Investing in American Health

A Special Advertising Supplement To The Washington Times

Investing in American Health

CONTENTS

The Washington Times
SPECIAL SECTIONS

Tony Hill
DIRECTOR OF ADVERTISING & INTEGRATED SALES

Advertising Department:
202-636-3027

Thomas P. McDevitt
CHAIRMAN

Christopher Dolan
PRESIDENT & EXECUTIVE EDITOR

Adam VerCammen
CHIEF REVENUE OFFICER

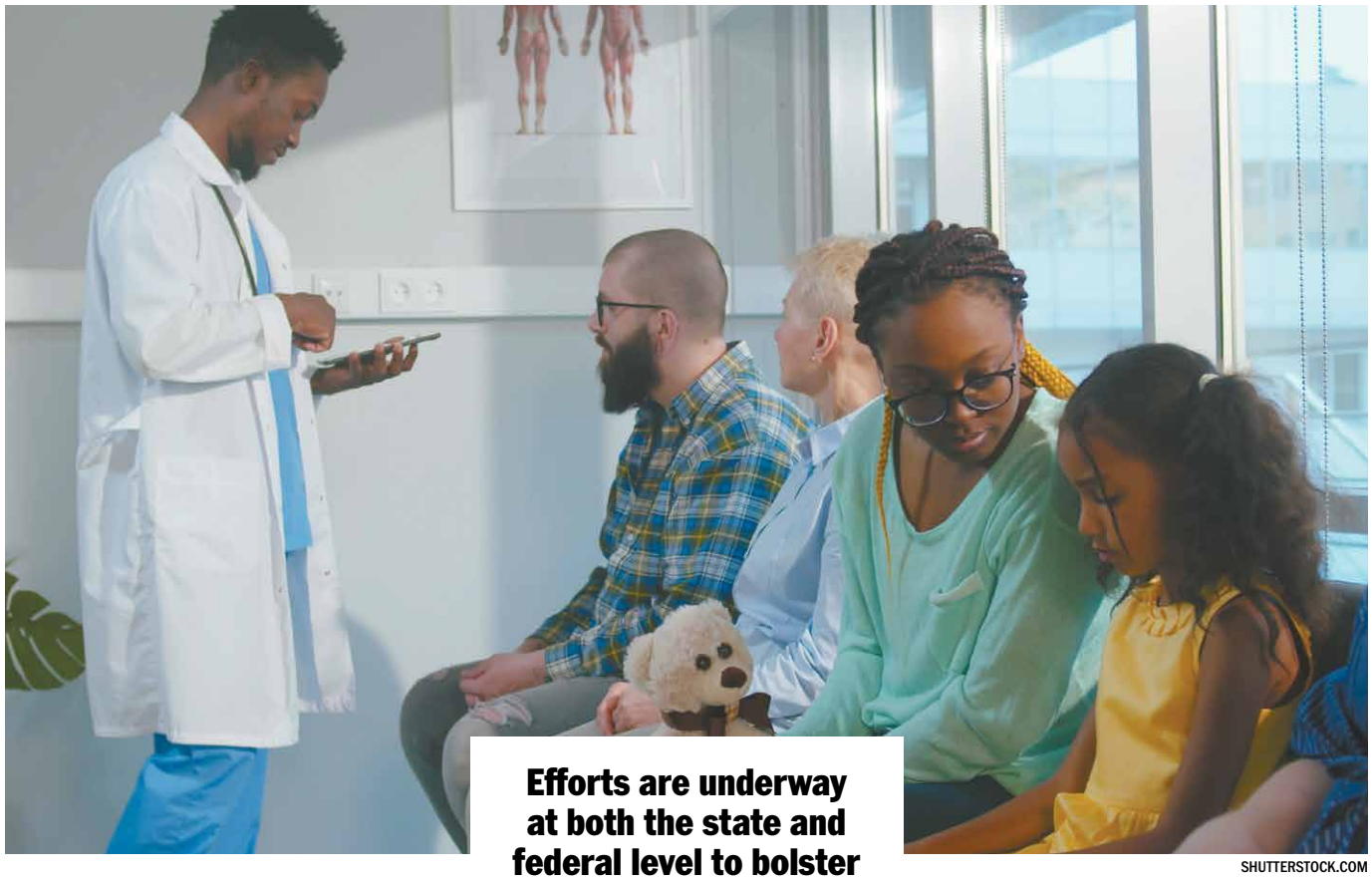
Hope Seck
SPECIAL SECTIONS EDITOR

Patrick Crofoot
GRAPHICS SUPERVISOR

Special Sections are multipage tabloid products that run in The Washington Times daily newspaper and are posted online and in PDF form on its website. Sponsors and advertisers collaborate with The Times' advertising and marketing departments to highlight a variety of issues and events. Unless otherwise identified, Special Sections are prepared separately and without involvement from the Times' newsroom and editorial staff.

The medical provider shortage threatens Americans' health

By U.S. Sen. John Boozman, R-Ark.



SHUTTERSTOCK.COM

Medical care is a high-stakes endeavor. But imagine if our ability to seek out quality health guidance and treatment was drastically hindered by a lack of available providers. The results could be detrimental or even life-threatening.

That challenge is becoming a reality for all Americans, and particularly those living in rural and underserved areas. It could get worse if we fail to attract, train and retain talent in this critical field to meet growing demand.

Doctors have traditionally served many health needs, but their ranks are diminishing.

In fact, the U.S. could face a shortfall of up to 86,000 physicians in the next decade, according to the Association of American Medical Colleges. This includes between 20,000 to 40,000 primary care doctors –– a gap that would jeopardize short and long-term health for millions.

There are multiple factors contributing to this deficit.

As our country's population ages, the need for more health care professionals will only increase. By 2036, the percentage of Americans aged 65 or older will climb by over 30 percent while those 75 or older will rise by over 50 percent. Since we know older individuals require more medical care, these trends indicate a likely need for more, not fewer, practitioners.

