Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

June 5, 2025

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, MD
Chairman
Health, Education, Labor, and Pensions Committee
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Chairman
Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Lindsey Graham
Chairman
Senate Budget Committee
United States Senate
Washington, DC 20510

Dear Majority Leader Thune, Chairman Crapo, Chairman Cassidy, and Chairman Graham:

As the Senate continues its work to extend and expand the Tax Cuts and Jobs Act (TCJA, P.L. 115-97) and considers the House-passed budget reconciliation legislation, the One Big Beautiful Bill Act (H.R. 1), the Association of American Medical Colleges (AAMC) encourages you to prioritize policies that ensure access to life-saving health care and improve the health of patients and communities through strategic investments in the nation's health care, education, research, and public health infrastructure. We urge you to avoid policies that harm the nation's health, particularly cuts to the Medicare and Medicaid programs, and policies that limit access to medical education for students.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited 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.

AAMC-member health systems and teaching hospitals play a vital and unique role in our nation's health care infrastructure and economy. These institutions train the next generation of physicians and other health care professionals, provide a wide range of high-quality health care services, and pioneer cutting-edge research, including new and more effective diagnostics, treatments, and cures. Only in academic medicine do these missions of education, patient care, and research coalesce for the benefit of the American public. Through these missions, AAMC-member institutions enhance both the health and economic vitality of our nation's communities. Teaching health systems and hospitals are anchor institutions, delivering essential health care and emergency services while also driving employment and economic growth. A 2022 report found that AAMC-member health systems and medical schools contributed over $728 billion to the U.S. economy, supporting more than 7 million jobs.[1]

Building on these vital contributions to the nation's health care and economy, we urge Congress to protect and strengthen key programs that directly impact our members' ability to serve patients and communities. We urge Congress to:

- Protect Medicaid and the health care safety net
- Preserve access to coverage and care
- Maintain access to care for Medicare patients
- Safeguard access to high-quality medical education

PROTECT MEDICAID AND THE HEALTH CARE SAFETY NET

Medicaid is a vital source of coverage and care for over 70 million Americans, including, infants, children, the frail elderly, people with disabilities, and working adults. AAMC-member health systems and teaching hospitals play an outsized role in caring for this population—although our members comprise just 5 percent of hospitals nationwide, they account for 29 percent of Medicaid inpatient days.[2] For this reason, any policy that would reduce federal Medicaid funding would disproportionately impact our member institutions, impeding their ability to serve our nation's most vulnerable patients. The AAMC is deeply concerned by and opposes policies contained in Title IV (Energy and Commerce), Subtitle D (Health), Part 1 (Medicaid) of the House-passed reconciliation legislation. We are concerned that, taken together, these policies would increase the number of uninsured throughout the country, exacerbating hospitals'

[1] https://www.aamc.org/data-reports/teaching-hospitals/data/economic-impact-aamc-medical-schools-and-teaching-hospitals
[2] AAMC analysis of FY2023 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2024, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2024.

uncompensated care burden while simultaneously reducing financial support for safety-net hospitals. Our specific concerns with the legislation are outlined below:

Section 44132: Moratorium on new or increased provider taxes

Consistent with federal law, states can leverage taxes imposed on a class of health care providers, referred to as "provider taxes," to finance the non-federal share of Medicaid spending. These taxes are widely used—in fiscal year 2024, every state (except for Alaska) relied on at least one provider tax to help fund its Medicaid program.[3] Absent these financing mechanisms, states would be forced to make difficult decisions about how to best support their Medicaid programs, forcing them to raise taxes or cut spending. Provider taxes allow states to supplement Medicaid programmatic funding and support access to comprehensive health care services for Medicaid enrollees, *without increasing the tax burden on individuals*.

If enacted, this provision would freeze states' existing provider taxes at current rates and amounts, precluding states from establishing new provider taxes. States would be similarly prohibited from modifying the tax base for existing providing taxes by expanding the items and services subject to the tax, or else expanding the base to include new providers. The AAMC is deeply concerned by this proposed moratorium on provider taxes, which would limit states' ability to raise revenues and finance the non-federal share of Medicaid spending. Preventing states from establishing new taxes or otherwise modifying existing provider taxes without offering them alternative financing mechanisms would create serious funding gaps, forcing states to make difficult decisions about their Medicaid programs. These financial challenges may result in restricted program eligibility, reduced benefit offerings, or lower provider reimbursement rates. The AAMC is concerned that the long-term consequences of these funding challenges would harm both Medicaid enrollees and the providers who care for them.

