Documents for the Record

Subcommittee on Health Hearing
"Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines"
July 16, 2025

Majority:

1. July 14, 2025, Letter to Reps. Griffith and DeGette from ATA Action
2. July 15, 2025, Letter from the SUNucate Coalition
3. July 15, 2025, Letter to Reps. Griffith and DeGette from the Muscular Dystrophy Association
4. July 16, 2025, Statement from the American Academy of Pediatric Dentistry
5. July 15, 2025, Statement from the Association of American Medical Colleges
6. July 15, 2025, Letter to Reps. Guthrie and Pallone from the Asthma and Allergy Foundation of America
7. July 16, 2025, Collection of letters submitted by Rep. Joyce

Minority:

1. July 15, 2025, Letter to Rep. Landsman from Habitat for Humanity of Summit County
2. July 15, 2025, Letter to Reps. Griffith and DeGette from the American Academy of Family Physicians
3. July 15, 2025, Statement from the Association of American Medical Colleges
4. July 16, 2025, Article from CTeL on Medicaid cuts and telehealth
5. July 15, 2025, Letter to Reps. Griffith and DeGette from the American Dental Association
6. July 16, 2025, Statement from the Environmental Working Group
7. July 16, 2025, Statement from the Muscular Dystrophy Association and the Parent Project Muscular Dystrophy
8. July 15, 2025, Letter to Reps. Griffith and DeGette from the Muscular Dystrophy Association
9. July 15, 2025, Letter to Reps. Griffith and DeGette from the American Federation of State, County, and Municipal Employees, AFL-CIO
10. June 18, 2025, Article from Inside Health Policy
11. July 15, 2025, Letter to Reps. Guthrie and Pallone from various organizations
12. July 15, 2025, Letter to Reps. Guthrie and Pallone from the Asthma and Allergy Foundation of America
13. April 17, 2025, Article from NBC News

July 14, 2025

Chair Morgan Griffith
House Energy and Commerce Health Subcommittee
2125 Rayburn House Office Building
Washington, D.C. 20515

Ranking Member Diana DeGette
House Energy and Commerce Health Subcommittee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair Griffith, Ranking Member DeGette, and Members of the Committee:

On behalf of ATA Action, the American Telemedicine Association's affiliated trade organization, I write to express support for H.R. 3419, legislation to amend the Public Health Service Act to reauthorize the Telehealth Network and Telehealth Resource Centers Grant Programs. We also thank the Committee for holding a hearing to examine this important legislation and for continuing to prioritize telehealth infrastructure and access.

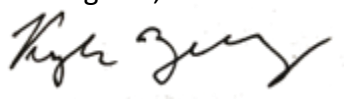
The Telehealth Resource Centers (TRCs) and the Telehealth Network Program are both vital to sustaining and expanding telehealth services nationwide. Today, there are 14 TRCs across the country, 12 regional centers and 2 national centers, that provide neutral, expert guidance and technical assistance to healthcare providers in every state and U.S. territory. These centers are critical to supporting the implementation of telehealth, especially in rural, underserved, and frontier communities.

During the COVID-19 pandemic, TRCs experienced a surge in demand of over 800%, and demand continues to remain at 400% above pre-pandemic levels. This sustained need underscores the importance of ensuring TRCs have the resources to scale operations and meet the moment.

We are especially pleased to see that H.R. 3419 includes a funding increase to $42,050,000 annually for fiscal years 2026 through 2030—a significant and timely investment in telehealth infrastructure. While the legislation reauthorizes both the TRC and Telehealth Network Grant Programs and does not specify how the increased funds will be allocated between them, we urge the Subcommittee to consider including intent language clarifying that a meaningful portion of this increase should be directed to support the work of the TRCs. Given the dramatic and sustained increase in demand for TRC services, ensuring that this funding supports their capacity and growth would align with the needs of the healthcare system.

Telehealth is now a core component of how care is delivered in the United States. Reauthorizing and strengthening these foundational programs is essential to preserving access and driving innovation. ATA Action urges swift passage of H.R. 3419 and appreciates the opportunity to voice support for this critical legislation.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

July 15, 2025

House Subcommittee on Health
House Energy & Commerce Committee
U.S. House of Representatives
Delivered Electronically

Dear Members of the House Subcommittee on Health:

As members of the SUNucate Coalition, including medical specialty associations, patient, public health, and other groups, we write in strong support of H.R. 3686, the SAFE Sunscreen Standards Act, which would streamline the FDA review process of the effectiveness and safety of new ingredients for nonprescription sunscreens. Skin cancer is a pressing public health issue, and we believe this would be a significant step in promoting skin cancer prevention by ensuring Americans have access to the most effective sunscreen ingredients.

Skin cancer is the most common form of cancer in the U.S.[1], and one in five Americans will develop skin cancer by the age of 70[2]. However, it is highly preventable as regular sunscreen use helps reduce overall lifetime skin cancer rates[3]. Despite the proven efficacy of sunscreen in reducing skin cancer risks, the United States lags behind many other countries which have nearly twice as many sunscreen ingredients that better absorb or block UV radiation[4].

The FDA has not approved a single new sunscreen ingredient since the 1990s, despite Congress passing the Sunscreen Innovation Act in 2014 to establish a process for review and approval of active sunscreen ingredients. Americans deserve the best possible sunscreen to protect themselves and their families.

The SAFE Sunscreen Standards Act is a bipartisan effort, and, if passed, would aid in reducing skin cancer rates in the United States. We urge you to support H.R. 3686 and encourage the committee to act now and vote for its passage out of the House Subcommittee on Health. Should you have any questions, please do not hesitate to

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[1] US Centers for Disease Control and Prevention. Melanoma of the Skin Statistics. https://www.cdc.gov/skin-cancer/statistics/.
[2] The Skin Cancer Foundation. Facts About Sunburn and Skin Cancer. https://www.skincancer.org/skin-cancer-information/skin-cancer-facts/
[3] Green, A., et.al.; Reduced Melanoma After Regular Sunscreen Use: Randomized Trial Follow-Up J Clin Oncol 2011 Jan. 29:257-263.
[4] Rogin, A., & Wilde, W. (2023, August 27). *Why Sunscreen in the United States is behind the rest of the world*. PBS. https://www.pbs.org/newshour/show/why-sunscreen-in-the-united-states-is-behind-the-rest-of-the-world

contact Kristin Hellquist, Senior Chief Advocacy Officer at the American Society for Dermatologic Surgery Association, at khellquist@asds.net.

Sincerely,

American Academy of Dermatology Association
American Society for Dermatologic Surgery Association
American Society of Plastic Surgeons
American Society for Mohs Surgery
Florida Academy of Dermatology
IMPACT Melanoma
Indiana Academy of Dermatology
Melanoma Action Coalition
Melanoma Research Alliance
Personal Care Products Council
Public Access to SunScreens Coalition
Rhode Island Dermatology Society
Skin Cancer Foundation
Society of Dermatology Physician Associates
Utah Dermatology Society

July 15, 2025

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

Dear Chairman Griffith and Ranking Member DeGette:

In service of the neuromuscular disease (NMD) patient community, the Muscular Dystrophy Association (MDA) thanks the Energy and Commerce Subcommittee on Health (the Subcommittee) for convening tomorrow's hearing titled "Legislative Proposals To Maintain And Improve The Public Health Workforce, Rural Health, And Over-The-Counter Medicines". In particular, we are incredibly grateful for the Subcommittee's consideration of the Newborn Screening Saves Lives Reauthorization Act of 2025, legislation that will strengthen and modernize our newborn screening ecosystem across the country. We ask that you support this legislation as part of your participation in tomorrow's hearing.

MDA is the #1 voluntary health organization in the United States for people living with muscular dystrophy, ALS, and related neuromuscular diseases. For 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.

Newborn screening is one of the most successful public health programs in U.S. history. Put together, each state's program collectively screens nearly every newborn in the United States for over 35 conditions that, if diagnosed at birth, can be treated, thus avoiding some of, if not all, of the most challenging features of the disease. Newborn screening saves thousands of lives every year, is one of the most cost-effective public health programs in history, and will only grow in importance as additional targeted and genetic rare disease therapies are developed and made available.

Newborn screening is particularly important to the rare neuromuscular disease community that we serve. Two conditions, spinal muscular atrophy (SMA) and Pompe disease, are currently included on the Recommended Uniform Screening Panel (RUSP) with universal state adoption of SMA, and the vast majority of states screening for Pompe disease. We, along with Parent Project Muscular Dystrophy, have also submitted Duchenne muscular dystrophy for consideration to be added to the RUSP. While the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) was disbanded this Spring, we remain hopeful that the Department of Health and Human Services and Secretary Kennedy will consider the evidence supporting our nomination and will add Duchenne to the RUSP.

The Newborn Screening Saves Lives Reauthorization Act is incredibly important to our community for a number of reasons. First, the legislation reauthorizes and updates programs at the Health Resources and Services Administration (HRSA) that support and guide states on which conditions for which to screen, how to construct follow up programs for those who are diagnosed, and more. Second, the legislation reauthorizes and updates programs at the Centers for Disease Control and Prevention (CDC) that are instrumental in assisting state public health laboratories on the process of collecting and assessing the dried blood spots that are tested in newborn screening as well as the confirmatory testing following positive screens. Finally, the legislation reauthorizes and updates the Hunter Kelly Newborn Screening Research Program at the National Institutes of Health (NIH) that researches new potential screens for diseases not currently on the RUSP among other newborn screening research endeavors.

This legislation gives the Subcommittee the opportunity to support a comprehensive update to our newborn screening ecosystem and infrastructure by ensuring the Federal programs dedicated to assisting states are robust, up-to-date, and well-funded. We urge Subcommittee members to support the legislation in this hearing.

We appreciate this opportunity to provide the Committee with the perspectives of the NMD community. 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

AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth®

Hearing of the United States House Committee on Energy and Commerce

Subcommittee on Health

On

"Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines"

By

American Academy of Pediatric Dentistry (AAPD)

July 16, 2025

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

The American Academy of Pediatric Dentistry (AAPD) appreciates the opportunity to submit this statement for the record for the Subcommittee on Health of the House Energy and Commerce Committee's July 16, 2025, hearing on "Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines."

The AAPD was founded in 1947 and is the leading national advocate dedicated exclusively to children's oral health, representing over 11,000 pediatric dentists across the U.S. Pediatric dentists provide care to millions of our nation's infants, children, adolescents, and persons with special health care needs, and are the primary contributors to professional education programs and publications on pediatric oral health.

The AAPD asks that the Subcommittee support and vote to pass legislation before it today to reauthorize the Title VII Pediatric Dental/General Dental Workforce and Faculty Development Programs that have long been administered through the Department of Health and Human Services.

