AMA has policy that supports 12 months of continuous eligibility in Medicaid and CHIP.

With respect to the community engagement requirements established under section 44141, the AMA appreciates the policy's goal of lifting people out of poverty by incentivizing stable employment. However, as physicians, we are particularly concerned about the potential for coverage losses and disruptions in continuity of care. Work requirements have in some instances contributed to fluctuations in coverage in and out of the program. Experience from state-level programs suggests that work requirements can be administratively complex and that they have not consistently achieved improved employment outcomes.[6] It should be noted that over 90 percent of adults enrolled in Medicaid through the expansion pathway either already work or meet the criteria for an exemption from the requirement, such

[3] https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/.
[4] https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/.
[5] https://www.kff.org/affordable-care-act/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured; https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/.
[6] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment.

as being the parent of a dependent child.[7] While the implementation challenges associated with work requirements and the resulting losses in coverage for working beneficiaries are universal, they are even more pronounced in rural areas.[8] This experience supports AMA policy that opposes work requirements due to serious concerns about the impact that such proposals may have on access to health care for patients who are otherwise eligible for coverage under Medicaid.

Adding complexity to the Medicaid expansion pathway by increasing administrative burdens for expansion patients could have substantial consequences. The expansion option provides an essential pathway to health insurance coverage for millions of low-income Americans (in 2025, the income eligibility threshold for the expansion pathway was $21,597 for a single-person household). Since it was first implemented in 2014, Medicaid expansion has been adopted by 40 states (including seven states that adopted expansion pursuant to a voter referendum) and the District of Columbia[9] and has filled a gap in the health care system by providing coverage to patients without access to employer sponsored insurance or the ability to pay for private insurance. The popularity of Medicaid expansion continues to grow, with new states reinforcing their commitment as recently as March 2025, when Montana voted to make its Medicaid expansion permanent.[10]

Medicaid expansion has been shown to have significant positive benefits for low-income patients, with many studies demonstrating improvements in health care coverage, access, utilization, and mortality.[11] Medicaid expansion has played an important role in fighting America's opioid epidemic, providing much-needed treatment and coverage of lifesaving medications for opioid use disorder to millions of beneficiaries with substance use disorders and creating significant savings through decreased hospital and emergency department utilization.[12] Medicaid expansion has also contributed to substantial improvements in maternal health outcomes in the United States, with research indicating that Medicaid expansion is associated with a 17 percent decrease in hospitalization rates in postpartum women.[13] The expansion has also been an important source of coverage for individuals with chronic health conditions, with 44 percent of expansion enrollees suffering from at least one chronic condition.[14]

For these reasons, we would urge the House to reconsider the proposed changes that create additional administrative barriers for all Medicaid and CHIP patients. To the extent additional program integrity measures are necessary, we would recommend that the House consider adding safeguards to ensure that such measures do not result in putting at risk eligible patients' coverage under Medicaid and CHIP.

---

[7] https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work; https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/.

[8] https://healthlaw.org/wp-content/uploads/2025/04/ParkerNewton_MedicaidWorkRequirementsUndermineRuralHealthcare_04042025.pdf.

[9] https://www.kff.org/status-of-state-medicaid-expansion-decisions/.

[10] https://www.mtpr.org/montana-news/2025-03-28/governor-signs-medicaid-expansion-renewal-into-law.

[11] https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/impact-medicaid-coverage-gap-comparing-states-have-and-have-not; Sarah Miller, Norman Johnson, Laura R Wherry, "Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data," The Quarterly Journal of Economics, Volume 136, Issue 3, August 2021, Pages 1783–1829.

[12] https://ccf.georgetown.edu/2025/02/19/how-medicaid-helps-people-with-substance-use-disorders.

[13] https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00819.

[14] https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/.

Another change that we note could impact timely access to care for some patients is the modification to retroactive coverage requirements contained in section 44122. Under current law, states are required to provide retroactive Medicaid and CHIP coverage for the three months preceding the month in which an eligible patient submits their application for assistance under the program. The proposed change would reduce this requirement to one month of retroactive coverage. To ensure that patients receive the care they need when they need it, AMA policy supports retroactive coverage for low-income patients to the time at which an eligible patient seeks medical care.

