John Clymer: And now let's turn our attention to a congressional update on health care policy and legislative developments. For that, we're pleased to welcome Carlos Jackson and Karen Richmond, both of whom are principals with Cornerstone Government Affairs. Carlos and Karen will provide us with insights into recent developments in health care policy, including updates on appropriations to the Centers for Disease Control and Prevention and National Institutes of Health, as well as congressional machinations around pharmacy benefit management reform. Let's welcome Carlos and Karen.

Carlos Jackson: Thank you, John, and good afternoon, everyone. Lawmakers are motivated to act this year to tackle health care costs, including lowering out-of-pocket costs for patients and consumers, with this being an election year. So the motivation is there for lawmakers to act to reform PBMs (pharmacy benefit managers), or pharmacy benefit managers, and the White House is very eager to get this done as well. Given that there has already been one legislative package focused on health care priorities that has gone through Congress and been signed into law, there's really one remaining opportunity for Congress to get action done by the end of this calendar year.

The difference is that, in terms of political benefits, again lawmakers being motivated to act because of the elections, that benefit will have passed. But even still, looking ahead to the end of the year, there is an opportunity to continue the work that has been done on a bicameral bases and on a bipartisan basis in all the communities of jurisdiction over this particular issue to advance this cause of reforming PBMs and, again, looking to tackle additional reductions in the price of prescription drugs.

Now, there are a lot of core provisions that were agreed upon by all the committees that have acted on this issue, and there have been six committees that have acted, as you all know to this point. A couple of the highlighted provisions, transparency requirements, are really important for lawmakers. They want to see what's under the hood, so to speak, for PBMs. And there's also been attempts by the committees to ban spread pricing, both within the Medicaid program and also looking to extend that to the commercial market.

Looking ahead in terms of why there has not been action up to this point in terms of a bill being signed into law is that there is a hangup between the House and the Senate, particularly on the Republican side, over how far to extend these PBM (pharmacy benefit managers) reforms. There's one side, again on a bipartisan basis, where these reforms would apply to federal health programs, again looking at Medicare Part

D, looking at Medicaid, etcetera. But there's also an element on the Republican side and also on the Democratic side.

We'd like to see these performers extended to the commercial market, and that's where the hangup has been this spring, at least, for lawmakers with respect to getting something done in this space. And this is the reason why we did not see PBM reforms be part of this health care package that was signed into law back in March.

So, between now and the end of the year, Republicans and Democrats in the House and Senate will need to hash out this difference. And looking when it comes to the commercial market side of this equation, it's really the Senate Health Committee, both Chairman Senator Bernie Sanders and the ranking Republican, Bill Cassidy. They were in favor of moving these PBM reforms through the commercial market, while on the House side, particularly within the Committee on Energy and Commerce, lawmakers were really focused on looking at again the federal health programs.

So that's one of the areas that needs to be sorted out between now and the end of the year. And the reason why the end of the year is going to be important in this respect is that lawmakers have set up what I call a cliff, where there are a number of expiring health care priorities that will hit at the end of this calendar year. So come December 31st, if there is no further action by Congress, there will be increases – or sorry, decreases to Medicare physician reimbursements. There will be decreases to Medicaid disproportionate share hospital funding for hospitals. There will be lower funding for community health centers, a number of priorities. And so, this is why we believe at the end of the year, after the November elections, during the post-election lame-duck session, Congress will look to advance another health care package. And, again, giving some of the items that I just mentioned, they will all need to be paid for.

And there are elements of the various PBM reform bills that are pending in Congress that would increase revenue for the federal government. So thinking about the simple math exercise that will take place at the end of this year, again, you have a number of health care items that you need to be paid for, and there are very few offsets that are in play right now to help address those that need to be paid for. So PBMs in this respect will be in the mix, simply because some of the provisions will raise revenue for the federal government. There's still that political benefit, but the immediate benefit will have passed. But, again, this is an issue that lawmakers on both sides of the aisle and both sides of Capitol Hill are committed to

addressing. And again, the president would like to get this done as well. We'll see if the November election kind of stymies these plans, but that's where the action will lie.