What is the Title VII Program and Why Is It a Priority

The Title VII dental workforce program is a cornerstone of America's oral health infrastructure, playing an essential role in expanding access to dental care—especially for children, medically underserved populations, and rural communities. By supporting dental faculty development, predoctoral and postdoctoral dental training, and loan repayment programs, Title VII has strengthened the dental workforce, directly addressing national shortages of pediatric and general dentists. Over the last two decades, these investments have enabled thousands of

dental professionals to serve in high-need regions, improving access to care for vulnerable families and helping to prevent and reduce the incidence of the leading children's chronic disease: dental decay.

Reauthorizing Title VII in 2025 is critical to sustaining these gains and building future capacity. The program not only increases the number of providers but also trains dentists to care for patients with special needs and helps ensure a robust pipeline of faculty who can prepare the next generation of oral health professionals. As the dental field faces ongoing challenges, including workforce maldistribution and rising demand from newly insured children and aging populations, continued federal commitment to Title VII is vital for promoting oral health, supporting local economies, and upholding the health of communities nationwide.

Supporting Rural Communities

Rural communities face pronounced shortages of dental professionals, with many counties having significantly fewer dentists per capita than urban areas. This scarcity results in lower dental care utilization and worse oral health outcomes for rural residents, including higher rates of untreated dental disease and tooth loss.

How Does Title VII Work

Title VII supports pediatric dentistry health care workforce education and training through grants to and contractual agreements with institutions to support predoctoral (dental school) education and post-doctoral residency programs and a Dental Faculty Loan Repayment Program (DFLRP), among other efforts. A dentist trainee learns advanced diagnostic and surgical procedures, along with unique care techniques and skills for dealing with children such as child psychology and behavior guidance; child development; and caring for patients with disabilities.

Since children's oral health is an important part of overall health, pediatric dentists often work with pediatricians, other physicians, and dental specialists. The Title VII program is an essential resource in meeting the unmet oral health needs for many families and addressing the national shortage of pediatric dentists. The program serves to build a health professions pipeline and a workforce that meets the needs of individuals in both rural and urban underserved communities. As we face nationwide shortages in the health professions, investment through Title VII programs in the dental workforces creates a robust network of dental and dental hygiene students to enter the field prepared to serve and support the unique needs of children in rural and other underserved communities throughout the country.

In addition to directly supporting dental residency training and placement of dentists, the program also supports a dental faculty loan repayment program, incentivizing dental professionals to train future practitioners who are able to then meet the needs of rural and other underserved communities. The program may support loan repayment contracts over five years to recruit and retain faculty. Full-time faculty members are eligible for repayment of 10, 15, 20, 25 and 30 percent of their student loan balance (principal and interest) for each year of service while they provide dental care in an underserved community.

Recent reports indicate that 69 percent of graduates serve in rural and other medically underserved communities, with an additional 20 percent contributing to primary care settings, such as Federally Qualified Health Centers (FQHCs), following their completion of the oral health training program.

We urge the Committee to support the Title VII program's re-authorization in 2025. This program is vital for bridging the gap in rural and other underserved communities' oral health by supporting education, recruitment, and placement of dentists in communities that need them most. Its continued support is key to reducing preventable dental disease and promoting overall health in America's rural and other underserved populations recognizing that the program is making an impact in the recruitment of dentists to serve these communities as well as developing new and needed pediatric and general practice dental faculty to train the next generation of dentists.

The AAPD looks forward to working with the Subcommittee and full Committee to pass Title VII reauthorization this year. For questions or further discussion, please contact AAPD's government relations representative, Julie Allen at Julie.allen@powerslaw.com or 202-494-4115.

Press Release

Association of
American Medical Colleges
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Media Contact:
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202-828-0473
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AAMC Statement on Reauthorization of Title VII Health Professions and Title VIII Nursing Workforce Development Programs

Washington, D.C., July 15, 2025—*AAMC President and CEO David J. Skorton, MD, and AAMC Chief Public Policy Officer Danielle Turnipseed, JD, MHSA, MPP, issued the following statement ahead of the U.S. House of Representatives Energy and Commerce Health Subcommittee hearing on legislative proposals to expand the health workforce:*

"Strengthening the health care workforce is a top priority for the AAMC. We strongly support committee action to reauthorize all of the Health Resources and Services Administration's (HRSA) Title VII health professions and the Title VIII nursing workforce development programs. These critical programs ensure the country can support training for physicians, nurses, mental and behavioral health professionals, public health practitioners, and other providers — many of whom go on to serve in rural and other medically underserved communities.

Reauthorizing Title VII and Title VIII programs is critical to recruiting, training, and retaining the next generation of health care professionals who are prepared to meet the needs of the American people. Legislation that makes meaningful investments in the health care workforce is especially critical at a time when the U.S. faces significant provider shortages, burnout, and widening gaps in health outcomes.

The AAMC strongly urges lawmakers to reaffirm the federal government's commitment to making America healthy by building a health care workforce capable of meeting the evolving health needs of patients and communities nationwide by reauthorizing all Title VII and Title VIII programs."

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The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers

International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe. Learn more at aamc.org.

Asthma and Allergy Foundation of America

July 15, 2025

The Honorable Brett Guthrie
Chair, House Committee on Energy & Commerce
U.S. House of Representatives Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member,
House Committee on Energy & Commerce
U.S. House of Representatives Washington, DC 20515

Re: *Amend H.R. 4273 to Reaffirm the GRAS/E Standard for Clarity and Trust*

Dear Chair Guthrie and Ranking Member Pallone:

On behalf of the Asthma and Allergy Foundation of America (AAFA), we are writing to express our support for H.R. 4273 which reauthorizes the Over the Counter (OTC) Monograph User Fee Program (OMUFA). AAFA is the leading patient organization for nearly 100 million Americans with asthma and allergies. AAFA is also the oldest asthma and allergy patient organization in the world, committed to saving lives and reducing the burden of disease for people with asthma and allergies through support, advocacy, education and research.

As you consider this important legislation, we urge you to include an amendment to reaffirm the foundational standard that ensures over the counter (OTC) medicines are Generally Recognized as Safe and Effective (GRAS/E), a principle that is essential to preserving consumer trust, regulatory clarity, and innovations that the people we serve want and need.

Why do we care about this specific policy?
Millions of Americans rely on safe and effective OTC medicines every day as their first line of defense from common self treatable conditions including pain relief, allergies, digestive health, oral care, and more. OTC medicines save the U.S. healthcare system $167 billion annually by reducing the need for prescription drugs and minimizing unnecessary visits to the doctor. Public trust in OTC products is rooted in confidence that they meet published, science

based standards with the GRAS/E framework as the foundation of the OTC monograph system.

Why is this important to consumers?

OTC medicines are intended to be used without a healthcare provider's supervision. The GRAS/E standard ensures OTC products are evaluated under a public process with a science based model that is uniquely designed for OTC ingredients, purposely different than the prescription drug evaluation model. Unlike the New Drug Application (NDA) process required for prescription drugs, the monograph pathway anchored by GRAS/E gives consumers faster access to new, innovative product formulations of existing, well known, proven ingredients to help meet their evolving needs without the added costs and delays of the NDA process.

What's the problem?

Since OMUFA was enacted in 2020, there has been growing misalignment between Congress's intent and the U.S. Food and Drug Administration's (FDA) implementation of the law. FDA has indicated it may want NDA type requirements to finalize standards for unfinished OTC monographs, rather than relying on the established GRAS/E framework based on published studies. As a result, monograph innovation has stalled, which is bad news for patients and consumers. In fact, in the last five years, there has only been one manufacturer initiated request for a monograph innovation, and it hasn't been issued yet, due in part to the perceived FDA shift away from established GRAS/E principles. This threatens to limit access to affordable self care and makes everyday health solutions harder to reach especially for vulnerable populations and underserved communities with limited healthcare options.

Reaffirming GRAS/E is good for public health.

A clear confirmation of the GRAS/E standard would remove uncertainty and ensure FDA, Congress, and industry are aligned. An amendment confirming GRAS/E isn't a rewrite, it's a affirmation that will keep the OTC monograph system operating as Congress always intended. This would strengthen public trust, encourage manufacturers to develop innovative new OTC products on behalf of consumers in your districts, and preserve consistent, science based standards that enable additional safe, effective, and affordable self care options for the communities we all serve.

Asthma and Allergy Foundation of America

We support H.R. 4273 and urge you to add an amendment reaffirming the GRAS/E standard to ensure that patients and consumers continue to have access to and confidence in the variety of safe and effective OTC medicines they want, need, and trust.

Sincerely,

Kenneth Mendez

Kenneth Mendez
President and Chief Executive Officer
Asthma and Allergy Foundation of America

June 13, 2025

The Honorable John Joyce, MD
2102 Rayburn House Office Building
Washington, District of Columbia 20515
United States

Dear Dr. Joyce:

As members of the SUNucate Coalition, including medical specialty associations, patient, public health, and other groups, we write to applaud the effort to streamline the FDA review process of the effectiveness and safety of new ingredients for nonprescription sunscreens through the introduction of H.R. 3686, the SAFE Sunscreen Standards Act. We believe this would be a significant step in promoting skin cancer prevention by ensuring Americans have access to the most effective sunscreen ingredients.

Skin cancer is the most common form of cancer in the U.S.[i], and one in five Americans will develop skin cancer by the age of 70[ii]. However, it is highly preventable as regular sunscreen use helps reduce overall lifetime skin cancer rates[iii]. Despite the proven efficacy of sunscreen in reducing skin cancer risks, the United States lags behind many other countries which have nearly twice as many sunscreen ingredients that better absorb or block UV radiation[iv].

The FDA has not approved a single new sunscreen ingredient since the 1990s, despite Congress passing the Sunscreen Innovation Act in 2014 to establish a process for review and approval of active sunscreen ingredients. Americans deserve the best possible sunscreen to protect themselves and their families.

We commend your commitment to public health through the introduction of this legislation and upholding the importance of skin cancer prevention as the only dermatologist in Congress. We look forward to continuing to support this legislation as it makes its way through Congress. Should you have any questions, please do not hesitate to contact Kristin Hellquist, Senior Chief Advocacy Officer at the American Society for Dermatologic Surgery Association, at khellquist@asds.net.