The proposed changes to Medicaid and CHIP also include additional provider screening requirements. While current regulations require states to verify provider eligibility upon enrollment or reenrollment, section 44105 would expand this to require provider eligibility databases to be checked every month, by every state, for every provider. Such a requirement would necessitate increased staffing, resources, and expenditures at a time when efficiency in Medicaid is at a premium. The AMA supports these eligibility checks being conducted upon provider enrollment and reenrollment, so as to avoid inefficiencies and undue administrative burdens which could ultimately reduce patient access to Medicaid services.

In a similar vein, section 44106 adds a requirement to screen providers against the Social Security Administration's Death Master File (DMF). We agree that being listed in the DMF is an important data point to flag for further inquiry into the provider's eligibility. However, we are also aware that false positives (names of living individuals) are erroneously added to the DMF at an average rate of 5,500 per month. The AMA recommends that any use of the DMF to determine provider eligibility would use the occurrence of a provider's name in the DMF as a trigger for further inquiry before pursuing any action adverse to that provider's participation in Medicare or Medicaid. Otherwise, should a provider be automatically barred from participation based on a false positive, that provider would suddenly be cut off from access to the program and more importantly, from their patients. Resolving the false positive by confirming the living provider's eligibility status could require an extended amount of time given the scale of these programs and is highly contingent on state staffing levels. Such a delay could unnecessarily disrupt patient care, place strain on small provider practices, particularly those with limited administrative capacity, and could ultimately force some physician practices to close, exacerbating the problem of patient access to their provider or to any care under these programs.

Again, while the AMA generally supports program integrity initiatives in Medicaid and CHIP, we would recommend that Congress include safeguards to ensure that physician practices and other providers are not erroneously barred from participating in these programs. These safeguards could include giving providers notice and an opportunity to appeal before they are adversely affected. Preventing providers who are without fault from participating in Medicaid and CHIP threatens beneficiary access to care and, in some cases, the continued viability of providers.

Another matter that raises concern is the new cost-sharing requirements included in section 44142. While these requirements would only apply to Medicaid expansion patients with incomes that are greater than 100 percent of the federal poverty level ($15,650 for a household of one in 2025), even modest cost-sharing requirements can deter patients from accessing medical care. There is an extensive body of research showing that copayments can make it harder for low-income people to afford needed medical services and force them to make difficult choices between needed health care and other necessities, such as food and rent.[15] This is especially the case for individuals with chronic conditions who may require

[15] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

more frequent medical care and thus be charged more copayments. As physicians, we fear that the proposed cost-sharing provisions could pose barriers to Medicaid beneficiaries' ability to access medically necessary services in a timely fashion, including adhering to physician-prescribed therapies, which could lead to delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.

Artificial Intelligence

The AMA has serious concerns about the inclusion of provisions in section 43201 that would prohibit state-level regulation of AI without additional federal action to create guardrails around the design, development, and deployment of AI. This lack of clear and consistent legislative and regulatory requirements is especially notable as applied to health care AI, including any AI that may be used in federal programs and may impact patient data privacy and patient access to care.

The AMA shares Congress' concerns that a patchwork of state legislation regulating AI would be problematic and confusing for developers, physicians, and patients alike. However, to ensure the safety and protection of our patients, additional federal action to ensure quality, performance, and transparency of AI must be in place. Without additional consumer protections, clear guidelines to assure AI quality, strong consumer data privacy protections, and further action to limit bias within AI systems, Americans will undoubtedly suffer harm. In the absence of any federal action to further these critical protections, states have taken action to fill critical gaps by mandating transparency and stepping up efforts to ensure their residents are covered by strong consumer protection laws that serve to limit unintended consequences from poorly performing AI systems.

In the health care space specifically, use of unregulated AI by federal departments and agencies could ultimately result in inappropriate dissemination and use of protected personal health information and denials of critical health care by federal payers—issues we have already seen come to fruition that have caused real harm to real patients. Stakeholders across industry, physicians, and patient organizations have consistently agreed that additional federal action to create clear and consistent guardrails that seek to ensure patient safety and data privacy are a critical need that remains unaddressed.

While the AMA remains a strong supporter of developing innovative AI tools that reduce physician burden and improve health outcomes for our patients, we also recognize the distinct and serious risks that health care AI poses to patient safety. These risks must be mitigated to the greatest extent possible. This legislation, as currently drafted, may fall short of achieving that goal. It sets a precedent for AI regulation that lacks sufficient clarity, contributes to ongoing confusion, and may fail to provide adequate assurances of performance and safety. We urge a reconsideration of this approach and encourage close collaboration with stakeholders to ensure the right balance between enabling innovation and upholding our shared responsibility to do no harm.