Simultaneously, more physicians will reach retirement age and begin to scale back or cease treating patients altogether. Right now, one in five doctors are over age 64 and nearly a quarter are between the ages of 55 and 64.

Finally, the intense nature of clinical care is also creating burdens on the physician workforce. Burnout, combined with concerns about reimbursement and inadequate support staffing, leads some providers to weigh changing careers. If left unaddressed, that outcome could exacerbate this crisis.

In my home state of Arkansas, we are acutely aware of these challenges.

Over 500,000 Natural State residents – more than one-sixth of our population, in about 50 of our 75 counties – live in an area defined by the federal government as lacking an adequate number of health professionals. As a largely rural state, we know broad issues in health care are only magnified in smaller communities with fewer resources.

Fortunately, efforts are underway at both the state and federal level to bolster the medical workforce pipeline. Building on this foundation will be pivotal to helping ensure Americans, no matter where they live, have access to quality and affordable care.

I am championing bipartisan policies to support the next generation of physicians and prompt them to practice in rural or underserved areas. Senator Jacky Rosen, D-Nev., and I have introduced bills that aim to increase access to medical residency slots as well as incentivize students to join the medical field by addressing direct financial concerns.

Specifically, our Resident Education Deferred Interest (REDI) Act would help increase the number of doctors and dentists by allowing them to defer student loan payments interest-free until the completion of their residency or internship programs.

Efforts are underway at both the state and federal level to bolster the medical workforce pipeline. Building on this foundation will be pivotal to helping ensure Americans, no matter where they live, have access to quality and affordable care.

Meanwhile, I have been a longtime advocate for expanding the availability of Graduate Medical Education (GME). The lack of medical residency positions across the country, but especially in Arkansas, has hindered our ability to prepare future doctors to live and serve in the communities that need them most.