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[i] US Centers for Disease Control and Prevention. Melanoma of the Skin Statistics. https://www.cdc.gov/skin-cancer/statistics/.
[ii] The Skin Cancer Foundation. Facts About Sunburn and Skin Cancer. https://www.skincancer.org/skin-cancer-information/skin-cancer-facts/
[iii] Green, A., et.al.; Reduced Melanoma After Regular Sunscreen Use: Randomized Trial Follow-Up J Clin Oncol 2011 Jan. 29:257-263.
[iv] Rogin, A., & Wilde, W. (2023, August 27). *Why Sunscreen in the United States is behind the rest of the world*. PBS. https://www.pbs.org/newshour/show/why-sunscreen-in-the-united-states-is-behind-the-rest-of-the-world

Sincerely,

AIM at Melanoma
American Academy of Dermatology Association
American Association of Kidney Patients
American Society for Dermatologic Surgery Association
American Society for Mohs Surgery
American Society of Plastic Surgeons
Arizona Society of Dermatology and Dermatologic Surgery
Colette Coyne Melanoma Awareness Campaign
Dermatology Nurses' Association
Florida Academy of Dermatology
Florida Society of Dermatologic Surgeons
Melanoma Research Alliance
Melanoma Research Foundation
Ohio Dermatological Association
Outrun the Sun
Personal Care Products Council
Public Access to SunScreens Coalition
Skin Cancer Foundation
Society for Pediatric Dermatology
Society of Dermatology Physician Assistants
Sun Hero
Utah Dermatology Society

July 15, 2025

House Subcommittee on Health
House Energy & Commerce Committee
US House of Representatives
Delivered via Email

Dear Members of the House Subcommittee on Health,

I write to you on behalf of *AIM at Melanoma* and *AIM at Skin Cancer* about **our strong support of H.R. 3686,** the *Supporting Accessible, Flexible, and Effective Sunscreen Standards Act* ("SAFE" Sunscreen Standards Act), legislation aimed at facilitating the development and approval of safe and effective sunscreen active ingredients.

I see an incredible amount of suffering from melanoma daily and firsthand, both personally and professionally. My husband is a Stage IV patient; a tumor appeared on his head last month after he had lived 12 years seemingly disease free. Our foundation was formed after our president's then 26-year-old sister died of melanoma. I work with patients every day who are struggling to beat their cancer and live their lives. AIM at Melanoma's mission is to end this disease in our lifetime while improving the lives of those it affects.

And melanoma affects a lot of people. In 2025, it is estimated that 212,000 cases of melanoma will be diagnosed in the United States, just under half of those invasive cases[1]. Over 8,400 people are estimated to die of the disease[1]. In the past 15 years, the number of new invasive melanomas diagnosed annually has increased by 54%[2].

But it's not just melanoma that's concerning: Squamous and basal cell skin cancer diagnoses are commonly estimated at over 5 million every year (based on data from 2012)[3], and squamous cell

[1] American Cancer Society. "Cancer Facts and Figures 2025". Atlanta: American Cancer Society; 2025.

[2] American Cancer Society. "Cancer Facts and Figures 2010". Atlanta: American Cancer Society; 2010

[3] Rogers HW, Weinstock MA, Feldman SR et al. Incidence Estimate of Nonmelanoma Skin Cancer (Keratinocyte Carcinomas) in the U.S. Population, 2012. JAMA Dermatol. 2015;151(10):1081-6. doi: 10.1001/jamadermatol.2015.1187

skin cancer deaths are estimated to be several thousand each year. Almost one in five Americans will develop skin cancer[4,5]. Each year, there are more new cases of skin cancer than the next five most prevalent cancer types combined[5]. For many millions of people, skin cancers are disfiguring, costly, and frightening.

However, melanoma and nonmelanoma skin cancers are mostly preventable because the vast majority are caused by UV damage from the sun[6]. In fact, your risk for melanoma doubles if you've had more than five sunburns[7]. Further, just one *blistering* sunburn in childhood or adolescence more than doubles your chances of developing melanoma later in life[8]. **These facts should be most concerning for your subcommittee, as sunscreen is a critical tool to protect our skin against sunburn and UV damage and therefore reduce the risk of developing melanoma and nonmelanoma skin cancers.**

We need a wide variety of safe and effective sunscreen products and formulations to help protect American citizens from these preventable cancers.

Unfortunately, no new sunscreen ingredients have been approved by FDA since the 1990s, despite multiple more effective sunscreen ingredients approved and used globally in that same time period. **Instead of being a leader in safe and effective product development, as the U.S. usually is, we are trailing the rest of the world in sunscreen development and availability. And instead of being a leader in clear public health messaging, as the U.S. usually is, we have inadvertently sent messages that something is wrong with sunscreen. Both of these circumstances translate into needless suffering by our citizens.**

The SAFE Sunscreen Standards Act streamlines the FDA review process for evaluating the safety and efficacy of sunscreen active ingredients, allowing for the use of real-world evidence, observational studies and non-animal testing methods. The SAFE Act is a bipartisan bill that will help reduce the rate of skin cancer in the U.S.

On behalf of *AIM at Melanoma* and *AIM at Skin Cancer*, **I urge you to support H.R. 3686.**

Thank you.

Sincerely,

Alicia Rowell
Vice President
AIM at Melanoma
925/800-9275

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[4]Rogers HW, Weinstock MA, Feldman SR et al. Incidence Estimate of Nonmelanoma Skin Cancer (Keratinocyte Carcinomas) in the U.S. Population, 2012. JAMA Dermatol. 2015;151(10):1081-6. doi: 10.1001/jamadermatol.2015.1187

[5] Benci JL, Minn AJ, Vachani CC et al. Survivorship care planning in skin cancer: An unbiased statistical approach to identifying patterns of care-plan use. Cancer. 2018;124(1):183-191. doi: 10.1002/cncr.30985

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SkinCancer.org

July 15, 2025

The Honorable Brett Guthrie
House Subcommittee on Health
House Energy and Commerce Committee
U.S. House of Representatives

Dear Representative Guthrie,

As president of The Skin Cancer Foundation and a practicing dermatologist who has spent more than three decades treating patients with skin cancer, I am writing with deep personal conviction to urge your support for **H.R. 3686, the SAFE Sunscreen Standards Act**.

Every day in my office, I care for patients who are facing the reality of a skin cancer diagnosis. Some require procedures to remove tumors that can be physically and emotionally draining. Others face complex treatment plans, a long recovery, financial burdens and the uncertainty that comes with any cancer diagnosis. For patients with melanoma, which is the deadliest form of skin cancer, that uncertainty can become a life-threatening battle. Tragically, **two people die of skin cancer every hour in the United States**. These are not just statistics to me; they are the faces and families I see and support every day.

Yet we know that **regular use of sunscreen can help reduce the risk of squamous cell carcinoma by about 40 percent and melanoma by 50 percent**. Sunscreen is a simple, proven tool in our fight against this disease.

While there are good sunscreen options already available in the United States, Americans deserve access to the broadest, most advanced range of products, like those approved in other countries. This would help them choose the ones that best suit their needs, preferences, skin tones and lifestyles.

The last new active sunscreen ingredient approved in the U.S. was in **1999, more than 25 years ago**. Meanwhile, countries like Australia and those in the European Union and Asia have approved newer, more effective filters that offer better protection and greater cosmetic elegance.

The reality is simple: Without the most up-to-date sunscreen options, we are leaving Americans unnecessarily exposed. **People are more likely to wear sunscreen if they have access to more product options, which they might prefer because they consider them to feel better, blend better and offer**

superior protection.

H.R. 3686 offers a pathway to modernize and streamline the FDA's sunscreen approval process, allowing American consumers access to the same advanced sun protection products available elsewhere in the world. This is not just regulatory reform, it is a crucial step toward reducing the burden of skin cancer in this country.

As a physician on the front lines of this public health crisis, I implore you to support the SAFE Sunscreen Standards Act and vote for its passage out of the House Subcommittee on Health. Millions of Americans would benefit from its passage.

Thank you for your leadership on behalf of our nation's health. I would welcome the opportunity to speak with you further on this issue.

With appreciation,

Deborah S. Sarnoff, MD
President, The Skin Cancer Foundation
Clinical Professor of Dermatology, NYU Grossman School of Medicine

July 15, 2025

Energy & Commerce Health Subcommittee

US House of Representatives

2125 Rayburn House Office Building

Washington, D.C. 20515

Dear Members of the Energy and Commerce Health Subcommittee,

On behalf of the Public Access to SunScreens (PASS) Coalition—a multi-stakeholder alliance of public health organizations, health care providers, and sunscreen manufacturers—we write to express our strong support for H.R. 3686, the SAFE Sunscreen Standards Act and to respectfully urge its inclusion in the upcoming Over-the-Counter Monograph User Fee Act (OMUFA) reauthorization.

As you may know, skin cancer remains the most common cancer in the United States, with over 5 million Americans treated annually and rising incidence rates projected for 2025. Despite the proven efficacy of broad-spectrum sunscreens in preventing skin cancer, Americans still lack access to the most advanced sunscreen technologies available globally. This is due in large part to the FDA's failure to approve a single new sunscreen active ingredient under the OTC monograph since the 1990s.

Congress took a critical step in 2014 by enacting the Sunscreen Innovation Act (SIA) to address this backlog. However, the FDA's implementation has fallen short of Congressional intent, imposing rigid and outdated testing requirements that have stalled innovation and denied consumers access to modern, effective sun protection.

The SAFE Sunscreen Standards Act, championed by bipartisan leadership of the Skin Cancer Caucus, offers a pragmatic solution. By allowing the FDA to consider real-world evidence, observational studies, and non-animal testing methods, the bill preserves rigorous safety standards while introducing much-needed flexibility into the review process. These reforms are essential to aligning U.S. regulatory practices with global standards and ensuring timely access to safe and effective sunscreens.

We believe the upcoming OMUFA reauthorization presents a timely and appropriate legislative vehicle to advance these reforms. Including the SAFE Sunscreen Standards Act in OMUFA would not only modernize the FDA's regulatory framework but also reaffirm your office's commitment to public health, innovation, and consumer protection.

We ask for your support on this issue and stand ready to supplement your efforts to ensure this critical legislation is enacted. Please do not hesitate to reach out if we can provide additional information.

Sincerely,

PASS Coalition

Habitat for Humanity of Summit County

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Rochelle D. Sibbio
President & CEO

The Honorable Greg Landsman
U.S. House of Representatives
Washington, DC 20515

Dear Representative Landsman:

I am writing today to ask for your support for the Geriatric Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Awards (GACA) program that are being considered for reauthorization at your upcoming July 16 hearing entitled: ***Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines.***

The Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program are two programs that successfully carry out exactly what you are looking for in this hearing: proposals that maintain and improve the public health workforce and rural health. GWEPs and GACAs are administered by the Health Resources and Services Administration (HRSA), are the only programs in our state and across the nation that do the important work of training primary care providers, doctors, nurses, pharmacists, social workers, other health professionals, as well as patients, families and caregivers with the skills and interdisciplinary tools needed to deliver age-friendly and dementia-friendly person-centered care to rural and underserved adults and their caregivers.