So what you can do between now and then is just remind lawmakers of the work that they've done up to this point and remind them that they need to act on this to get it done. And there are some revenue-raising provisions that will be important for the math exercise at the end of the calendar year. So, it's really incumbent upon all of you just to keep your voices going on this particular issue. Keep the drumbeat and remind lawmakers that the work is not done here, and there are still high prices that are impacting patients and consumers across the country.

Karen Richmond: Thank you. So pleased to be here with you today to discuss funding appropriations in the future, looking at advocacy for research and prevention related to heart disease and hypertension. When thinking about what to address today, I realize the future falls into two buckets, and they're really just math and politics. And so, I'll start with the math, 'cause that might be a little easier. What we'll see for the next fiscal year is a one percent increase totally over FY24, and that was written to law on the Fiscal Responsibility Act.

And as many of you all know, mathematically one percent is a lot of money, but one percent growth doesn't keep up with inflation, doesn't keep up with pay increases at federal agencies, as well as other fixed costs. So, one percent increase across the board really ends up being a bit of a cut when we talk about the actual activities and program level that agencies can work at, especially, and I know this has been an ongoing for years, that the cost of medical research at NIH (National Institutes of Health) always exceeds one percent for an increase.

So that's the first thing, is just that the lawmakers will want to stick to the Fiscal Responsibility Act that was negotiated, and so that defines where we are for the next year. Other considerations on the funding side, the math, is that – and these relate to mostly labor, HHS (Health and Human Services) Bill, NIH, CDC that we're talking about today – is some of the funding streams that have been available in the past are now drying up. So, these are outside of the normal appropriations allocations that the agencies get every year, but I'll give a couple examples. The first is for NIH.

Many of you, I'm sure, are aware of the 21st century CARES funding was mandatory funding, but that basically makes more

room in the budget. And it's my understanding that that will no longer exist into the future. And last year they started making up for that a little bit to make it seem like an increase over the year before, but, really, when you add all the numbers together, it wasn't an increase for NIH.

And then, as my colleague mentioned, the word cliff: We have a similar one in discretionary funding for public health and that's what we're calling a COVID cliff. I work a lot on CDC programs, and that's where we will – I see this, and what is happening is that we as a community came up with some really innovative programs using COVID funding that then expanded into other pathogens and that those programs have been largely funded through COVID supplemental funding. And many of you know probably the last or near the last of that funding was taken back by Congress in the end-of-the-year negotiations, and so we as a community are working hard to try to get funding into these base bills that is going to move into the future and be there as base funding for some of these programs.

But given what I just outlined about one percent growth, making up for the billions that was available in COVID funding is going to be a hard pill for Congress to swallow. So, there's a number of programs that we have to be looking at that are COVID-specific or pathogen-specific programs that that aren't in your world of the noncommunicable, non-infectious diseases. But it's only one size of a pie. And so, if we are looking to make up some of these COVID dollars that are going away, it's a concern on the other side of the non-infectious side. So that's the math part. And I'll say in my years working on appropriations, in the end, negotiators get creative, and they find ways, so I'm not super worried about that. But those are some of the big hurdles that we will face but that you might also hear about when you're out on the Hill and advocating for these programs.

So now I'll turn to politics, and the best thing I can say is a whole heck of a lot is going to happen between now and the end of the calendar year. Possibly that will be if fiscal '25 is appropriated, maybe not. That will depend on elections, largely. But in good news at this point right now, Tom Cole out of Oklahoma has been named the chair of the Appropriations Committee, and it's very good news for this community, for public health, for research and for CDC. He's been a big fan for the agencies and a big supporter of this kind of work in the past. And so that's great news.

I'll say the not-so-great news is out on the Hill in certain communities, there's unfortunately still a cloud of – remnants of COVID and people's

experiences, and some agencies are still suffering a bit reputationally. And I'd say CDC's probably up there and maybe within the community in Atlanta, there might not be as much of a knowledge of just how careful people still have to be. So that's not the great news going into it. But I have seen the feelings towards CDC, I think, soften in the last year or so. So, I'm hopeful we're on that trajectory.