This problem stems from an outdated federal cap on the slots available for medical residents at hospitals that went into effect in 1997. Thankfully, leaders in my state have recognized this issue and are pursuing multiple pathways to remedy it. Previously, I have been pleased to help secure modest increases in Medicare-supported GME positions and will look to deliver more during this Congress.

Ensuring we are training more doctors to provide adequate care and encouraging enough to locate in areas already experiencing a strain on available medical assistance is a high priority.

One Little Rock-based primary care provider recently recalled the agonizing dilemma he experienced after a patient suffered a stroke, was hospitalized and discharged before subsequently experiencing another stroke before he could schedule a follow-up appointment. The reason for that delay was the crushing demand his practice is already grappling with and complicating the delivery of care.

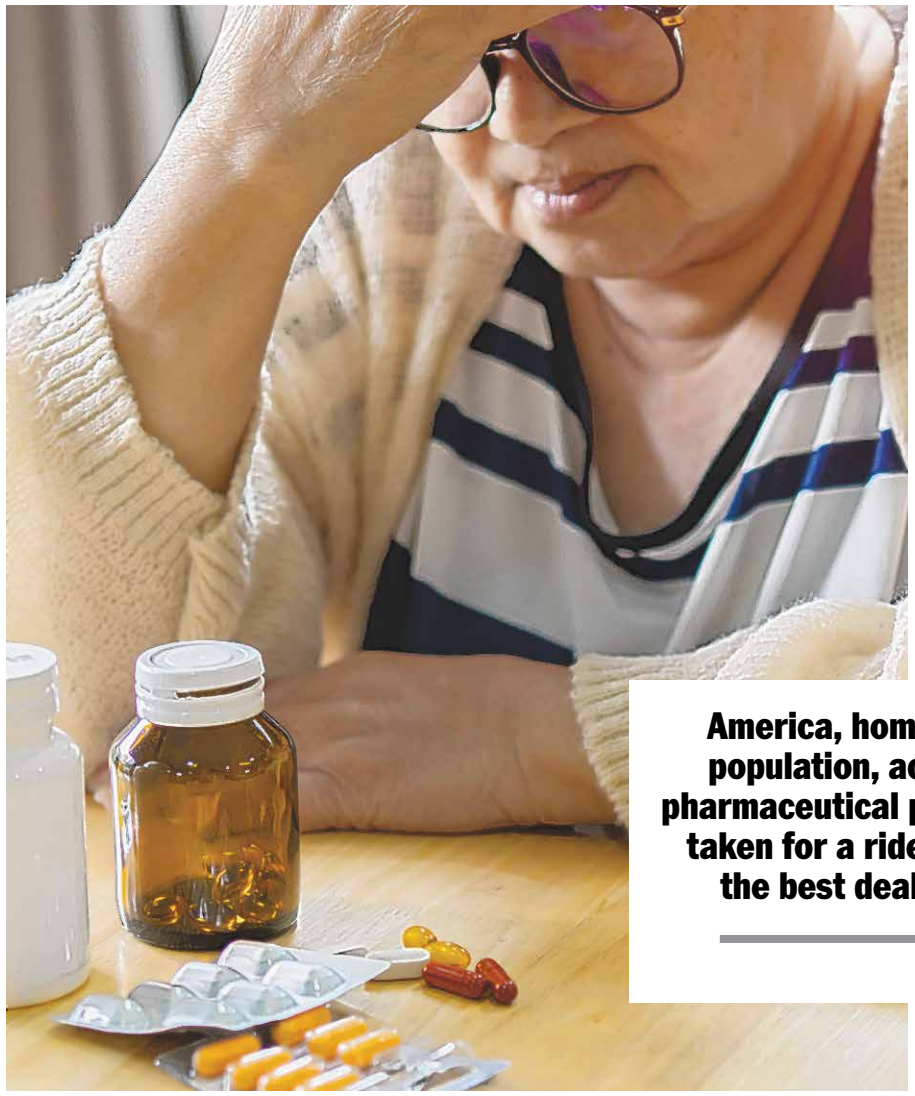
That story is one of many across primary and specialty care practices. And it could become more common if we fail to act.