The U.S. spends nearly $1 trillion annually on Medicare and Medicaid for older adults. Falls alone cost approximately $50 billion, dementia care $384 billion, average nursing home $65 billion, and chronic illness care exceeds $169 billion for just heart disease, COPD, and diabetes. The entire GWEP program across the U.S. costs just $41.2 million per year to fund 42 GWEPS across 37 states. Thus, GWEP programs that mitigate these geriatric issues are highly cost-effective. **Therefore, I ask that you support reauthorization of the GWEPs in the upcoming hearing whether as part of the full bill (HR4262) or as a separate entity if support of the full bill is not possible.**

Ohio's only GWEP is housed at Northeast Ohio Medical University with collaborators across the State including The Ohio State University, Ohio University, The University of Akron, Cleveland State University, multiple Area Agencies on Aging, the Alzheimer's Association, Summa Health, Benjamin Rose Institute on Aging, Veterans Affairs, Community Support Services of Akron, Ohio Council for Cognitive Health, Habitat for Humanity, and numerous Federally Qualified Health Centers. Nationally GWEPs have provided training to over 467,154 healthcare professionals,

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community-based providers, students, patients, and caregivers. Our GWEP has trained thousands of healthcare providers, community-based providers, students, faculty, residents, fellows, patients, families, and caregivers. Real patient outcomes are improved through better access to expertise to mitigate social determinants of health, including through health technology. As you know it is these social drivers of health, even more than diseases, that drive costly healthcare utilization, yet less than 3% of current healthcare spending focuses on prevention. We also educate students and their faculty to fill current widespread gaps in geriatrics and dementia education. In fact, there are fewer than 7,000 geriatricians in the U.S.A. with just 163 in Ohio. Few professional training programs incorporate any geriatrics training. Importantly, we have educated hundreds of patients, families and caregivers who are the backbone of caregiving for older adults and those with dementia (providing $11.4 billion in unpaid care annually) to improve their chronic illness management skills and keep patients living independently in their own homes and preventing avoidable costly hospitalizations and nursing home placement. These preventive measures can significantly impact both Medicare and Medicaid payment systems and decrease the burden on rural health systems. With continued funding we will continue to expand this educational and clinical model into new rural and medically underserved primary care sites to broaden the impact across the State of Ohio.

I would be happy to speak with you further about my work and the ways that we can equip health care professionals to suitably care for us all as we age.

Sincerely,

Rochelle D. Sibbio
President & CEO
Habitat for Humanity of Summit County

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AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

July 15, 2025

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

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Energy and Commerce Committee
2322A Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the more than 128,300 family physicians and student members of the American Academy of Family Physicians (AAFP), we would like to encourage the Committee to consider additional legislative and policy proposals for your upcoming hearing, "Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines."

The U.S. faces a critical family physician workforce shortage, which has led to disparate access to care for patients nationwide and disproportionately affects rural and underserved communities. The AAFP encourages the Committee to consider policies that reimagine our country's recruitment, training and retention of primary care physicians in these areas. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

We appreciate that reauthorization of Title VII programs administered by the Health Resources and Services Administration (HRSA) is on the docket for this hearing. For decades, Title VII programs have played an integral role in our nation's primary care physician training. The legislation specifically seeks to reauthorize programs that the Academy has long supported, such as Primary Care Training and Enhancement (PCTE), Area Health Education Centers, and scholarships and educational assistance for individuals from disadvantaged backgrounds. Unfortunately, the Department of Health and Human Services (HHS) proposed budget aims to cut all funding for PCTE and Medical Student Education programs. We urge the Committee to continue to not only reauthorize these essential programs but to champion them in discussions with the Administration.

As you consider continuation of these essential workforce programs, the AAFP also strongly encourages the Committee to prioritize continuation and expansion of other primary care workforce programs with approaching expirations. We also urge advancement of other proposals within the Committee's jurisdiction that would bolster the primary care workforce and expand access to care, particularly in rural communities. The AAFP welcomes the opportunity to work with you to support future hearings and markups that would address these issues that we discuss below.

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Further, the Committee must act before September 30 to reauthorize, and should provide increased funding for, community health centers (CHCs), including federally qualified health centers (FQHCs) and rural health clinics (RHCs). Primary care physicians make up nearly 90 percent of physicians working in CHCs, and most of those physicians are family physicians. [i] Not only are CHCs often the only primary care access point in communities, but they serve as a natural hub for primary care physician training as well. To ensure every American has access to comprehensive primary care, we look forward to partnering with you to invest in both CHCs and the programs that help embed family physicians within them, as further described below.

Physician Education and Training in Rural Areas

Teaching Health Center Graduate Medical Education

Evidence indicates that physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees in large academic hospitals also leads to physician shortages in medically underserved and rural areas. These shortages result in access barriers and disparities in health outcomes for patients living in these communities.

Currently, the Teaching Health Center Graduate Medical Education (THCGME) program is one of the only federal programs that train residents in a community-based outpatient setting. To date, the THCGME program has trained more than 2,027 primary care physicians and dentists in community-based settings, 61 percent of whom are family physicians.[ii] In the 2023 – 2024 academic year, the program funded the training of over 1,096 residents in 81 community-based residency programs.

THCGME programs have also been proven to increase patient care in underserved communities. A 2024 evaluation of THCGME programs found that over a five-year period (academic years 2018-2023), residents provided care to nearly 3.9 million patients and 85 percent of the 1,059 residents who graduated and provided employment data worked in a medically underserved community.[iii] However, even with these measured successes, permanent or long-term funding for THCGME programs does not currently exist. This funding uncertainty only undermines the programs, delays the creation of new primary physician training programs, and has also led to some program closures.[iv]

The AAFP continues to support legislative efforts that would *permanently* authorize the THCGME program such as the Doctors of Community (DOC) Act. However, absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program. We were encouraged by the funding levels and five-year authorization for THCGME that were included in the latest bipartisan year-end health care package, but were disappointed when that bill was defeated by outside influence. We urge the Committee to consider this proposal as a floor moving forward in reauthorization efforts. Supporting THCGME, in conjunction with comprehensive reforms to traditional graduate medical education programs, is one of the only ways to ensure a robust primary care workforce and increase access to care in rural and community-based settings.

Traditional Graduate Medical Education Reforms

The AAFP believes substantial reforms to traditional graduate medical education (GME) are necessary to support an adequate national primary care workforce, especially in rural communities. The AAFP holds that effective health care systems should have a physician workforce comprised of around 50 percent primary care physicians. While we have been encouraged by some legislative proposals that would allocate 25 percent of GME slots for primary care physicians, we would encourage an even larger percentage to further mitigate the primary care physician shortage that many areas of the country are already experiencing or will soon be.

Additionally, while the Academy appreciates the intent of some legislative proposals to increase distribution of new GME slots to rural and underserved areas, they still rely heavily on a Health Professional Shortage Area (HPSA) designation to determine allocation. While many residency training programs are located in HPSAs, the physicians training in these programs often do not go on to continue practicing in HPSAs.[v] In addition, not all HPSAs have residency training programs located in them and therefore basing distribution of residency slots based solely on a HPSA determination is limiting. Ultimately, the current methodology for GME slot distribution is not meaningfully increasing the workforce in rural and underserved communities. Instead, GME funding could be used more efficiently by investing in programs with a track record of producing physicians who are more likely to fill existing gaps in health care access – such as those programs that train physicians who then continue practicing in HPSAs after residency.[vi]

To achieve this aim and more effectively train and distribute primary care physicians across the country, the AAFP urges the Committee and your colleagues in Congress to:

- **Require the Centers for Medicare and Medicaid Services (CMS) to utilize the AAFP's "impact factor".** This is one way that Congress could ensure that the majority of new GME slots are really reaching communities of need. This "impact factor" would be added to the current methodology for awarding GME slots and prioritize applications for programs where a higher proportion of trainees ultimately go on to practice in HPSAs.

- **Create a new GME council specifically focused on the retention of physicians in HPSAs and medically underserved communities.** This council should utilize existing and new collection of data that would then be incorporated in any updated methodology used to determine the allocation and prioritization of GME slots. This would help ensure that the physicians trained through rural and medically underserved residencies go on to care for underserved populations. The Academy would be happy to work with Committee staff to assist with the development of this methodology, especially if it aligns with the AAFP's "impact factor."

- **Update the current GME program definition of rural (all people and territory in an area with 100,000 people) to align with other CMS-defined criteria (all**

people and territory in an area with less than *50,000* people) and use that parameter to allocate at least 10 percent of slots to rural hospitals, regardless of their HPSA score. Further, we support legislative efforts that aim to diversify the physician workforce by prioritizing slots at hospitals with an affiliation with a historically black college or minority serving institution. The Academy has long supported policies that aim to diversify the health care workforce. Evidence has shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[vii]

- **Eliminate the cap on residency slots for programs serving rural and underserved communities.** The AAFP supports increasing the cap for GME slots, but we believe that capping slots for all programs at a specific number is not the most effective way to increase access to care through these programs. We would encourage increasing the cap for most hospitals, and have no caps for programs serving rural and underserved communities. Given the data that illustrates the direct correlation between where a physician trains and ultimately decides to practice, removing the cap for GME programs located in rural and underserved areas (as we have defined above) would create more opportunities for physicians to continue practicing in those areas beyond their training. The AAFP supports a bill that would remove the caps on rural hospitals specifically. Rural Physician Workforce Production Act, a bill that would remove the caps on rural hospitals specifically.

- **Codify the Rural Residency Planning and Development (RRPD) program,** which is intended to help address rural GME distribution disparities by supporting the creation and sustainability of rural residency programs. Funding from this program is crucial for training and retaining health care clinicians in rural areas and helps to cover start-up costs, accreditation, faculty development, and recruitment, and it expands the number of trained physicians in rural settings. We have supported legislation to support the codification of this program in statute and continue to urge its enactment.

Supervision of Primary Care Residents

This Committee has the opportunity to advance policies that would meaningfully reform supervision requirements for primary care residents, thus improving both physician bandwidth and patient care. Specifically, the Academy continues to advocate for residents permanently being permitted to provide care via telehealth with the same level of supervision from the teaching physician as occurs during their in-person office visits.

Additionally, the AAFP supports the expansion of allowable services under the Primary Care Exception (PCE). The PCE permits a teaching physician to bill for certain lower and mid-level evaluation and management (E/M) services furnished by residents in certain types of residency training settings, even when the teaching physician is not present with the resident, if certain conditions are met. These flexibilities would afford teaching physicians – especially

those that travel great distances in rural communities – more time to train additional residents and to focus their training on more complex and in-depth services.

By allowing all levels of E/M services under the primary care exception, CMS will support primary care workforce development and improve patient continuity of care without compromising patient safety. Further, including additional preventive services in the PCE services list will increase utilization of high-value services.

The AAFP has submitted extensive comments to CMS highlighting research that supports these changes and also names the specific codes that should be allowed under the PCE. Unfortunately, CMS did not take steps to enact these changes in the proposed rule for the Calendar Year 2026 Medicare Physician Fee Schedule that was released yesterday. **Therefore, we urge congressional support for these changes and, if necessary, legislative action to achieve these changes should CMS not pursue them on its own.**

While the AAFP is encouraged by the Committee's commitment to exploring policies that support the health care workforce, especially in rural areas, we believe additional hearings must be held soon to fully address the multi-pronged approaches necessary to ensuring robust access to care for all patients.