Section 44133: Revising payments for certain state directed payments

It is widely acknowledged that Medicaid base reimbursement rates are inadequate, creating profound financial challenges for providers who serve this population and barriers to care for patients. To address these challenges, many states choose to leverage state-directed payments (SDPs) to augment Medicaid payment to providers and ensure access to comprehensive health care services for Medicaid enrollees. SDPs allow states the flexibility to tailor investments in their Medicaid programs and ensure that they are able to recruit a sufficient number and mix of providers to serve their enrollees. Restrictions on SDPs would exacerbate the financial

[3] https://www.kff.org/medicaid/state-indicator/states-with-at-least-one-provider-tax-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

challenges already facing safety-net providers, forcing them to curtail services. The downstream consequences of this type of policy would invariably impact Medicaid enrollees, who may be faced with restricted provider networks and reduced service availability.

If enacted, this section would substantially reduce the ceiling for SDPs from the average commercial rate (ACR) to the Medicare rate, or 110 percent of the Medicare rate in non-expansion states, for arrangements approved after the enactment of the legislation. Pinning SDPs to the Medicare rate is particularly problematic in light of data demonstrating that Medicare underpays hospitals for the care they provide—in 2022, hospitals received just 82 cents for every dollar spent caring for Medicare patients,[4] as fee-for-service margins declined to negative 13 percent.[5] While the AAMC appreciates that the legislation would preserve states' ability to use SDPs, limiting these payments to the Medicare rate would dramatically reduce the funding available to safety-net hospitals, furthering worsening the financial difficulties they already face. These restrictions would have downstream consequences for Medicaid enrollees, who may find it more difficult to find a provider who accepts Medicaid.

The AAMC also appreciates that the legislation would grandfather in SDPs that were submitted to or approved by CMS prior to the enactment of the legislation. However, it is worth noting that these grandfathered arrangements would be capped at the total payment amount agreed to at the time of the original submission. Under this framework, SDP funding would be effectively frozen and would therefore fail to keep up with hospitals' year-over-year cost increases. This would increase the financial burden on safety-net hospitals at a time when they will likely witness increased uncompensated care costs due to other policies contained in the legislation. For these reasons, the AAMC opposes this provision and urges policymakers to preserve states' ability to leverage SDPs to expand access to care and maintain the ACR as the ceiling for these payments.

Sec. 44142: Modifying cost sharing requirements for certain expansion individuals under the Medicaid program

This section would require states to implement cost-sharing requirements at an amount not to exceed $35 per-service for Medicaid expansion enrollees, effective October 1, 2028. While the AAMC appreciates that the legislation exempts certain types of services from these cost-sharing requirements (e.g., primary care and prenatal care), we remain concerned that such requirements would prevent low-income patients from seeking medically necessary care. Evidence from previous section 1115 waiver demonstrations reveals that cost-sharing increases the financial burden placed on Medicaid enrollees, resulting in forgone care and worse health outcomes. Non-

[4] https://www.aha.org/2024-01-10-infographic-medicare-significantly-underpays-hospitals-cost-patient-care
[5] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

payment of new cost-sharing requirements would further increase the uncompensated care burden on our member teaching hospitals and health systems, exacerbating the financial difficulties they already face. This policy would place an undue burden on vulnerable patients and the providers who serve them.

Sec. 44108: Increasing frequency of eligibility redeterminations for certain individuals

Effective December 31, 2026, this provision would require states to increase the frequency of Medicaid eligibility redeterminations for the expansion population from every year to every six months. The AAMC is concerned by and opposes this policy, which would impose additional costs and administrative burden on the health care system, while resulting in potential coverage losses. The health care system's experience with the unwinding of the COVID-19 public health emergency and a mass redetermination of Medicaid eligibility demonstrated that bureaucratic hurdles—such as failing to complete required paperwork—can lead to coverage losses, even for individuals who remain categorically eligible for Medicaid. More frequent redeterminations will compound the paperwork burden on Medicaid enrollees, increasing the likelihood that enrollees fall through the cracks of the system and lose coverage for procedural reasons. Evidence shows that states that conduct more frequent checks for Medicaid eligibility report higher rates of churn (i.e., individuals who are disenrolled and subsequently re-enrolled in a 12-month span).[6] Lapses in coverage resulting from this churn can reduce continuity of care, delay access to medically necessary care, and worsen health outcomes, while increasing states' administrative burden. To prevent these negative consequences and ensure continuous access to coverage and care, we urge Congress to remove this provision from the reconciliation bill.