As an optometrist by training, I fully understand the consequences of delaying or denying adequate health care. Americans will benefit from the concerted efforts we can make to ensure convenient access to well-trained medical providers for years to come.

Sen. John Boozman, R-Ark., is the chairman of the Senate Committee on Agriculture, Nutrition, and Forestry, and the state's senior senator. He also accumulated decades of experience as a successful healthcare provider, co-founding a major regional eye care practice in Arkansas.

Big pharma puts other countries first and America last. It's time we change that

By J.D. Hayworth



SHUTTERSTOCK.COM

Americans are sick and tired of being sick and tired. Worse, they're fed up with being ripped off in the process. More than half of all Americans fret over the price of prescription drugs, and nearly everyone agrees that Big Pharma's unchecked pursuit of profit is to blame.

It's promising that this issue has finally captured attention in Washington, where lawmakers are decrying unaffordable prescription drug costs and calling for action. But what exactly can be done to rein in the most powerful industry in America?

Put simply, our leaders must hold pharmaceutical companies accountable for their actions. The time has come to demand that Big Pharma lower drug prices, stop the use of anti-competitive practices that enrich drugmakers and restrict access to cheaper generics, and bring transparency to direct-to-consumer advertising so Americans know the real cost of the products they're being sold.

Let's be clear — despite Big Pharma's best efforts to shift blame, the drugmakers themselves are responsible for high drug prices. Pharmaceutical companies control the price of their products and can raise them any time they need a cash infusion. In fact, between 2022 and 2023, manufacturers raised the price of 4,000+ drugs by an average of 15.2% – a rate far exceeding inflation. American families have been rightly concerned about the price of eggs, but can you believe that these increases translate to nearly $600 per drug? Americans can't afford to keep up.

What's even more egregious is that Big Pharma gives America the world's worst deal on prescription drug prices. On average, Americans pay over three times more than consumers in other wealthy nations for the exact same drugs. For some products, the disparity is jaw-dropping — a difference of more than 10 times on drugs to treat blood clots and heart conditions, or 30 times on inhalers to treat asthma. In President Donald Trump's own words, "it's very unfair" that Big Pharma price gouges Americans while giving foreign countries a massive discount.

This price disparity isn't an accident. It's a deliberate scheme to rip off the American people in pursuit of profits. Luckily, President Trump's Most Favored Nation executive order rightly called out Big Pharma for putting other countries first and America last, declaring that "this egregious imbalance [in drug prices] is orchestrated through a purposeful scheme in which drug manufacturers deeply discount their products to access foreign markets, and subsidize that decrease through enormously high prices in the United States." In other words, Big Pharma takes more of Americans' hard-earned money to cut other countries a break.

Knowing this, it isn't a surprise that America, home to just 5% of the global population, accounts for 75% of global pharmaceutical profits. Americans are being taken for a ride while other countries get the best deal, and we've had enough.

So how does Big Pharma manage to keep prices so high in America? Simple: through flagrantly unfair practices that stifle competition — the very bedrock of American capitalism. Pharmaceutical companies find legal loopholes to extend patents beyond their intended lifespans, which block cheaper alternatives from reaching the market and, in turn, the American people. To put it plainly, Big Pharma cheats the system to strengthen its monopoly, reinforcing its power to charge Americans any price they want.

At the core of Big Pharma's ability to rip off the American people is its continuous efforts to mislead the public — both to deflect blame for high prices and to sell Americans more ineffective, overpriced products.

It's true — Big Pharma has mastered the blame game, spending tens of millions of dollars a year to maintain undue influence in Washington and our state capitals. As part of these efforts, Big Pharma throws its weight behind bills and initiatives that point the finger at everyone else while taking zero accountability for manufacturers' central role in driving up drug costs. Big Pharma also funds a vast web of organizations that conceal their ties to the industry and push baseless narratives that obscure drugmakers' responsibility for soaring healthcare costs. Meanwhile, Big Pharma profits from the status quo, using its influence to stop real reform.