The AMA has significant concerns about section 112204, under which a total of $25 million will be transferred from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund to the Centers for Medicare & Medicaid Services to enter into contracts with AI tool vendors to help identify and reduce improper payments made under Medicare Parts A and B. While supportive of rooting out improper payments, delegating Medicare integrity functions to opaque, black-box algorithms would strip physicians of due-process visibility, invite biased or erroneous claw-backs, and erode clinical autonomy. The legislation is also silent regarding any appeals processes available to physicians or physician practices subjected to errors committed by the AI technology. The AMA is

concerned about the precedent of using AI technology for this purpose and the lack of statutory protections for physicians. Congress should instead require transparent, evidence-based audit standards with meaningful physician oversight and appeal rights before allowing any AI-driven payment policing.

ACA Marketplace

The AMA believes there are opportunities to enhance program integrity and protect taxpayer dollars with regard to the ACA Exchanges. We are concerned, however, that several provisions within sections 44201, 112201,112202, and 112203 codifying provisions of the proposed ACA "Marketplace Integrity and Affordability Rule"[16] will effectively reduce marketplace coverage for middle and low-income Americans. The Trump administration previously estimated that the various reforms included in this package will cumulatively reduce projected enrollment by up to two million individuals, and result in $11-14 billion in fewer advanced premium tax credits (APTC) available to help Americans afford their health insurance every year.[17] We are also concerned by the cumulative effect of these policies happening at once, shortening the enrollment window at the same time income verification processes and timelines are being ramped up, for example. These estimates also do not account for the scheduled expiration of enhanced tax credits at the end of 2025, which would result in an additional $26.1 billion reduction in 2026 alone.[18]

The AMA has significant concerns with provisions in section 44201 that would permanently limit the annual ACA marketplace open enrollment period to 45 days, rather than the previous 75-day timeline. A primary reason for the longer open enrollment period is to give consumers more time to make plan decisions, particularly when their subsidy has changed compared to the previous year. Individuals that are automatically reenrolled may not be aware of subsidy changes or impacts on their premiums until January, so this extended timeframe provides a valuable opportunity for consumers to make more informed decisions about switching plans and should be maintained to prevent coverage disruptions. Further, by shortening the standard annual enrollment period, the Agency is likely deterring healthy individuals from enrolling, which runs counter to the goal of stabilizing the risk pool.

The AMA is also concerned about the potential impacts of sections 44201 and 112202 as they relate to special enrollment periods based on income. We are concerned that the language in the bill could be interpreted to disallow special enrollment periods that are triggered by a change to an individual's income, such as the special enrollment period for individuals who become newly eligible for premium tax credits following a change in income. While the AMA appreciates the need to address potential adverse selection concerns associated with continuous special enrollment periods that allow an individual to enroll in any month provided that their income is below a certain threshold, we also believe it is essential that individuals retain the ability to enroll in a health plan if they experience a change in circumstances, including a change in income, that impacts their health insurance coverage or their eligibility for premium tax credits or cost-sharing reductions. AMA policy would oppose the limitations placed on special enrollment periods by sections 44201 and 112202 if they would prohibit any special enrollment period that allows individuals to enroll in, or change, health plans following a change to their income or coverage status.

---

[16] https://www.cms.gov/files/document/MarketplacePIRule2025.pdf.
[17] https://www.healthaffairs.org/content/forefront/house-republican-budget-reconciliation-legislation-unpacking-coverage-provisions.
[18] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.

If carefully designed, reasonable income verification measures have the potential to strengthen program integrity and ensure enrollees meet income-based and other eligibility requirements. However, we are strongly concerned that provisions within sections 44201 and 112201 may be both burdensome on individual enrollees and difficult for states to administer and may ultimately negatively impact enrollment of eligible individuals, particularly healthy individuals, in marketplace plans, thus also negatively impacting risk pools. For example, automatic enrollment with verification from federal data sources is an effective way to protect the integrity of eligibility requirements and promote coverage for eligible individuals while reducing enrollment burden, yet this would be eliminated under section 112201. Many states already have robust verification processes in place. Adding additional verification criteria and moving up the timeline to require verification prior to enrollment may lead to coverage disruptions, interfering with enrollees' abilities to see their physicians. The AMA also strongly supports flexibility for state exchanges to design their own pre-enrollment verification processes, which these provisions would interfere with.