Sec. 44141: Requirement for states to establish Medicaid community engagement requirements for certain individuals

Under this provision, states would be required to establish community engagement requirements for certain Medicaid enrollees, effective December 31, 2026. Under these new requirements, Medicaid enrollees between the ages of 19 and 64 who do not qualify for an exemption outlined in the legislation would be required to report at least 80 hours of work or work-related activity per month as a condition of their continued eligibility for Medicaid. The section outlines exemptions for caretakers, individuals with disabilities and the medically frail, people under the age of 19, pregnant and post-partum women, and others. If a state is unable to verify that an enrollee has satisfied their community engagement requirements, the enrollee will have 30 days to come into compliance before their coverage is terminated. We are also confused and dismayed

[6] https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf

that individuals who are disenrolled from Medicaid because of these requirements would not be able to access premium tax subsidies to purchase insurance in the marketplace.

While the AAMC appreciates the thought policymakers have put into who should be eligible for exemptions to these requirements, we are nevertheless concerned that these requirements will result in coverage losses for enrollees, increasing the uncompensated care burden on hospitals and reducing access to care for the nation's most vulnerable patients. Evidence from previous experiments with work requirements in Georgia and Arkansas demonstrates that these policies do not meaningfully incentivize work and result in coverage losses, while increasing the administrative burden on state Medicaid agencies.[7,8] We urge the Senate to consider targeted modifications to these requirements, such as providing enrollees greater opportunities to come into compliance with these requirements before their coverage is terminated or allowing individuals who have been disenrolled from Medicaid to qualify for premium tax credits to purchase alternative coverage.

PRESERVE ACCESS TO COVERAGE AND CARE

The AAMC is committed to ensuring that all people have access to comprehensive, affordable health care coverage. Premium tax credits have been critical to helping working- and middle-class individuals and families purchase insurance through the marketplace exchanges, providing them with reliable coverage and care. The AAMC urges policymakers to ensure the continued affordability of plans offered through the marketplaces and strengthen coverage options for everyday Americans by extending the enhanced premium tax credits provided by the American Rescue Plan beyond 2025. These tax credits have enabled millions of people to purchase commercial health insurance coverage, increasing access to high-quality care in health systems and hospitals. Absent congressional action to extend these credits, millions of people could lose coverage, thereby jeopardizing their access to care. The loss of coverage would place considerable financial stress on teaching health systems and hospitals, which will face higher levels of uncompensated care. To preserve access to coverage for working Americans and ensure the financial stability of the providers they rely on, the AAMC urges policymakers to extend these tax credits.

The AAMC is concerned that certain policies included in the House-passed reconciliation legislation will make it more difficult for individuals to enroll in and afford their commercial plans provided through the marketplace exchanges, thereby increasing the uninsured rate. More

[7] https://www.urban.org/urban-wire/new-evidence-confirms-arkansas-medicaid-work-requirement-did-not-boost-employment
[8] https://www.georgiapathways.org/data-tracker

specifically, we are concerned by provisions that would limit open and special enrollment periods for the marketplaces, prohibit automatic reenrollment for individuals with zero-dollar premiums, require additional verification of eligibility for premium tax credits, and remove the cap on repayment of excess premium tax credits. Taken together, these policies would limit opportunities for working- and middle-class Americans to use the premium tax credits and increase the administrative burden on individuals who rely on these credits to afford their coverage. The AAMC is concerned that these restrictions could result in disruptions in the individual marketplace, resulting in less affordable coverage and higher rates of uninsurance.

MAINTAIN ACCESS TO CARE FOR MEDICARE PATIENTS

AAMC-member health systems and teaching hospitals and their affiliated physician faculty practices continue to face profound financial challenges that seriously endanger their ability to care for patients, train the next generation of physicians, drive medical innovation, and foster economic growth. Historic workforce shortages, unprecedented capacity constraints, insufficient reimbursement from payers, supply chain disruptions, and a growth in expenses, all contribute to the acute financial pressures currently facing academic medicine. According to the Medicare Payment Advisory Commission, hospitals' overall fee-for-service Medicare margins dropped to a record low -13 percent in 2023,[9] a trend that is expected to persist. This is further exacerbated by a 2.8 percent reduction to the Medicare Physician Fee Schedule that took effect in January. These compounding challenges jeopardize access to care for Medicare patients at a time when their needs are increasing.