Let's not forget Big Pharma's advertising practices. Did you know that the United States is one of only two countries in the world where pharmaceutical companies can advertise directly to patients? So Big Pharma takes full advantage, flooding Americans' TV screens with about 9 ads a day, or 16+ hours of ads per year. That's significantly more time than most Americans spend with their primary care physicians. Big Pharma spends tens of billions more on ads than on research to improve drugs for patients, an expense they get to write off even as hardworking Americans pay their fair share in taxes.

America, home to just 5% of the global population, accounts for 75% of global pharmaceutical profits. Americans are being taken for a ride while other countries get the best deal, and we've had enough.

Worse still, many of the medications Big Pharma advertises cost more and work less effectively than cheaper alternatives. Simply stated, Big Pharma is selling the American people lie after lie. And not only are we buying it, we are paying top dollar.

Enough is enough. Americans are tired of being ripped off and misled, and tired of watching Big Pharma cheat the system, cash in, and put America last. It's time for policymakers to step up and do what's right, and to fight for We, the People — not Big Pharma.

J.D. Hayworth is a former U.S. Congressman (R-Ariz.) and spokesperson for the Pharmaceutical Reform Alliance (PRA), an organization dedicated to growing awareness about Big Pharma's anti-consumer practices that are resulting in skyrocketing prices in the United States for a wide range of vital pharmaceutical drugs. Read more: www.pharmareformalliance.com.

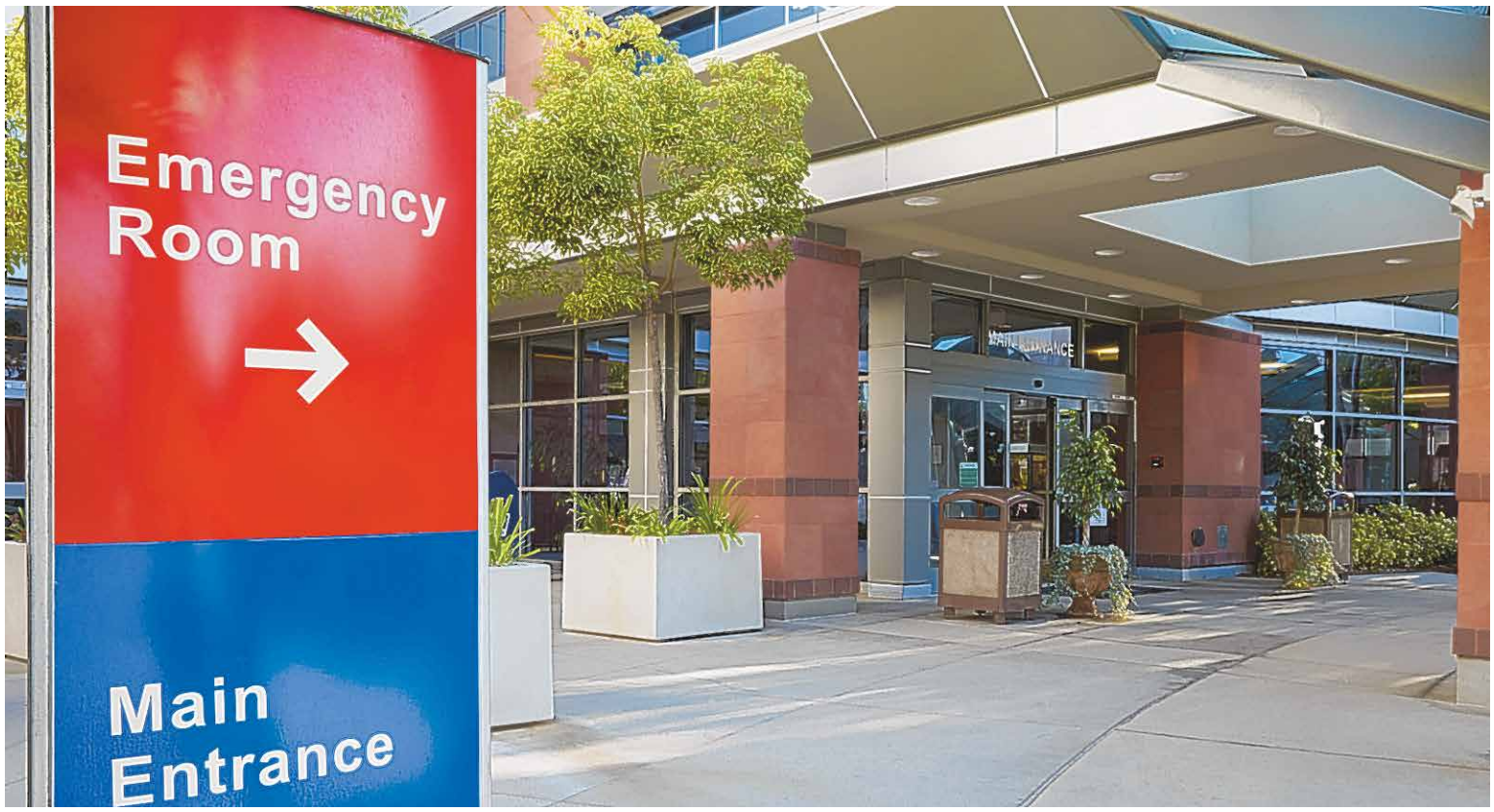
Thanks to Big Pharma, Epi-Pen prices have risen $550 in recent years.

