American College of Physicians
Leading Internal Medicine, Improving Lives

Statement from the American College of Physicians

Markup before the U.S. House of Representatives

Energy and Commerce Committee

Budget Reconciliation Text

May 13, 2025

On behalf of the American College of Physicians (ACP), we appreciate the opportunity to provide our input and recommendations as the House Energy and Commerce Committee marks up its portion of legislative proposals to comply with the reconciliation directive included in section 2001 of the Concurrent Resolution on the Budget for Fiscal Year 2025, H. Con. Res. 14.

All Americans should have access to high quality, affordable health care coverage. The Medicaid program, which provides health care coverage for approximately 80 million Americans, allows for our most vulnerable patients – children, mothers, seniors, low-income adults, and those with physical and mental disabilities and substance use disorders – to receive health care coverage. ACP is concerned that the proposed legislation would result in significant coverage loss for these Medicaid beneficiaries who rely on the critical program. **We urge you to carefully consider the long-term implications of the proposed legislative text in the current budget reconciliation package being considered for markup today. The proposed policy changes would substantially change the Medicaid program by limiting health care access to millions of Americans across the country.**

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

Significant Health Care Coverage Loss

According to the Congressional Budget Office's preliminary scoring, the health provisions under Title IV, Subtitle D, would lead to significant coverage loss for at least 8.6 million Americans by 2034. If Congress does not extend the premium tax credits under the Affordable Care Act (ACA) that have allowed millions of Americans to buy into the ACA health care exchange, an additional 4.2 million Americans will be uninsured by 2034. The College is very concerned that high health care coverage loss will have grave consequences for our most vulnerable patient populations. Further, it would destabilize independent health care practices, hospitals, and health systems, especially those in rural and disadvantaged communities, leading to widespread disruption of health care services and economic decline.

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We are particularly concerned with the long-term consequences of the following sections on patients' access to care. We urge you to reconsider the following provisions that would result in significant coverage loss and administrative burden for states, physicians, hospitals, and Medicaid beneficiaries:

Section 44108, Increasing Frequency of Eligibility Re-determinations for Certain Individuals

Under this section, states that have expanded Medicaid are required to conduct eligibility determinations twice a year, rather than annually. The College is concerned that increasing the frequency of Medicaid redeterminations, without providing states with clear directives on implementation of such efforts, would lead to unnecessary coverage loss due to procedural or administrative terminations and not because of ineligibility. States should be given ample time to design and implement best practices for their Medicaid redetermination plans, ensuring that Medicaid beneficiaries are given sufficient time and resources to provide the necessary paperwork for continued health care coverage.

Section 44141, Requirement for states to establish Medicaid community engagement requirements for certain individuals

This section requires states to establish work requirements for low-income adults without dependents. To be eligible for Medicaid coverage, work-abled adults must have documentation showing that they have completed at least 80 hours per month of work, education or community service. A KFF analysis published in February 2025 found that in 2023, 64% of work-abled adults in Medicaid were working, with 44% employed full-time and 20% employed part-time. Research has shown that imposing work requirements does not lead to meaningful impact on employment and that the savings would mostly come from Medicaid recipients losing coverage as a result of challenges with new paperwork and reporting requirements. Further, work requirements would lead to higher costs for states since states will have to design and implement the reporting requirements.

Medicaid work requirements have been implemented with little success, as evident in Arkansas and Georgia. Under the Medicaid 1115 waivers, Arkansas implemented Medicaid work requirements, which resulted in more than 18,000 people losing coverage in just a seven-month period. Launched in July 2023, Georgia's work requirement program provides only 4,231 Americans with Medicaid coverage. State officials initially estimated more than 100,000 people would sign up in the first year. Georgia is currently seeking to revise its work requirement program, with one significant change being reducing the reporting requirement for beneficiaries from monthly to annually.

As currently written, this section allows states to conduct lookbacks, at any time, to see if Medicaid enrollees have been compliant with the community engagement requirements, as far back as they could go. This is very concerning considering that states could use this as a loophole to get more people off of Medicaid. For example, if a Medicaid enrollee was laid off six months ago, but has found employment for the last three months, if the state they live in decides to conduct a lookback to see if the Medicaid enrollee meets the community engagement requirements at the six-month timeframe, the Medicaid enrollee would not be considered eligible for Medicaid. Further, this section allows states to determine the frequency of how often they want to conduct lookbacks, in addition to the biannual redetermination requirement.

While we appreciate that there is a list of exemptions, it appears that there will be no oversight or any type of formal guidance on how states should report on such exemptions.