Misguided policies such as so-called "site-neutral" payment cuts would further exacerbate these financial challenges, targeting and disproportionately harming teaching health systems and hospitals, many of which are safety net providers. Despite representing just 5 percent of all hospitals, AAMC-member institutions would shoulder nearly half of the cuts under current proposals.[10] These policies fail to account for the more clinically and socially complex patient population cared for in teaching health systems and hospitals' outpatient departments (HOPDs) than physician offices, while complying with greater licensing, accreditation, and regulatory requirements. Reducing Medicare payments for care provided in these settings would threaten patients' access to critical services, particularly in rural and underserved communities, and diminish the ability of our members to sustain their missions.

Additionally, Congress must act to protect access to care for Medicare beneficiaries by enacting meaningful Medicare Physician Fee Schedule reform. While we understand the difficult fiscal

[9] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf
[10] AAMC Analysis of 2021 100% Medicare Standard Analytic File

decisions before the Senate, the AAMC strongly opposes financing temporary provisions through permanent reductions to the Medicare program. Teaching health systems and hospitals cannot absorb additional cuts without dire consequences for patients, communities, and the future of the physician workforce. We urge you to preserve and strengthen Medicare's support for academic medicine to ensure that our nation's most vulnerable patients continue to receive the high-quality care they need and deserve.

SAFEGUARD ACCESS TO HIGH-QUALITY MEDICAL EDUCATION

Sec. 30011: Loan limits

The AAMC urges the Senate to maintain the Graduate (Grad) PLUS program and protect full access to Unsubsidized Direct Loan borrowing, including the $224,000 aggregate limit for health professions students. Nearly 40 percent of medical students rely upon the Grad PLUS Loan program to finance their medical education. Grad PLUS loans have several key features that support prospective medical students, offering flexible income-driven repayment options, allowing students the ability to borrow up to the cost of attendance, and other essential borrower protections. Investing in financial aid for medical students strengthens the physician workforce and offers strong returns for the government. With physician loan default rates near zero, each $1 in federal loans to medical student borrowers yields more than $2 over the lifetime of repayment. Eliminating Grad PLUS not only could further exacerbate the physician workforce shortage by forcing medical students into a lending market with fewer protections, it also could diminish the federal government's ability to maximize potential returns from lending to the extremely low-risk medical student population.

Sec. 30024: Public Service Loan Forgiveness

The AAMC also encourages the Senate to maintain current eligibility requirements for the Public Service Loan Forgiveness (PSLF) program, including for medical residents. The PSLF program is a critical tool to incentivize public service, including practice in rural and urban medically underserved communities where serious health care workforce shortages impede access to care. Over 55 percent of medical school graduates plan to work in public service roles, such as in nonprofit hospitals, public health departments, and rural clinics. Removing incentives to pursue such career paths would reduce access to quality care for rural and underserved communities, and other populations who face the greatest barriers to care.

Sec. 4968: Excise tax based on investment income of private college and universities

Alongside the higher education community, we urge Congress to oppose any expansion of the excise tax on university endowments. Medical school endowments primarily support research, teaching positions, and student financial aid.[11,12] Increasing the tax on institutions that receive these endowments would redirect charitable contributions from donors to the federal government, without expanding students' access to financial aid. The AAMC is particularly concerned that this tax would disproportionately burden students and further restrict access to high-quality medical education. We encourage lawmakers to consider the long-term implications for the health care workforce.

We welcome the opportunity to provide any additional feedback or information on these requests. If you have any further questions, please contact me at dturnipseed@aamc.org, Len Marquez, Senior Director, AAMC Government Relations and Legislative Advocacy, at lmarquez@aamc.org, or Tannaz Rasouli, AAMC Senior Director of Public Policy and Strategic Outreach, at trasouli@aamc.org.

Sincerely,

Danielle P. Turnipseed

Danielle Turnipseed, JD, MHSA, MPP
Chief Public Policy Officer
Association of American Medical Colleges

CC: David J. Skorton, MD
President and CEO
Association of American Medical Colleges

[11] https://www.aamc.org/media/75946/download
[12] https://www.aamc.org/media/78706/download?attachment