In sections 44201 and 112203, which bar premium tax credits for individuals that fail to reconcile their previous tax returns, the AMA urges a grace period for enrollees to retroactively reconcile and apply for coverage and have their coverage be retroactively effective to the beginning of the coverage year. This grace period would balance the need to ensure income is verified while averting coverage disruptions for eligible enrollees. Failure to reconcile income status likely reflects a lack of understanding of the need to file taxes based solely on the receipt of APTC, reiterating the strong need to provide educational resources and enrollment support, including through care navigators, particularly during the initial transition period.

Section 44201 would allow issuers to redirect premium payments for the current payment year to instead repay past-due premiums from any previous plan year before coverage can be effectuated for a new benefit year. We have several concerns with this policy. Typically, once insurance premiums go unpaid for a certain period of time, coverage is terminated, and any outstanding claims made during the non-payment window may not be covered. Once coverage is terminated, the enrollee would be responsible for paying for his or her own medical bills moving forward. Therefore, if enrollees are required to pay for any outstanding premiums for any plan year, they are likely paying insurance companies for coverage from which they will not actually benefit. There are also several unanswered questions about how this policy will work logistically, including how services in previous plan years during which coverage was interrupted would be treated, as well as how incomplete payments for premiums would impact coverage for services moving forward. The fact that this policy would extend to unpaid premiums during any period of time in the distant past adds further complication and concern. At a minimum, the lookback period should be limited to 12 months as it was during a prior Trump administration rule and issuers should be required to disclose this policy to enrollees prior to making any payments for new policy premiums. Not disclosing how their money will be spent creates a potentially serious breach of contractual obligations to enrollees.

Section 112203 would remove the current cap on paying back excess advance premium tax credits received during the coverage year based on an enrollee's income. Moving forward, enrollees would owe the full past due amount, regardless of income. The AMA is concerned that this change might be particularly difficult for low-income enrollees to comply with and may result in additional coverage losses.

The AMA is concerned by provisions in section 44201 to widen required de minimis ranges and loosen restrictions on silver-level plans, which would negatively impact patients' ability to afford their coverage

and access health care services. Under the new growth rate methodology, the growth rate for 2026 would be approximately 7.2 percentage points higher than under the previous methodology, which would have several important implications for enrollee cost-sharing, including higher maximum annual cost-sharing limits, higher required contributions (and therefore decreased APTCs), and higher employer shared responsibility payment amounts. Higher out-of-pocket expenses disproportionately impact those with more complex health needs, including those with chronic disease. Broader ranges also confuse enrollees and make it more difficult for enrollees to compare coverage options within the same metal tier levels. Regarding easing silver level plan restrictions, we are concerned about the negative impact on APTCs, which are calculated using the difference between the second lowest cost silver plan premium and the applicable percentage of the enrollee's income. If these provisions are enacted, it will be incumbent on the U.S. Department of Health and Human Services to provide clear information to enrollees about the differences in out-of-pocket costs across plan options and to closely monitor plan premiums to ensure that these proposals are indeed correlating to lower premiums that offset the higher out of pocket costs. If not, patients are simply paying more for the same coverage.

Finally, the AMA is concerned by provisions in 44201 and 112102 that would eliminate marketplace eligibility for lawfully present immigrants including deferred action for childhood arrivals (DACA) recipients, and in the case of section 112102, asylum seekers, and green card holders. The AMA appreciates the need to protect taxpayer dollars. With this in mind, we believe there is an economic argument to be made to maintain ACA coverage and subsidies for immigrants who are in the U.S. legally, as these groups often have minimal alternative health insurance options and would otherwise be uninsured and it is well-established that expanding access to coverage improves population health and is likely to result in reduced costs for the American taxpayer since individuals without insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, often resulting in higher health care costs down the road. Legal immigrants such as green card holders and DACA recipients also play a critical role in local economies. For example,[19] more than 200,000 DACA recipients serve as frontline workers and studies show that individuals with health coverage are likely to miss fewer days of work.[20] Allowing legal immigrants to enroll in exchange coverage would provide stability for these individuals to seek out lawful education and employment opportunities. Furthermore, many of these classes of individuals including DACA recipients are relatively young and healthy,[21] and thus would have a positive impact on ACA risk pools. Therefore, the AMA opposes the proposal to restrict the definition of "lawfully present" to exclude immigrants who are in this country legally.