Family physicians, residents and medical students interested in primary care are facing more uncertainty than ever before – uncertainty that will manifest in worse access to care for patients. Right now, physicians and students are experiencing:

- Continued cuts to Medicare payments;
- Reduced access to federal financial support to pursue a medical degree;
- An unrelenting barrage of administrative and paperwork burden that is severely limiting their time for patient care;
- Threats to the very existence of loan repayment programs that disproportionately impact primary care physicians;
- Policies that interfere with the physician-patient relationship; and
- Inconsistent, unpredictable funding for primary care workforce programs and care settings.

This is creating a regulatory and policy environment that not only deters prospective physicians from pursuing primary care, but threatens the viability of our nation's primary care infrastructure altogether. The AAFP appreciates the Committee's holding this hearing, and we look forward to working with you to advance the recommendations outlined above to ensure that primary care remains accessible, both for the patients who need it and the individuals hoping to pursue it as a career. Should you have any questions, please contact Natalie Williams, Senior Manager, Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

AMERICAN ACADEMY of FAMILY PHYSICIANS

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[v] How We Define Rural | HRSA
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[vii] The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties - PubMed

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Press Release

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AAMC Statement on Reauthorization of Title VII Health Professions and Title VIII Nursing Workforce Development Programs

Washington, D.C., July 15, 2025—*AAMC President and CEO David J. Skorton, MD, and AAMC Chief Public Policy Officer Danielle Turnipseed, JD, MHSA, MPP, issued the following statement ahead of the U.S. House of Representatives Energy and Commerce Health Subcommittee hearing on legislative proposals to expand the health workforce:*

"Strengthening the health care workforce is a top priority for the AAMC. We strongly support committee action to reauthorize all of the Health Resources and Services Administration's (HRSA) Title VII health professions and the Title VIII nursing workforce development programs. These critical programs ensure the country can support training for physicians, nurses, mental and behavioral health professionals, public health practitioners, and other providers — many of whom go on to serve in rural and other medically underserved communities.

Reauthorizing Title VII and Title VIII programs is critical to recruiting, training, and retaining the next generation of health care professionals who are prepared to meet the needs of the American people. Legislation that makes meaningful investments in the health care workforce is especially critical at a time when the U.S. faces significant provider shortages, burnout, and widening gaps in health outcomes.

The AAMC strongly urges lawmakers to reaffirm the federal government's commitment to making America healthy by building a health care workforce capable of meeting the evolving health needs of patients and communities nationwide by reauthorizing all Title VII and Title VIII programs."

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The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers

International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe. Learn more at aamc.org.

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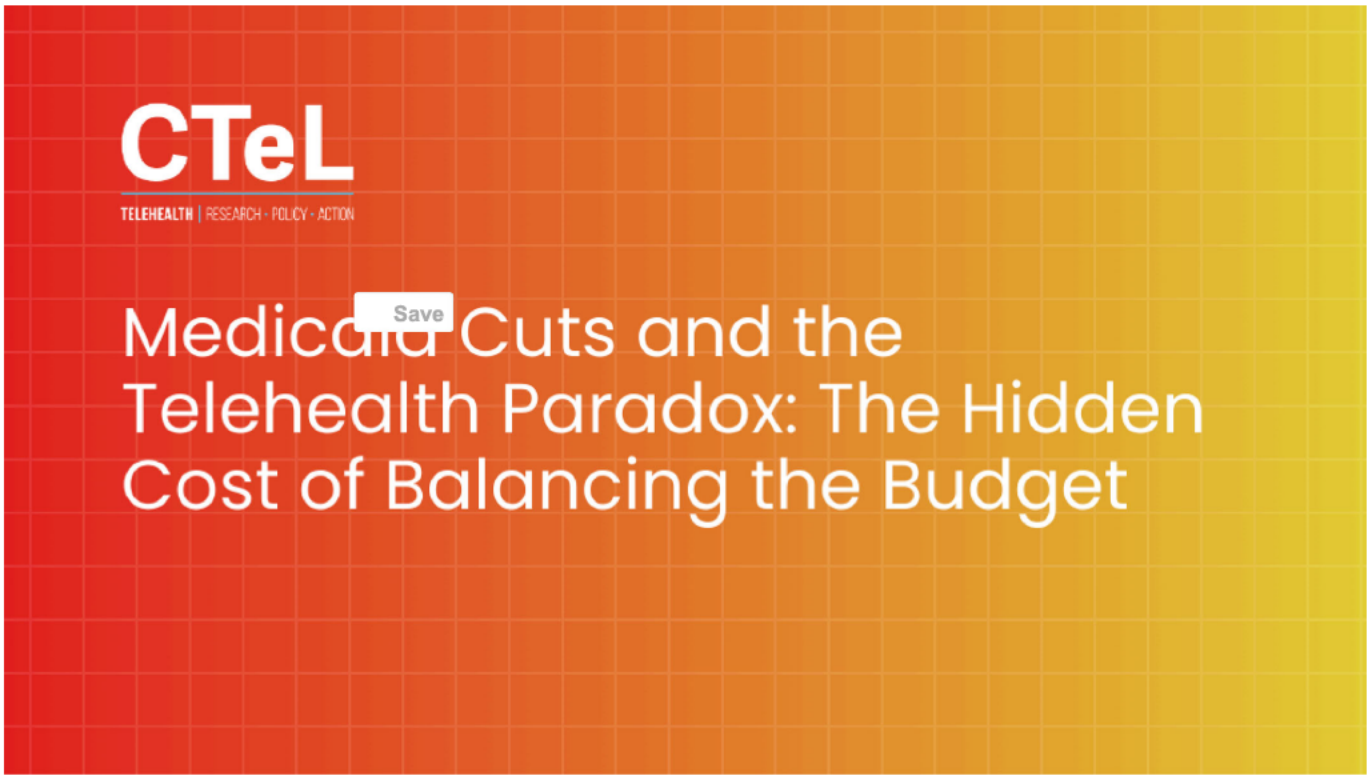
Medicaid Cuts and the Telehealth Paradox: The Hidden Cost of Balancing the Budget



The latest analysis from the Congressional Budget Office (CBO) exposes the stark reality behind proposed Medicaid cuts being pushed by Republican lawmakers. These cuts, aimed at offsetting the $4.5 trillion cost of extending Trump-era tax cuts (Weixel, 2025), would not only disrupt healthcare access for millions of low-income Americans, but they also jeopardize the future of telehealth—a vital service that has transformed care delivery, particularly for Medicaid recipients.

Fiscal Trade-offs and Telehealth's Vulnerability

According to the CBO, Republican proposals would slash nearly $880 billion in federal Medicaid funding over the next decade to finance the extension of Trump's tax cuts (Weixel, 2025). While Republicans argue that such reductions are necessary for fiscal responsibility, the proposed cuts overlook the profound role Medicaid plays in sustaining telehealth services, especially in rural and underserved communities.

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July 15, 2025

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
House Energy and Commerce Committee
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
House Energy and Commerce Committee
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette,

As the leading authority on oral health in the United States, the American Dental Association (ADA), representing more than 159,000 dentists nationwide, writes to thank you for convening the July 16 hearing, "*Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines*." We appreciate your commitment on strengthening the health care workforce and want to highlight the urgent need to reauthorize and invest in the Health Resources and Services Administration (HRSA) Title VII oral health training programs, which are proven tools for expanding access to dental care, especially in rural and underserved communities.

Millions of Americans, particularly in rural and low-income communities, face persistent barriers to dental care due to workforce shortages. Title VII investments help address this gap by strengthening the pipeline of dental professionals and supporting training programs that serve high-need areas. Continued investment in the dental workforce is essential for addressing the rising needs of an aging population, reducing the oral-systemic health burden, and curbing costly emergency department visits for preventable dental conditions.

Title VII Primary Care Dental Training Cluster (General, Pediatric and Public Health Dentistry)
Title VII supports postdoctoral dental residency programs that prepare dentists to serve in high-need areas. These residencies enhance clinical readiness and foster long-term commitments to public health dentistry. In Academic Year 2022-2023, these programs supported over 5,500 dental students and professionals and facilitated care for more than 1.5 million patients in underserved areas. Data from HRSA shows that nearly 70% of graduates from Title VII-funded programs serve in these communities, with an additional 20% working in primary care settings such as Federally Qualified Health Centers (FQHCs). These residencies are often the first step toward a long-term commitment to rural practice.

Dental Faculty Loan Repayment Program
The Dental Faculty Loan Repayment Program plays a vital role in addressing the dental faculty shortage by helping academic institutions recruit and retain qualified educators, especially in pediatric dentistry and community-based clinical settings. By alleviating the financial burden of student loan debt, this program ensures the development of a strong pipeline of future dental professionals. Dental faculty shortages not only limit the number of new dentists trained but also reduce access to care in safety net settings where faculty and students provide essential services. We strongly support the continuation and expansion of the Dental Faculty Loan Repayment Program, including prioritization for pediatric dental faculty providing care in rural and underserved communities.

State Oral Health Workforce Grants/Action for Dental Health
State Oral Health Workforce Grants, funded through Title VII, enable states to develop and implement innovative strategies to address workforce shortages and access gaps tailored to local needs. These grants have helped states expand dental services, integrate dental care into primary care settings, and improve recruitment and retention in rural areas. According to the ADA's Health Policy Institute (HPI), more than one-third of dentists are actively recruiting dental hygienists and dental assistants, with nearly 90 percent finding it extremely difficult. These staffing shortages limit patient access, particularly in underserved communities. The ADA's Action for Dental Health (ADH) initiative, supported through section 340G funding, complements this effort by focusing on prevention,

education, and targeted interventions for vulnerable populations. We support continued funding for ADH initiatives that reduce barriers to care through the advancement of H.R. 2001, the Action for Dental Health Act.

Health Careers Opportunity Program
The Health Careers Opportunity Program (HCOP) is a critical pathway initiative aimed at increasing diversity in the healthcare workforce by supporting individuals from disadvantaged backgrounds as they pursue health professions, including dentistry. Given the well-documented shortages of dentists in underserved communities, fostering a diverse and representative dental workforce is essential for expanding access to culturally competent care. Pathway programs like HCOP help strengthen the pipeline of future oral health providers and ensure that the next generation of dental professionals reflect the communities they serve.

Area Health Education Centers
Area Health Education Centers (AHECs) are another valuable resource for improving health care access in rural and underserved regions. AHECs support the training and retention of health professionals, including dentists, by providing community-based education and clinical training in shortage areas. They serve as a bridge between academic institutions and rural communities, helping to build a sustainable workforce that remains committed to serving these populations.

****

We urge the Subcommittee to reauthorize funding for HRSA's Title VII dental training cluster, along with continued robust funding for Action for Dental Health, State Oral Health Workforce, HCOP and AHECs. These investments are critical to building and sustaining a dental workforce capable of meeting the needs of underserved populations, improving health access, and strengthening community resilience.

We appreciate your leadership on public health workforce issues and stand ready to work with you to ensure that all Americans, regardless of where they live, can access the oral health care they need. To facilitate further discussion, please contact Natalie Hales, Senior Congressional Lobbyist, at halesn@ada.org.