Section 44142. Modifying cost sharing requirements for certain expansion individuals under the Medicaid program.
Under this section, states can impose additional cost-sharing requirements for the Medicaid expansion population. ACP opposes policies that would apply financially burdensome premiums or cost-sharing requirements on Medicaid beneficiaries. As internal medicine physicians who diagnose, treat and manage patients' complex, chronic conditions, we have seen firsthand our patients' struggles with affording care and drug coverage. Higher cost-sharing in Medicaid would deter our most at-risk patients from seeking necessary medical services. Our patients' chronic conditions will not go away, rather they will become more difficult and expensive to manage since patients will choose to delay care until they no longer can – ending up in the emergency rooms – raising uncompensated care for hospitals and shifting the burden to states and taxpayers.

Medicaid Physician Payment Rates
With the proposed changes to Medicaid, states will be forced to drop Medicaid enrollees from coverage, limit the health care services patients can access, and cut payment rates for clinicians. Slashing already-low Medicaid payment rates will make it even harder for physicians to provide care to Medicaid enrollees. It could lead to independent health care practices and hospitals closing their doors, decreasing health care access for patients, exacerbating the health care workforce shortage, and increasing health care costs as patients are forced to forgo vital preventive care.

Medicare Physician Payment Reform
While ACP appreciates that the legislative package includes Section 44304, which would modify updates to the Medicare conversion factor under the physician fee schedule, we encourage the Committee to do more to ensure long-term physician payment reform. Section 44304 provides an increase to payment rates for 2026 that would be 75% of Medicare Economic Index (MEI), which is appreciated. However, it would reduce the MEI increase included in current law for 2027-2034. While well below projected MEI rates and illustrative of why medical practices are not keeping up with the rising costs of patient care, current law includes a 0.25 percent increase for 2027-2034; this legislation reduces that increase to 0.10 percent for the same period. Further, the provision would apply the 0.10 percent uniformly, resulting in lower payments for participants in value-based care programs, such as alternative payment models (APMs). We support the transition to value-based payments and are concerned that this would deter progress made in value-based care.

There is a critical need for Congress to reform Medicare physician payment as many independent and rural practices are collapsing, being merged or acquired into hospitals, private equity and other entities, thus adversely affecting access and critical care to patients. Moreover, there has not been any Medicare physician payment updates for inflation for decades. The Medicare Physician Fee Schedule (MPFS) does not have an annual update based on inflation. As a result, when accounting for inflation, Medicare physician payments have declined 33 percent since 2001. The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising inflation. That has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended and physicians are in a six-year period with no updates. The result is real reductions to payments when accounting for inflation and budget neutrality requirements. The 2025 MPFS includes a 2.83 percent cut to payment rates. Compounded with CMS' own estimates of a projected 3.6 percent increase in practice cost expenses for this year, physicians are facing a 6.43 percent cut. As a result, patients and their physicians are left to deal with the uncertainty of cuts to Medicare payment rates each year. These cuts, especially when practice expense costs have markedly increased, further strain our nation's doctors, limiting patient access to care. Each year, physicians routinely face harmful payment cuts making it increasingly difficult to remain in practice and accept Medicare patients. The current structure of the MPFS does not provide sustainable, reliable and consistent payment rates for physicians who see Medicare beneficiaries.

A reasonable but important step that the Committee could take is to include H.R. 879, the Medicare Patient Access and Practice Stabilization Act, bipartisan legislation in the markup. H.R. 879 would protect access to care for Medicare beneficiaries and enable small, rural and independent physician practices to remain financially viable. The Medicare Patient Access and Practice Stabilization Act would stop the 2.83 percent cut to Medicare payments, while also providing a 2 percent payment update, aiming to stabilize physician practices and protect patients' access to care.

Section 44305, Modernizing and Ensuring PBM Accountability
ACP appreciates the Committee's continued interest in improving transparency, accountability, and competition in Pharmacy Benefit Manager (PBM) practices to reduce the price of prescription drugs for our patients. Prescription drug prices have increased by more than 10 percent per year for each of the top 20 brand-name drugs prescribed to seniors, and PBMs negotiate rebates from those higher prices. Increased transparency from PBMs and health plans is needed to provide greater understanding of drug prices, help patients make informed decisions, and support a more sustainable health care system. There needs to be greater transparency to reduce confusion about how PBMs work and how they make decisions regarding formularies.

Conclusion
We appreciate this opportunity to provide input to the Committee as it marks up its portion of the budget reconciliation package. We strongly urge the Committee to reconsider provisions that would reduce funding and impose structural changes to Medicaid that would result in significantly less coverage and benefits for Medicaid enrollees. Further, we urge the Committee to prioritize long-term Medicare physician payment reform that would ensure patients' access to high-quality, physician-led care. Should you have any questions, or if we can be of further assistance, please contact Vy Oxman at voxman@acponline.org.