Source: CNBC

Cost of Epi-Pen in the U.S.

PHARMACEUTICAL REFORM ALLIANCE

Learn More:
PharmaReformAlliance.com



SHUTTERSTOCK.COM

We must tackle the medical professional shortage

By U.S. Sen. Jacky Rosen, D-Nev.

By almost any measure, our nation faces a shortage of qualified medical professionals, and this shortage is causing a crisis in my home state of Nevada when it comes to accessing quality health care. In 2021, Nevada ranked 48th in the nation in the availability of primary care providers. However, the challenges we face are not unique. Across the nation, the lack of active medical professionals is leading to longer waiting times for care and worse health outcomes.

Access to health care is not just a "red state" or a "blue state" problem; it's an American problem, and we need to come together to fix it. Now more than ever, we must take action, Democrats and Republicans, to address this crisis with the urgency it demands.

In Nevada, the lack of physicians is hurting the ability of all Nevadans to get the care they need in a timely manner. Many people in my state have to wait over a month to see their primary care providers, and even longer to see a specialist. Research has shown that this is putting stress on emergency rooms and makes re-admission to the hospital more likely.

Families in Nevada and across our country deserve better, and that's why I've made it a priority to address this issue by pursuing commonsense solutions to expand the number of doctors and nurses in communities that need them most.

I'm addressing the physician shortage by working in a bipartisan way to expand medical residencies and training opportunities. Studies have shown that medical students are more likely to stay and practice medicine in the locations where they completed their residencies. Nevada is the fifth fastest-growing state in the country, but the number of medical residency slots we are allocated from the federal government has not kept pace with our growth.

Access to health care is not just a "red state" or a "blue state" problem; it's an American problem, and we need to come together to fix it. Now more than ever, we must take action, Democrats and Republicans, to address this crisis with the urgency it demands.

My bipartisan Physicians for Underserved Areas Act revises the existing residency re-allocation process so that the redistribution of residency positions better reflects the needs across the country as hospitals close. I also wrote a letter to the Secretary of Health and Human Services at the end of last year, requesting that Nevada be allocated its fair share of the new residency slots. If Nevada were allocated the residency slots it needs, then more doctors would likely choose to practice medicine in our state.

My bipartisan Resident Education Deferred Interest (REDI) Act incentivizes doctors and dentists to work across Nevada, including in rural and underserved areas by deferring student loan payments.