Sincerely,

Brett Kessler, D.D.S.
President
American Dental Association

Elizabeth Shapiro, D.D.S., J.D.
Interim Executive Director
American Dental Association

Environmental Working Group Statement

In Advance of the Hearing "Legislative Proposals to Maintain and Improve the Public Health Workforce, Rural Health, and Over-the-Counter Medicines"

Before the Health Subcommittee

of the House Committee on Energy and Commerce

July 16, 2025

The Environmental Working Group is a national environmental health group which has advocated for safer, more effective sunscreens for two decades.

EWG strongly supports the use of sunscreens and other sun protection measures. The number of Americans suffering from skin cancer has increased dramatically in recent decades.[1] But, many sunscreens fail to adequately protect consumers from the sun's harmful Ultraviolet, or UV, rays. In addition, the use of the Sun Protection Factor, or SPF, value may lead some consumers to mistakenly believe that a sunscreen provides broad-spectrum protection against both UVA and UVB rays.[2]

[1] American Academy of Dermatology Association, https://www.aad.org/media/stats-skin-cancer

[2] During the last two decades, EWG has tested products and reviewed the results of various other studies to verify the sun protection performance of sunscreen products. An EWG peer-reviewed study found several sunscreens sold in the U.S. provide inadequate UVA protection, compared to the listed SPF claim. *See* David Q. Andrews et al., *Laboratory Testing of Sunscreens on the US Market Finds Lower In Vitro SPF Values Than on Labels and Even Less UVA protection*, 38 Photodermatology, Photoimmunology, & Photomedicine 224 (2021), https://onlinelibrary.wiley.com/doi/full/10.1111/phpp.12738. A total of 51 sunscreen products were tested for UV absorption in a laboratory using in vitro methodologies, and results showed that, on average, products reduced the UVA exposure by only half of what would be expected based on the labeled SPF. Just 18 of 51 products passed the UVA protection test required of products sold in Europe.

Some sunscreen ingredients may pose health harms, including harm to the hormone system. In particular, oxybenzone, octinoxate,[3] octisalate, octocrylene, homosalate[4] and avobenzone are systemically absorbed into the body, according to recent studies published by the FDA.[5] These studies also found that these ingredients could be detected on the skin and in the blood weeks after they had last been used. Other studies have reported sunscreen ingredients detected in breast milk, urine, and blood plasma samples.[6]

The most worrisome sunscreen active ingredient is oxybenzone, which is readily absorbed through the skin, behaves like a hormone disruptor,[7] and may be more harmful to children as they are more susceptible to the effects of chemicals.[8] One evaluation found that adolescent boys with higher oxybenzone levels had lower total testosterone levels.[9]

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[3] Octinoxate, a non-mineral UV filter, is readily absorbed into the skin and continues to be absorbed after the sunscreen has been applied. According to the FDA's 2020 study, octinoxate has been found in blood samples at levels 16 times above the proposed FDA safety threshold. Animal studies have reported octinoxate has hormone effects on the metabolic system and affects thyroid hormone production, with some evidence for other endocrine targets, including androgen and progesterone signaling. See Dana Seidlová-Wuttke et al., *Comparison of Effects of Estradiol with Those of Octylmethoxycinnamate and 4-Methylbenzylidene Camphor on Fat Tissue, Lipids and Pituitary Hormones*, 24 Toxicology & Applied Pharmacology 1 (2006), https://pubmed.ncbi.nlm.nih.gov/16368123/. *See also* Michael Krause et al., *Sunscreens: Are They Beneficial for Health? An Overview of Endocrine Disrupting Properties of UV-Filters*, 35 International Journal of Andrology 424 (2012), https://pubmed.ncbi nlm nih.gov/22612478/.

[4] A recent European Commission opinion reported that homosalate has a recommended maximum concentration of 1.4 percent, because of concerns for potential hormone disruption. https://health.ec.europa.eu/system/files/2022-08/sccs_o_244.pdf. The FDA allows U.S. sunscreen manufacturers to use it in concentrations up to 15 percent.

[5] Murali K. Matta et al, *Effect of Sunscreen Application on Plasma Concentration of Sunscreen Active Ingredients: A Randomized Clinical Trial,* 323 Journal of the American Medical Association 256 (2020),https://jamanetwork.com/journals/jama/fullarticle/2759002

[6] Susie Suh et al., *The Banned Sunscreen Ingredients and Their Impact on Human Health: A Systematic Review*, 59 International Journal of Dermatology 1033 (2020), https://www ncbi nlm nih.gov/pmc/articles/PMC7648445/

[7] Mayra Ghazipura, *Exposure to Benzophenone-3 and Reproductive Toxicity: A Systematic Review of Human and Animal Studies*, 73 Reproductive Toxicology 175 (2017), https://pubmed.ncbi.nlm.nih.gov/28844799/

[8] Environmental Protection Agency, Children Are Not Adults, https://www.epa.gov/children/children-are-not-little-adults (last updated June 12, 2024).

[9] Franco Scinicariello et al., *Serum Testosterone Concentrations and Urinary Bisphenol A, Benzophenone-3, Triclosan, and Paraben Levels in Male and Female Children and Adolescents: NHANES 2011-2012*, 124 Environmental Health Perspectives 1898 (2016), https://pubmed.ncbi nlm nih.gov/27383665/. A 2017 systematic review of 23 studies reported that there was evidence of associations between oxybenzone exposure and adverse reproductive outcomes, including birth outcomes. *See* Ghazipura et al., *supra* note 7.

Safer, more effective ingredients are available, but the current review process has so far failed to make them available to American consumers. In particular, the FDA has failed to ban or restrict potentially harmful, less effective sunscreen ingredients, and sunscreen manufacturers have so far failed to generate the studies needed to admit safer, more effective ingredients into our market. Many of these ingredients, available elsewhere, appear to be safer and are better able to provide protection against both harmful UVA and UVB rays.[10]

Potentially harmful, less effective ingredients remain in the marketplace. In particular, the FDA has failed to meet a legislative deadline to determine whether 12 active sunscreen ingredients should still be permitted, including oxybenzone, octinoxate, octisalate, octocrylene, homosalate and avobenzone. Some of these ingredients may not only pose health harms but may also provide less protection from UVA rays than alternatives that are available elsewhere. Only two active sunscreen ingredients, zinc oxide and titanium dioxide, have been determined, so far, to be safe and effective by the FDA.

Past attempts at reform have failed. Since the FDA first published standards, called a monograph, for marketing sunscreens in 1999, the FDA has tried and failed to update these standards to include new sunscreen ingredients. Congress sought to address these failures in 2014, when Congress enacted the Sunscreen Innovation Act,[11] and in 2020, when Congress

[10] The FDA has approved 16 active ingredients; the European Union has approved 27 active ingredients, some of which provide broad spectrum protection.

[11] Between 2002 and 2009, manufacturers submitted applications for eight new sunscreen active ingredients used in Europe and Asia. Several of the ingredients, including bemotrizinol (Tinosorb S), bisoctrizole (Tinosorb M), ecamsule (Mexoryl SX), and drometrolizole trisiloxane (Mexoryl XL), were UVA or UVA/UVB filters which could provide broad spectrum protection but submitted insufficient data for FDA to determine if the ingredients were safe.

enacted the CARES Act. In both cases, companies still had insufficient incentive to produce the data needed to demonstrate the safety and effectiveness of new ingredients. The short period of exclusivity provided by the CARES Act may provide insufficient reward for companies to complete needed studies.[12] Only one company has so far sought to use the process created in the CARES Act.[13]

Congress should address the need to complete safety studies. To provide the resources to finance needed safety studies, Congress should consider alternative funding mechanisms, including registration, facility, maintenance, and user fees, so that FDA can complete needed studies of existing and promising new ingredients.[14] Congress should also grant the FDA test order authority to require studies of currently available ingredients, as Congress did for other chemical safety studies in 2016.[15]

H.R. 3686, the SAFE Sunscreen Standards Act, will not address the need to complete safety studies. Rather than providing the resources needed to complete needed safety studies, H.R. 3686 would lower the bar for sunscreen safety by allowing "real world evidence" and marketing history that will not address concerns posed by the chronic risks posed by sunscreen chemicals. Allowing the use of evidence that may be relevant to acute risks, but not chronic risks, will simply repeat past policymaking mistakes.

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[12] *See* U.S. Government Accountability Office. GAO-18-61 (2017), https://www.gao.gov/products/gao-18-61

[13] DSM is seeking FDA approval of bemotrizinol, or BEMT. If approved, BEMT would be the first new UV filter in nearly 30 years.

[14] Fees are commonly used by agencies to fill data gaps and fund other programs and services. For example, pesticide safety reviews are funded through registration and maintenance fees. https://www.epa.gov/pria-fees/pria-5-implementation. Many FDA reviews are funded by fees, including application fees, annual program fees for certain products, and registration fees. Many other agencies charge fees to fund reviews, ranging from the National Credit Union Administration to the Nuclear Regulatory Commission to the Securities and Exchange Commission.

[15] *See* 15 U.S.C. § 2603.

The current system has created a double standard that allows potentially harmful, less effective sunscreen ingredients to remain on the market while potentially safer, more effective ingredients remain off limits - even though both categories present similar safety data challenges, as indicated in feedback letters.[16] Rather than designate some promising ingredients as Category III ingredients, pending the development of new information, the FDA has created a regulatory purgatory from which certain ingredients never escape while other legacy ingredients remain available.[17]

Congress should direct the FDA to ban ingredients that are not safe. The CARES Act required the FDA to determine whether ingredients currently in use were safe. However, the FDA has failed to do so, and companies have not provided the safety data needed by the FDA to make this determination. Congress should set a new deadline by which companies provide needed safety data. If companies fail to do so, and the FDA cannot conclude that a chemical is safe, the ingredient should be removed from the market within one year.[18] In particular, Congress should end the use of four ingredients for which the industry has not sought deferred action by

[16] Food and Drug Administration, Regulatory Policy Information, Sunscreen Innovation Act, https://www fda.gov/drugs/guidance-compliance-regulatory-information/regulatory-policy-information-sunscreen-innovation-act (last updated Sept. 02, 2021).
[17] Category I ingredients are GRASE. Category II ingredients are not GRASE. Category III ingredients lack data needed for final classification but can continue to be marketed. In 2019 and 2021, FDA determined that two ingredients are in Category I, two are in Category II, and 12 are in Category III.
[18] If safety data is not available, the FDA has previously said it may consider deferring further action to allow additional time for data to be developed, if "the party seeking the deferral had made timely and diligent progress in trying to obtain that safety information." The FDA has also said it would move forward if it determines that studies are not progressing or otherwise productive. *See* Food and Drug Administration, An Update on Sunscreen Requirements: The Deemed Final Order and the Proposed Order https://www fda.gov/drugs/cder-conversations/update-sunscreen-requirements-deemed-final-order-and-proposed-order (last updated Dec. 16, 2022). The sunscreen chemical manufacturers have requested that the FDA defer action on 8 of the 12 sunscreen active ingredients while data gaps are filled. But, there is no evidence that needed safety studies are being conducted.

the FDA,[19] and Congress should direct the FDA to finalize limits for spray sunscreens and conduct needed studies.[20]

Congress should also address consumer confusion about sunscreens. Consumer confusion about the protection – or lack of protection – provided by sunscreens can create a false sense of security and lead to consumers to spend more time outdoors with inadequate protection. Even though sunscreens with high SPFs provide only marginally greater protection, many consumers assume that a sunscreen with an SPF of 60 provides twice as much protection as a sunscreen with an SPF of 30.