Student Loans

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. As such, we greatly appreciate the provision in section 30022 that would defer the accrual of student loan interest during the first four years of residency in a somewhat similar manner to the Resident Education Deferred Interest Act (H.R. 2028/S. 942)[22] and believe this provision should be extended to cover the entire residency period of a physician. However, we are extremely concerned about the negative

[19] https://cmsny.org/daca-essential-workers-covid.
[20] https://pmc.ncbi.nlm.nih.gov/articles/PMC2690190.
[21] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[22] https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfra.zip/2025-4-2-Letter-to-Babin-and-Houlahan-re-HR-2028-REDI-Act-v3.pdf.

ramifications of the overall implementation of this bill and ask that at a minimum, carveouts are provided for medical school education to ensure that we can continue to educate our next generation of physicians.

Medical education remains the most expensive post-secondary education in the United States with about 71 percent of medical students graduating with a mean of over $212,000 in educational debt.[23] This is in part due to the fact that the median cost of graduating from a public in-state medical school is $286,454, while the cost of graduating from a private institution is $390,848.[24] As a result, the cost of attending medical school was the number one reason why qualified applicants chose not to apply.[25]

Unfortunately, section 30002 would base the amount of student loans offered on the median cost of attendance for students enrolled in the same program of study nationally. And section 30011 would eliminate subsidized loans and Federal Direct Graduate (GRAD) PLUS loans, limit parents' ability to borrow loans on behalf of their children, and cap the amount of Federal Direct Unsubsidized loans that a student can borrow for professional school to $150,000 not including any amount borrowed to help fund an undergraduate degree.

Currently, Direct Unsubsidized Loans and GRAD PLUS loans are the most common loan types taken out by medical students.[26] Therefore, the combined effect of the elimination of GRAD PLUS loans along with a borrowing cap for Direct Unsubsidized Loans that is $62,000 below the mean amount needed to graduate from medical school will severely limit the number of individuals that can afford a medical degree and likely exacerbate the looming shortage of 86,000 physicians.[27] Moreover, limiting the amount of Direct Unsubsidized Loans that an individual can take based on the median cost of attending medical school will likely require students, especially those from low income backgrounds, to scramble to find multiple funding streams to support their medical education since a significant portion of medical schools will cost more to attend than the national median.

We appreciate the importance of working to create an affordable and sustainable higher education system. However, we worry that the bill, as currently drafted, would make medical school unaffordable for most students, even if they are the most qualified candidates applying. As such, we urge you to maintain subsidized and GRAD Plus loans, allow parents to have better borrowing terms to help fund their children's higher education, and not cap the amount that an individual can borrow to pay for medical school.

Section 30024 would make it so that time spent in residency would not count as a public service job, thereby making residents ineligible for the Public Service Loan Forgiveness (PSLF) program. The PSLF program has increasingly gained popularity since its creation, and in 2024 over 88 percent of medical student graduates with student debt noted in their graduation questionnaire that they intended to participate in the PSLF program.[28] Additionally, studies have shown that more future primary care physicians intend to use PSLF than programs that were historically designed to promote primary care, a

[23] https://store.aamc.org/downloadable/download/sample/sample_id/633/.
[24] *Id.*
[25] https://www.researchgate.net/publication/324523861_Doctors_of_debt_Cutting_or_capping_the_Public_Service_Loan_Forgiveness_Program_PSLF_hurts_physicians_in_training.
[26] https://students-residents.aamc.org/media/9941/download.
[27] https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage.
[28] https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq.

stated bipartisan concern of many members of Congress.[29] These studies show that the PSLF program has the ability to incentivize physicians to work for qualifying employers, which ultimately equates to more physicians practicing for 10 or more years in underserved communities. However, if time as a resident does not count towards loan forgiveness, significantly fewer physicians will participate in this program and in turn access to much needed medical care for patients in rural and underserved communities will be diminished.

Moreover, non-physician practitioners (NPPs), including nurse practitioners and physician assistants, are currently able to count their training time toward loan forgiveness under PSLF.[30] Proposing to exclude physicians from the same eligibility raises concerns about fairness especially given that physicians often enter residency with significantly more education and training than NPPs and, as they progress through their residency, ultimately take on larger workloads and more complicated tasks than their NPP counterparts. Instead, all resident physicians should have access to PSLF during their training years since regardless of whether they are working in a public, private, or nonprofit setting, they are working for low wages to better public health.