So in the next year, between – not year, nine months, maybe, between now and when we see the FY25 appropriations pass, the best thing I can say is there's going to be a lot that happens and there's going to be times to freak out and times that you think you should freak out but you really don't have to. And I'll give examples of both. The first one is I imagine we will see very low funding levels in what we see come out of the House this year again, similar to last year. If any of you were following those bills, the House Republicans will cut, I'm sure, CDC, other public health, other HHS programs. This is not the time to freak out. You can go out with an advocacy strategy, for sure, and you should be talking to them, but this House – the levels we see out of the House Republicans is not what's going to be in law.

I'll say another example for maybe when to freak out for this community is – and this has nothing to do with Democrats or Republicans, but I think we've seen words out of the Trump administration that are potentially concerning about non-infectious disease work, especially at CDC and other agencies and what we might see out of that administration, should they come back in for the executive branch and the presidency. And that will be concerning. Fortunately, we do have checks and balances in Congress, and in the end, the Trump administration, or potential Trump administration, will not be able to fully change how the agencies look. But I think we have also seen that they're quite creative and have really good lawyers and can figure out some ways to really use the laws to their advantage. And so, I think this kind of community of public health and research should be prepared for thinking through the kind of leadership and the kind of changes that might come in under that administration, should they be re-elected into Congress.

So a couple things I'd like to leave you with, and I've been talking about advocacy for a while and I'm sure you hear this from other people, but really the number-one thing to think about when you're in front of an audience or you're talking to anyone about your work and your advocacy is to know that audience. And it's not just their politics but where they fall in the organization of their congressional office or their agency or where they work. So, if

they're an expert in your field or in your policy area or whether they're – they need a 101. And those are important things, and it's pretty easy to prep for ahead of time.

The other thing I would say is to make it compelling and state specific. Especially members of Congress' office, they'd like to know what you're doing in their state and for their community directly. And so those examples are really important. And I'll be a little more sensitive here, but knowing your audience also means sometimes avoiding words that will trigger them to just stop listening to you. And in this community, in public health, you definitely can't go into different political organizations and offices with different political backgrounds and have the same thing to say to them. You have to be very careful about the word you use and the examples you're giving.

It's not to say you should hide anything, but you want to make sure that your message is being received. And so, it's important just to know the kind of words to use for the audience here in front of. And the last thing I'll leave you with is I think we focus a lot on NIH and CDC, and I would just open the aperture a little bit. We talked with the leadership of this organization a little bit about ARPA-H. If you're not familiar with that organization, their Advanced Research Projects Agency for Health, modelled after DARPA, which is a defense-focused agency, and they're doing some really cool and innovative things that are in preventive health care.

Their mission as an organization is to do cutting-edge, high-risk, high-reward research. So, if you're interested in looking at that, I highly recommend it. They have a lot of money, and they have not yet upset many members of Congress, so I think we should help them spend their money. And if you're ever questioning the kind of messaging you should give or the people to go talk to, I think you – a lot of your organizations have government-relations folks. This organization has one. I'm always open to – if you have questions, you can contact me, but I think we're happy to answer your questions today.

Interviewer: Well, thanks, Carlos and Karen. Thank you, Karen, for that invitation to Q-and-A. We would like to invite everybody now to hop in with your questions. Please submit them using the Q-and-A feature in Zoom. We already have a couple. Carlos, the first one is for you, and the question is, what can audience members, today's audience members, do to help a PBM reform bill get over the hump on the Hill and extend the reforms to the commercial

market? And I'd add to that, given what Karen just said about trigger words: Are there certain arguments to emphasize or perhaps not to make when advocating for PBM reforms to include commercial markets?

Carlos Jackson: Yeah, so that's a great question. And we have to think about this in the context of where we are. In the current environment, we're in an election year. We know that the elections are this November. There's a lot of attention that will be placed on what is going to be a very tight election, so most lawmakers that are on the ballot are going to be looking to try to do what's best for their voters, their constituents.