Congress should learn from past mistakes. Consumers expect our sunscreens to be safe and effective. Unfortunately, many sunscreens do not adequately protect consumers from harmful UV rays and pose needless health risks – even though better alternatives are available. Allowing legacy ingredients that are less effective and less safe to remain on the market while more effective and safer ingredients are available makes little sense.

Congress should take steps to quickly ban harmful ingredients and take steps to ensure the production of the data needed to resolve questions, if any, about the safety and effectiveness of

[19] Manufacturers have not requested deferred action on cinoxate, dioxybenzone, padimate O, or sulisobenzone. *See* Food and Drug Administration, Proposed Order (OTC000008): Amending the Over-The-Counter (OTC) Monograph M020: Sunscreen Drug Products for OTC Human Use (Sept. 24, 2021), https://dps-admin.fda.gov/omuf/omuf/sites/omuf/files/primary-documents/2022-09/Proposed%20Administrative%20Order%20OTC000008_Amending%20M020_Sunscreen_Signed24Sept2021.pdf.

[20] The 2021 proposed order would require that all spray and power sunscreen products undergo particle-size analysis to ensure that the particles cannot be inhaled and cause damage. The proposal would require that at least 90 percent of the particles dispensed from a spray product be 10 micron or larger and that the minimum particle size dispensed from the consumer container must be no less than 5 µm. *Id.* This provision should be included in the final order. The FDA should also specify that only rutile titanium dioxide sunscreens should be allowed on the market.

promising alternatives. To avoid the policymaking mistakes of the past, Congress should consider funding mechanisms and deadlines which require the FDA to quickly complete needed studies of existing and promising new ingredients.

Joint Statement of the Muscular Dystrophy Association (MDA) and Parent Project Muscular Dystrophy (PPMD)
Submitted to the U.S. House Committee on Energy & Commerce, Subcommittee on Health
July 16, 2025

Chairman Guthrie and Chairman-Designate Griffith, Ranking Member Pallone, and Members of the Subcommittee:

On behalf of the Duchenne muscular dystrophy community, the Muscular Dystrophy Association (MDA) and Parent Project Muscular Dystrophy (PPMD), who served as the nominators of the Duchenne newborn screening package, submit this joint statement regarding the status of the Duchenne newborn screening nomination package and the future of newborn screening in the United States. As you consider the Newborn Screening Saves Lives Reauthorization Act during today's hearing, we wanted to be sure that you had the latest information on where things stand with the Duchenne nomination.

As you know, Duchenne muscular dystrophy is a devastating, progressive neuromuscular disease. Early identification through newborn screening has the potential to improve outcomes, enable timely care, and provide families with critical information and support.

The Duchenne nomination package submitted to the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) was developed over many years with significant community and expert input. It reflects a robust body of scientific evidence demonstrating the benefits of early diagnosis.

The formal evidence-based review, foundational to understanding the impact of newborn screening for Duchenne, has continued following the disbanding of the ACHDNC.

MDA and PPMD stand ready to support the Department of Human Health Services (HHS) in assessing the objective evidence presented by the Evidence Review Group's report. We have urged HHS to take all necessary steps to complete the review of the Duchenne nomination package, finish the report, and maintain the integrity of the evidence evaluation process that underpins the Recommended Uniform Screening Panel (RUSP).

Additionally, we call on Congress to reauthorize and strengthen the Newborn Screening Saves Lives Act, which has been instrumental in supporting state newborn screening programs and the infrastructure necessary to implement new conditions on the RUSP. This law has dramatically expanded early detection of serious health conditions, saving and improving thousands of lives. Reauthorization will ensure states have the resources they need to continue this progress, address current challenges, and prepare for the addition of conditions like Duchenne.

Thank you for your continued commitment to the rare disease community and to strengthening newborn screening in the United States. We look forward to working with you to ensure families affected by Duchenne have the opportunity for earlier diagnosis and intervention.

Respectfully submitted,

Muscular Dystrophy Association (MDA)
Parent Project Muscular Dystrophy (PPMD)

July 15, 2025

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

Dear Chairman Griffith and Ranking Member DeGette:

In service of the neuromuscular disease (NMD) patient community, the Muscular Dystrophy Association (MDA) thanks the Energy and Commerce Subcommittee on Health (the Subcommittee) for convening tomorrow's hearing titled "Legislative Proposals To Maintain And Improve The Public Health Workforce, Rural Health, And Over-The-Counter Medicines". In particular, we are incredibly grateful for the Subcommittee's consideration of the Newborn Screening Saves Lives Reauthorization Act of 2025, legislation that will strengthen and modernize our newborn screening ecosystem across the country. We ask that you support this legislation as part of your participation in tomorrow's hearing.

MDA is the #1 voluntary health organization in the United States for people living with muscular dystrophy, ALS, and related neuromuscular diseases. For 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.

Newborn screening is one of the most successful public health programs in U.S. history. Put together, each state's program collectively screens nearly every newborn in the United States for over 35 conditions that, if diagnosed at birth, can be treated, thus avoiding some of, if not all, of the most challenging features of the disease. Newborn screening saves thousands of lives every year, is one of the most cost-effective public health programs in history, and will only grow in importance as additional targeted and genetic rare disease therapies are developed and made available.

Newborn screening is particularly important to the rare neuromuscular disease community that we serve. Two conditions, spinal muscular atrophy (SMA) and Pompe disease, are currently included on the Recommended Uniform Screening Panel (RUSP) with universal state adoption of SMA, and the vast majority of states screening for Pompe disease. We, along with Parent Project Muscular Dystrophy, have also submitted Duchenne muscular dystrophy for consideration to be added to the RUSP. While the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) was disbanded this Spring, we remain hopeful that the Department of Health and Human Services and Secretary Kennedy will consider the evidence supporting our nomination and will add Duchenne to the RUSP.

The Newborn Screening Saves Lives Reauthorization Act is incredibly important to our community for a number of reasons. First, the legislation reauthorizes and updates programs at the Health Resources and Services Administration (HRSA) that support and guide states on which conditions for which to screen, how to construct follow up programs for those who are diagnosed, and more. Second, the legislation reauthorizes and updates programs at the Centers for Disease Control and Prevention (CDC) that are instrumental in assisting state public health laboratories on the process of collecting and assessing the dried blood spots that are tested in newborn screening as well as the confirmatory testing following positive screens. Finally, the legislation reauthorizes and updates the Hunter Kelly Newborn Screening Research Program at the National Institutes of Health (NIH) that researches new potential screens for diseases not currently on the RUSP among other newborn screening research endeavors.

This legislation gives the Subcommittee the opportunity to support a comprehensive update to our newborn screening ecosystem and infrastructure by ensuring the Federal programs dedicated to assisting states are robust, up-to-date, and well-funded. We urge Subcommittee members to support the legislation in this hearing.

We appreciate this opportunity to provide the Committee with the perspectives of the NMD community. 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

AFSCME
We Make America Happen

President

Secretary-Treasurer

Vice Presidents

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American Federation of State, County and Municipal Employees, AFL-CIO

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Inside Health Policy's
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Medicaid Cuts Threaten To Shutter Telehealth Programs Across Health Care System

By Cara Smith / June 18, 2025 at 4:52 PM

Post Share

Health technology stakeholders are sounding the alarm that the proposed hundreds of billion-dollar cuts to Medicaid in the draft Senate reconciliation bill would likely shutter some telehealth and health technology programs that underserved and rural patients rely on to maintain access to care.

A recently released survey of AMGA members in March found 25% of respondents would be forced to shut down telehealth programs, disproportionately impacting rural communities, if Medicaid cuts are enacted. AMGA represents multispecialty medical groups and integrated health care systems.

The potential cuts in March were estimated to be less than the currently proposed cuts in the Senate version of the reconciliation package.

“If this is what our members were saying in March, I can't imagine when we resurvey them, what it's going to look like,” said Laren Lattany, AMGA director of government relations. "Anything that happens in Medicaid happens to all of health care. Nothing is in isolation. If patients can't get access to Medicaid services, it goes to the emergency room, which means double the wait times, which means increased premiums for people who have private health care insurance. Everyone is going to be impacted by this.”

Staff reductions at medical facilities as a result of the funding cuts will likely impact physicians’ ability to offer telehealth to patients, according to Lattany, because of layoffs of nonclinical staff.

“Many of our members do a hybrid situation, so they are both in the office and also doing telehealth work from their office,” Lattany said. “Telehealth is not just your doctor logging on with you on Zoom. There are so many things that go into the appointment long before the appointment happens.”

The proposed Medicaid cuts are exacerbated by ongoing cuts to the Medicare conversion factor, which makes the cuts proposed in the reconciliation package even more substantial because there is not enough money to keep up staffing levels, Lattany said.

“The likelihood of some of those academic medical centers being able to sustain these things might be possible,” Lattany said. “But when you're doing rural health care, it just might be harder for members to continue that consistently.”

Medicaid cuts also threaten to reverse progress made at expanding pre- and post-natal care through digital health technology, including telehealth appointments and remote patient monitoring devices, according to experts.

The Medicaid cuts “would be devastating,” said Ariana McGee, founder and CEO of Navigate Maternity, at the Consumer Technology Association’s Congressional Digital Health Caucus Maternal Health Staff Briefing on Wednesday (June 18).

Medicaid pays for nearly 50% of births across the country, according to panelists. CMS already does not reimburse maternal care at the same level as other health services, forcing maternal care centers or departments to run tight margins.

Medicaid cuts would compound reimbursement issues and lead to a reduction in prenatal and postpartum care, experts say, increasing the risk of expensive hospitalization costs for pregnancy complications.

Telehealth services are also essential for pregnant women dealing with mental health and substance use disorders, which would be in jeopardy under the proposed cuts.

Some of AMGA's members already cut telehealth programs after then President-elect Donald Trump and Elon Musk tanked a December spending bill that would have extended most telehealth flexibilities for two years. Instead, lawmakers temporarily extended pandemic telehealth flexibilities though Sept. 30 of this year.

"If you're only doing months at a time in terms of reimbursement, that's kind of hard to make sure that you have enough funds to keep the services going," Lattany said.