Section 30021 would end current repayment plans and replace them with a standard plan and a Repayment Assistance Plan. We applaud the provisions under the Repayment Assistance Plan that would allow those borrowers that are making full- and on-time payments to avoid interest accrual and reduce their principal loan balance by $50 or less for each qualifying payment that is made. However, since this section would do away with the current income driven repayment (IDR) plans, it could cause significant hardship for medical students since over 77 percent of physicians were participating in IDR plans in 2020.[31]

Moreover, under the Repayment Assistance Plan a borrower would have to remain in repayment for 30 years, instead of 25 years, before they could receive forgiveness, and repayment amounts would be based on the borrower's adjusted gross income maxing out at 10 percent for individuals that make more than $100,000 per year. Since year one residents earn a mean salary of about $66,700, they would be paying six percent of their adjusted gross income just to student loans, which is a significant amount for anyone in that salary range.[32] Even those physicians who do eventually go on to earn $100,000 or more will be paying 10 percent of their adjusted gross income for 30 years or until they pay off their balance. This is a significant payment and would likely place substantial stress on, and impede, residents and young physicians from meeting important financial goals like saving for retirement, buying a house, marrying, and more.[33] Furthermore, research finds that students with larger student loan balances, such as those with medical degrees, tend to default less frequently,[34] and the Congressional Budget Office found that only about five percent of individuals who financed a graduate degree (including professional degrees) using federal student loans were in default after six years.[35] Given the high success rate of student loan

[29] https://pubmed.ncbi.nlm.nih.gov/27295187/.
[30] https://www.aapa.org/news-central/2024/12/how-physician-associates-can-qualify-for-student-loan-forgiveness/#:~:text=Public%20Service%20Loan%20Forgiveness%20for%20PAs&text=For%20example%2C%20a%20full%2Dtime,student%20loan%20debt%20management%20strategy.
[31] https://www.degruyterbrill.com/document/doi/10.7556/jaoa.2020.058/html.
[32] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits.
[33] https://www.tandfonline.com/doi/full/10.3402/meo.v19.25603.
[34] https://upcea.edu/wp-content/uploads/2018/03/Exploring-the-Determinants-of-Student-Loan-Default-Rates.pdf#:~:text=2%20As%20student%20loan%20debt,at%20managing%20financial%20risk%2C%20for.
[35] https://www.cbo.gov/system/files/2024-09/58963-student-loan.pdf.

repayment for physicians, we would urge you to continue to allow physicians to access the current repayment plans along with the new repayment plans so that they can choose a plan that will be best suited for them.

Physicians are the backbone of the entire medical system and central to one of the most important federally promised benefits, Medicare. Physicians serve as the gatekeepers of Medicare not only by determining medical necessity and authorizing care, but also by safeguarding the system against fraud, waste, and abuse. By law, Medicare only reimburses for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury" which requires physician certification or documentation.[36] This requirement is even more explicit in key areas of the Medicare statute, such as home health care[37] and hospice services,[38] both of which condition coverage based on physician certification. Therefore, without a robust physician workforce, Medicare could not meet its statutory obligation to provide appropriate, medically necessary care to its beneficiaries, and beyond that medical care cannot be provided to our country at large without an adequate supply of physicians. Unfortunately, this bill may deter individuals from applying to medical school, make medical school unaffordable for all but the wealthiest, make student loan repayment harder for some, and deter physicians from serving in health professional shortage areas. As such, we ask that carveouts be provided for medical school education in recognition of the unique role that physicians play in society and in alignment with the heavy educational burden that they undertake to care for those most in need.

Conclusion

The AMA appreciates the House's careful consideration of the potential impact of proposed changes on physicians and the patients they serve. We stand ready to work collaboratively with Congress to advance policies that promote access to high-quality, affordable care, ensure the sustainability of physician practices, and protect the integrity of vital safety net programs like Medicare, Medicaid, and CHIP.

Sincerely,

James L. Madara, MD

cc: The Honorable Brett Guthrie
The Honorable Frank Pallone
The Honorable Jason Smith
The Honorable Richie Neal
The Honorable Tim Walberg
The Honorable Bobby Scott
The Honorable Jodey Arrington
The Honorable Brendan Boyle
The Honorable Virginia Foxx
The Honorable Jim McGovern

[36] 42 U.S.C. § 1395y(a)(1)(A) https://www.law.cornell.edu/uscode/text/42/1395y.
[37] 42 U.S.C. § 1395f(a)(2)(C) https://www.law.cornell.edu/uscode/text/42/1395f.
[38] 42 U.S.C. § 1395f(a)(7) https://www.law.cornell.edu/uscode/text/42/1395f.