Another bill, my bipartisan Specialty Physicians Advancing Rural Care (SPARC) Act, brings specialty doctors to rural and underserved areas by providing student loan repayment incentives to those who stay and practice in these areas.

And it's not just doctors, it's nurses too. Nevada ranks near the bottom in terms of the number of nurses per capita throughout our state, which means greater barriers to accessing care.

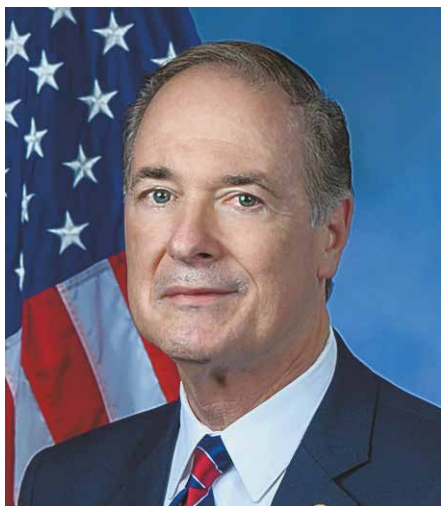
My bipartisan Train More Nurses Act invests in nursing faculty and increases pathways available to Licensed Practical Nurses to become Registered Nurses. This bipartisan bill actually passed the Senate unanimously last Congress. This Congress, I'm confident we can get this legislation passed again and signed into law.

People in Nevada and across the country have asked us to take action to improve care time and time again. With a shortage of doctors and nurses in my state and so many others, it is critical that we work together – Democrats AND Republicans – to address this crisis with the urgency it demands. I'm ready to work with anyone to move these commonsense initiatives forward, to keep our communities healthy, and to save lives.

Sen. Jacky Rosen represents Nevada.

This is our prescription to fix a broken health care system

By U.S. Reps. Greg Murphy, M.D., R-N.C. and John Joyce, M.D., R-Penn.,



SHUTTERSTOCK.COM

As physicians who have practiced for decades and the co-chairs of the GOP Doctors' Caucus, we have witnessed firsthand the breakdown of our health care system. We pay too much for care that is too often delayed or denied altogether by those who never directly touch a patient. Too many of these middlemen have been allowed to come between our patients and the care they need. Composed of some of the only members of Congress who have ever directly cared for patients, the GOP Doctors' Caucus brings a critical patient-focused perspective to healthcare policy debates.

Access to Quality Healthcare

Patients across America, particularly in rural and underserved communities, are losing access to their trusted physicians as independent practices close. When a family doctor closes an independent practice, Medicare beneficiaries face the painful reality that they have to travel further to find another practice or hospital system that accepts their insurance or go without care.

This growing crisis stems directly from Medicare's continued underfunding of physician services. Hospital-owned practices typically charge more for the same services, creating higher out-of-pocket costs that Medicare patients bear through increased copays and deductibles. Patients also lose the trusted relationships that they've built with local doctors who know their medical history, preferences, and unique needs, disrupting continuity of care. For elderly and disabled patients, increased travel distances create significant hardships, especially for those with limited mobility or transportation options, resulting in a lower quality of life. These combined factors place vulnerable patients at even greater risk of poor health outcomes and financial strain.

Medicare patients deserve a stable and predictable payment system that incentivizes providers in all settings and all areas to keep their doors open and to serve their communities.

Medicare Advantage Reform

Insurance companies are playing games with their own customers' health for record-breaking profits. Medicare Advantage (MA) was created with the premise of providing wrap-around services for seniors at lower costs. Unfortunately, profit-driven insurance companies have destroyed that model. While MA continues to provide important benefits to millions of seniors, these plans must stop seeing rewards for delaying or altogether denying care to beneficiaries that need it. Even worse, insurance companies that provide MA plans "upcode" beneficiaries with diagnoses that are clinically irrelevant and often dangerous. Despite the goal of saving money through better preventive care, evidence indicates these plans currently cost taxpayers up to 20% more than traditional fee-for-service, without better outcomes. Stopping these unfair and unethical practices will mean better healthcare now and protecting Medicare benefits for the future.