So in this respect, again, focusing hard on what would be the impact to the everyday American, the average American, what does it mean, the fact that you still have certain fees that would be associated with PBM arrangements and with those fees would mean for consumers when they're spending money out of their pockets, so to the extent that you can share the difference or at least articulate and highlight the difference in what you'd be paying under one arrangement and what you'd be paying under the other. If you take away certain fees, that's something that will always get lawmakers' attention, especially right now. They want to make sure that they're acting in reaction to the needs of their constituents, particularly those who are sitting around their kitchen tables and thinking about how much money did they have to spend at the end of the month after paying all their bills.

And obviously prescription drug costs are a big part of these conversations that are happening around kitchen tables across the country. You have various PBM bills that have gone through various committees on both sides of the Capitol, and you have very technical provisions that are being debated, but at the end of the day, what comes across to the everyday American? What's in it for them? And so I think when it comes to advocacy, focusing on the what's in it for the everyday American, the average voter out there, is really communication that would –most lawmakers are going to listen to in one way or another. And so even if this action, legislative action, happens after the election, again, you have another big midterm election coming in 2026. So particularly for those senators, they want to make sure they're doing right by the voters. So those are some of the activities I feel that can make a difference.

Interviewer: Thanks, Carlos, and a follow-up on that: I hear you emphasizing out-of-pocket cost for the consumer or a patient. We who are

focused on cardiovascular health, on heart health, see a lot of people who have cardiovascular disease, and particularly people with high cholesterol, having difficulty getting access to therapies that we know would help them, because the PBMs have put certain barriers in place, procedural barriers to access to those therapies. Are members of Congress going to care about access like that, and are they going to care about it in the same way that they do cost as an access function, or is that something you just wouldn't get into? I mean, what advice do you have for us in terms of building and broadening the case that we take to the Hill?

Carlos Jackson: Yeah. I think when it comes to advocacy, particularly for certain – in health care, it's really important to speak from the standpoint of, most of us have experienced one way or another with our health care industry, whether it's as a patient, whether it's someone who's using insurance coverage. But to the extent that policymakers, lawmakers, their staff, they understand exactly by putting themselves in your shoes, or maybe they've had relatives that have been in your shoes, really being able to communicate in way where they understand that point. So to the point where you're receiving the best care, the care that will take care of the patient, that's important if you're continuing maintaining access to high-quality care for patients.

Again, that's also very important. You don't want to shut yourselves off or shut off, actually, your constituents or voters from being able to access high-quality care. So that's something that most folks will understand. Now, when we talk about some of these things, again in a way that everyone will get – and again, like I've mentioned, we all have experience one way or another with health care in this country. We do have to think about, what are some of the barriers that are in place for lawmakers? And when it comes to Capitol Hill and Congress, it's always the cost equation that's something that has to be considered.

But we have a representative government. Our lawmakers have been elected to take care of us, their constituents, here in the halls of Congress at the federal-government level, so let's make sure they understand exactly some of the policy actions that they're taking or maybe not taking – what they mean for you and potentially what it can mean for their family members. So to the extent that we can out communicate some of the cost-down factors, that that's one thing there. But I just feel it's very effective to be able to speak in a way that everyone gets and everyone understands. And if cost is a barrier, there are other offsets that lawmakers can use and let them make those decisions. Just focus squarely on what the benefit

would be for patients and why it would be in the best interest for lawmakers to act.

Interviewer: Great. That's very helpful, Carlos. Thank you. Karen, we have a question from Donna Grande, the CEO of the American College of Preventive Medicine, about what you've discussed. She said you highlighted the mathematical constraints, the appropriator space. What strategies or advocacy efforts do you recommend audience members take to ensure that there's adequate funding for public health, as well as medical research?