Meanwhile, the American Telemedicine Association has decided not to engage in the politically charged lobbying over House Republicans' efforts to glean potentially hundreds of billions in Medicaid savings as the national telehealth lobby separately advocates for states to continue Medicaid telehealth flexibilities and federal and state programs to cover digital therapeutics. -- *Cara Smith* (csmith@iwpnews.com)

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The Honorable Brett Guthrie
Chair
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

The undersigned organizations write to express our concerns with H.R. 3686 **SAFE Sunscreen Standards Act,** which would weaken FDA oversight of sunscreen active ingredients and set a troubling precedent for new chemical reviews.

While we strongly support expanding access to effective sun protection through the approval of new filters, the FDA should not do so at the expense of robust safety and efficacy review.

FDA studies have shown that many commonly used sunscreen filters are absorbed into the body.[1] Topically applied drugs that show systemic absorption must be evaluated for their potential to cause long-term harms—including cancer, hormone disruption, and reproductive toxicity. To date, sunscreen manufacturers have failed to produce this data for most of the ingredients currently approved in the U.S., as well as for international filters seeking U.S. market access.

Instead of compelling the generation of this data, the SAFE Sunscreen Standards Act instead simply weakens the data requirements for U.S. market access. It does this by emphasizing the use of **real-world evidence** (RWE), and foreign marketing history. While this kind of evidence may be useful in identifying acute risks from sunscreen filters, it cannot provide the rigorous toxicological testing needed for the FDA to identify potential long-term, chronic risks.

At a time when industry is seeking to weaken review standards for new industrial chemicals and stakeholders and the current administration are seeking to close loopholes that allow new food chemicals to escape FDA review, Congress should not weaken review standards for sunscreen chemicals.

Instead of lowering FDA's evidence standards, we urge Congress to provide the agency with the resources it needs to conduct or commission the required safety studies. A modest increase in OTC facility user fees would help fund these efforts and support a regulatory framework that works better for consumers, manufacturers, and regulators alike.

The public deserves sunscreens that are not only effective, but safe for daily, long-term use by children, pregnant individuals, and all consumers. We urge Congress to reconsider the current approach in the SAFE Sunscreen Standards Act and to work with public health experts and stakeholders to craft legislation that strengthens—rather than bypasses—FDA's scientific review

[1] *See, e.g.*, https://jamanetwork.com/journals/jama/fullarticle/2759002.

process. We urge Congress to strengthen, not weaken, the evidence regulators must demand before we allow new chemicals to be used in commerce,

Sincerely,

Breast Cancer Prevention Partners

Center for Environmental Health

Clean and Healthy New York

Defend Our Health

Earthjustice

Environmental Working Group

Safer States

Toxic Free Future

Asthma and Allergy Foundation of America

July 15, 2025

The Honorable Brett Guthrie
Chair, House Committee on Energy & Commerce
U.S. House of Representatives Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member,
House Committee on Energy & Commerce
U.S. House of Representatives Washington, DC 20515

Re: *Amend H.R. 4273 to Reaffirm the GRAS/E Standard for Clarity and Trust*

Dear Chair Guthrie and Ranking Member Pallone:

On behalf of the Asthma and Allergy Foundation of America (AAFA), we are writing to express our support for H.R. 4273 which reauthorizes the Over the Counter (OTC) Monograph User Fee Program (OMUFA). AAFA is the leading patient organization for nearly 100 million Americans with asthma and allergies. AAFA is also the oldest asthma and allergy patient organization in the world, committed to saving lives and reducing the burden of disease for people with asthma and allergies through support, advocacy, education and research.

As you consider this important legislation, we urge you to include an amendment to reaffirm the foundational standard that ensures over the counter (OTC) medicines are Generally Recognized as Safe and Effective (GRAS/E), a principle that is essential to preserving consumer trust, regulatory clarity, and innovations that the people we serve want and need.

Why do we care about this specific policy?
Millions of Americans rely on safe and effective OTC medicines every day as their first line of defense from common self treatable conditions including pain relief, allergies, digestive health, oral care, and more. OTC medicines save the U.S. healthcare system $167 billion annually by reducing the need for prescription drugs and minimizing unnecessary visits to the doctor. Public trust in OTC products is rooted in confidence that they meet published, science

based standards with the GRAS/E framework as the foundation of the OTC monograph system.

Why is this important to consumers?

OTC medicines are intended to be used without a healthcare provider's supervision. The GRAS/E standard ensures OTC products are evaluated under a public process with a science based model that is uniquely designed for OTC ingredients, purposely different than the prescription drug evaluation model. Unlike the New Drug Application (NDA) process required for prescription drugs, the monograph pathway anchored by GRAS/E gives consumers faster access to new, innovative product formulations of existing, well known, proven ingredients to help meet their evolving needs without the added costs and delays of the NDA process.

What's the problem?

Since OMUFA was enacted in 2020, there has been growing misalignment between Congress's intent and the U.S. Food and Drug Administration's (FDA) implementation of the law. FDA has indicated it may want NDA type requirements to finalize standards for unfinished OTC monographs, rather than relying on the established GRAS/E framework based on published studies. As a result, monograph innovation has stalled, which is bad news for patients and consumers. In fact, in the last five years, there has only been one manufacturer initiated request for a monograph innovation, and it hasn't been issued yet, due in part to the perceived FDA shift away from established GRAS/E principles. This threatens to limit access to affordable self care and makes everyday health solutions harder to reach especially for vulnerable populations and underserved communities with limited healthcare options.

Reaffirming GRAS/E is good for public health.

A clear confirmation of the GRAS/E standard would remove uncertainty and ensure FDA, Congress, and industry are aligned. An amendment confirming GRAS/E isn't a rewrite, it's a affirmation that will keep the OTC monograph system operating as Congress always intended. This would strengthen public trust, encourage manufacturers to develop innovative new OTC products on behalf of consumers in your districts, and preserve consistent, science based standards that enable additional safe, effective, and affordable self care options for the communities we all serve.

Asthma and Allergy Foundation of America

We support H.R. 4273 and urge you to add an amendment reaffirming the GRAS/E standard to ensure that patients and consumers continue to have access to and confidence in the variety of safe and effective OTC medicines they want, need, and trust.

Sincerely,

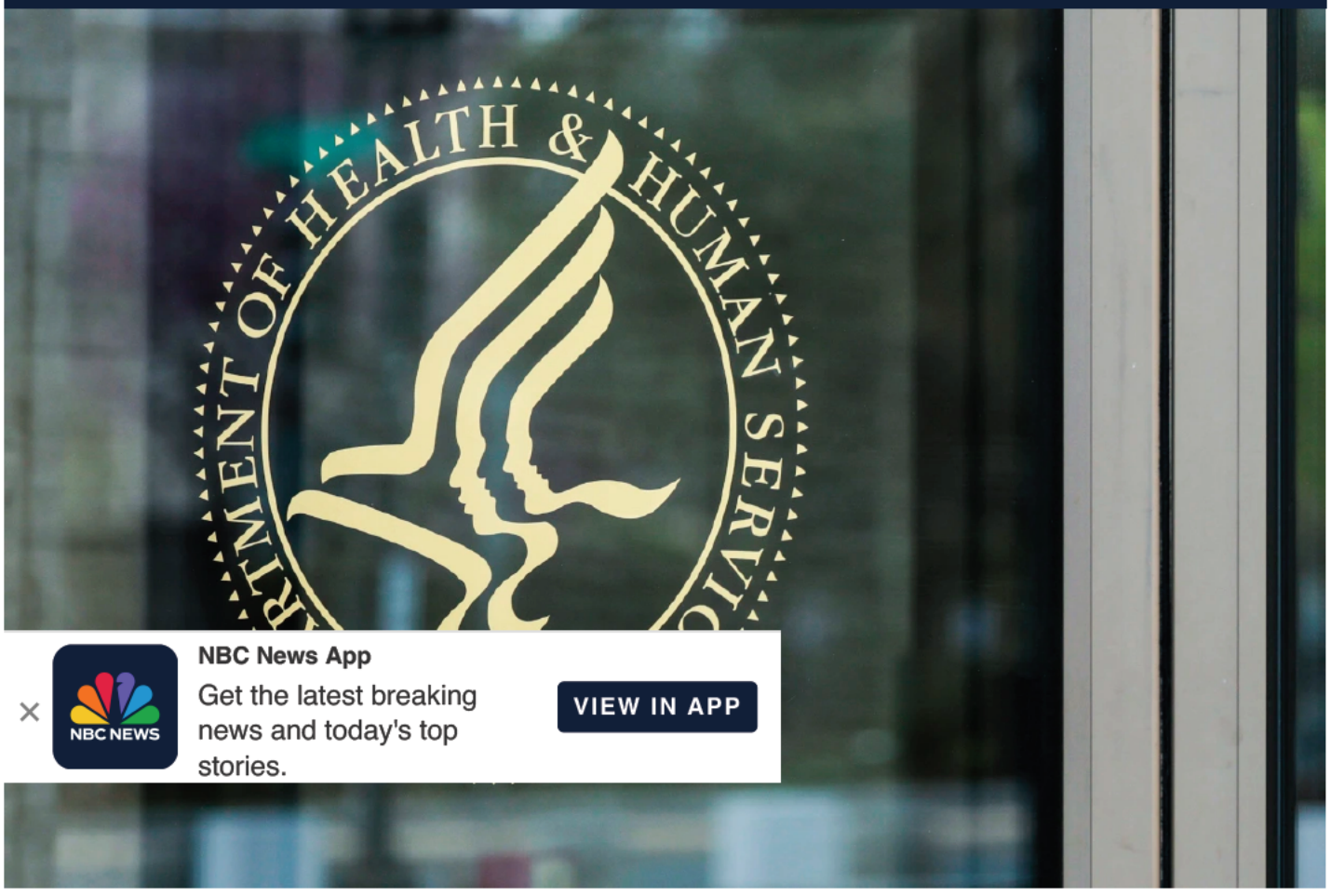
Kenneth Mendez

Kenneth Mendez
President and Chief Executive Officer
Asthma and Allergy Foundation of America

HEALTH NEWS

HHS eliminates advisory committee on newborn screening ahead of vote on rare disorders

The committee's central role was to recommend which conditions should be included on a universal screening panel for infants.



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Anna Moneymaker / Getty Images

April 17, 2025, 11:24 AM EDT

By Aria Bendix

Health and Human Services Secretary Robert F. Kennedy Jr. has pledged in office to make Americans healthier, with a specific focus on reducing health burdens among children. But his department this month quietly eliminated an advisory committee on genetic disorders in newborns and kids.

For the last 15 years, the central role of the Advisory Committee on Heritable Disorders in Newborns and Children was to make recommendations to the health and human services secretary about which conditions to include on a universal screening panel for newborns.

Though Kennedy has been focused on identifying the origins of more pervasive childhood diseases like autism, asthma and obesity, rare diseases are collectively a large public health concern. Around 15 million children in the United States have rare diseases, most of which are genetic.

Newborn screenings identify around 14,000 babies every year who have potentially

life-threatening or life-altering conditions, according to the National Organization for

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