Karen Richmond: Sure. Thanks, John, and thanks for the question. The best thing I can say right now, adding to what I already commented on, which is knowing your audience and making it personal, bring stories to members of Congress in their office that their constituents care about, 'cause that's – all policy is local, right? The other things I would say is, especially in what we'll see, is more austere funding environments. And the NIH advocacy community has done well. Maybe we can look to CDC to do the same kind of "rising tide lifts all boats" approach. Instead of all asking for your own specific programs, go in with advocating for the whole Chronic Disease Center, or – and I understand everyone has their own programs, but the Labor H subcommittee on funding gets thousands and thousands of requests. And so when everyone comes in with their own line item that's like another meeting they've had, and they walk away.

But if the community starts talking together with one voice a little bit about advocating for non-infectious disease, I think that could be helpful. The other thing I'd add are there's other tools available to you besides just funding that you can use. And one is directed-report language to the agency. And I'm happy to chat further with anyone who'd like to know more about that – and then also things like working with the agencies on grant guidance. There are ways to move the needle that aren't necessarily growing the pot of money but finding ways that you can address your challenges without further appropriations or expanded appropriations.

Interviewer: Right. Thank you. That very helpful. I have to say, I know I have a bias, but your comments about everybody getting on the same page and singing the same song about support for non-infectious disease is music to my ears and I think great advice for all of us to follow. The last question is from Julie Harvell, and it's for both of you. And she asks, how can we get Congress to pay more attention to hypertension and the need to improve hypertension control?

You heard at the beginning of today's meeting the deputy assistant secretary, Paul Reed, talk about hypertension costing us as many what could've been preventable deaths as the pandemic did, and hypertension being a pandemic of its own, and yet I don't think it's recognized that way on Congress or on the Hill. And, Karen, you talked about the stigma around pandemic discussion, so how would you recommend those of us who are listening to you now encourage members of Congress to raise the priority on hypertension control nationally?

Karen Richmond: I can get started and I'll lead a little bit into areas I am not as up to date on, but I would say you look for the deep pockets, which is probably CMS in this case. And we've been successful in the past with, I think, the precedent-setting diabetes-prevention program, where they were able to get the reimbursement to the YMCA for that program, which – so I'd consider that kind of strategy of trying to get the CMS and the hospitals to care. And then I think you just have to build real champions who care about this policy, not just because of public health but because they'll understand the cost associated to the government and the nation, and that takes some time, and it takes building champions that are probably more looking at the committee chairs and then the down-dais of the people who really have chosen to be on those committees and care deeply about those issues.

Interviewer: Carlos, you get the last word.

Carlos Jackson: Sure. Thanks. No pressure there. No, I think that this is an issue that lawmakers do recognize and policymakers recognize. I mean, the numbers are there. The data's there. We can see what the costs are in terms of spending on certain diagnoses, services, etcetera. And so I think from a policymaking standpoint it's really trying to figure out the challenge involved of, how do you break down some of the silos? How do you break down some of the barriers, when it comes to federal programs, what the federal programs are reimbursed for and how you can get clinicians, providers, others to actually try to do some of the frontend work that will, again, focus more on the prevention element of this in terms of making sure that not just individuals but entire communities or populations are also managing their health to the point where you do not have the numbers of hypertension where they are today. But in order to do that, it's going to take a whole government approach, and also we'll need to break down against some of those silos and barriers. There are certain arbitrary rules that are in place, frankly, that will say Medicare or Medicaid will not reimburse for certain things. In this case, yes, but, okay, we'll pay for certain services or programs that

are offered outside the walls of the provider. We are seeing some of that happen. More of it needs to happen, and that's one thing that lawmakers and policymakers can focus on.

But Medicaid, that's 50 different Medicaid programs for 50 different states. And then Medicare, without demonstrations or other more permanent policymaking, I mean, it's just tough. So I think we are where we are. Folks know where we need to go in terms of how to get our arms around some of these issues, but we have to just look at some of those barriers that are in place from a policymaking standpoint or a regulatory standpoint, and figure out how to minimize those as much as possible.

John Clymer: Well, thank you. We really appreciate your insiders' perspectives and your advice. Karen Richmond, Carlos Jackson, thank you for sharing your perspectives on the links between public health policy and hypertension control and support for public health and prevention. Now let's go to the final round of haiku.