Prior Authorization Burdens

Another dirty game that insurance companies play is utilizing the prior authorization process. Denying the care that you and your doctor believe to be necessary is a common tactic used by insurance companies to wear down beneficiaries and their care team. This results in worse care for patients and costs both the federal government and providers more, as patients and providers must then spend time fighting these useless denials.

When decisions on patient care are made by faceless bureaucrats with no experience or expertise, care is often delayed or denied altogether. We must pass policies that reduce these burdens of prior authorization by demanding peer-to-peer reviews for these conversations and streamline processes so that patients and physicians know when prior authorization is needed.

Pharmacy Benefit Manager Reform

Patients throughout the country are faced with higher costs for the prescription drugs that they need which limits their ability to get the care that they deserve.

One factor driving up costs is the Pharmacy Benefit Managers (PBMs), yet another group of middlemen, who play a problematic role in determining pricing and access to medication. PBMs negotiate with manufacturers, develop formularies, and even own pharmacies — further consolidating the American health care system. They capture monies from pharmaceutical companies to gain access to formularies and then keep the rebates meant for the patients. PBMs also keep drug prices higher because they earn a commission rather than just a simple fee.

Congress needs to establish greater transparency in how medications are priced and selected for coverage. Patients and prescribers deserve a process that protects the doctor-patient relationship and not the PBMs' bottom line. Establishing flat fees for PBM services would remove the incentives that drive prices higher and deliver relief for American patients.

The Path Forward

While not comprehensive, these small reforms provide practical steps toward true relief to our system and improve the care that American patients receive.

Meaningful health care transformation demands collaboration across all stakeholders. Americans deserve care that both preserves the sacred doctor-patient relationship and ensures access to affordable high-quality care. The Trump administration has called for needed improvements to strengthen our healthcare system, and we in the Doctors' Caucus look forward to continuing our great partnership with the administration to deliver results for American patients.

The time for these focused reforms is now.

Rep. Greg Murphy, M.D., represents North Carolina's 3rd Congressional District. He serves on the Health subcommittees of both the Ways and Means and Veterans' Affairs Committees, and co-chairs the House GOP Doctors' Caucus.

Rep. John Joyce, M.D., has represented Pennsylvania's 13th Congressional District January 2019 and currently serves as Vice-Chair of the House Committee on Energy and Commerce and as co-chair of the House GOP Doctors' Caucus.

Supporting loan repayment programs is key to strengthening the primary care workforce

SHUTTERSTOCK.COM

By Jen Brull, MD, FAAFP

As a family physician, I've seen firsthand what happens when people can't access the care they need, when they delay seeing a doctor because there's no clinic nearby or when they wait until symptoms become emergencies. This crisis is especially acute in rural and medically underserved areas. But the solution starts upstream, in our nation's classrooms and medical schools — and it requires policymakers to take urgent action on medical student debt.

The U.S. is facing a critical shortage of primary care physicians. According to the Association of American Medical Colleges (AAMC), we'll need as many as 40,400 more primary care physicians by 2036. That's just over a decade away, and we're already feeling the squeeze. The path to becoming a family doctor is increasingly difficult to walk, especially for those who train and practice in rural and underserved areas.

Medical school debt is a huge part of the problem. The average debt for new physicians now hovers around $250,000. That number alone is enough to steer many interested, passionate, talented students away from primary care and toward higher-paying specialties. It is also more than just a financial burden. For young physicians, it's a source of crushing stress that often shapes career paths in ways that don't align with our country's health care needs.

Recent actions from the White House and legislative activity in Congress could undermine public student loan forgiveness (PSLF). While the ultimate outcome will depend on rulemaking by the Department of Education and votes in this Congress, I urge policymakers not to overlook how essential PSLF Is — not just to physicians, but to the patients and communities we serve.

More than 40% of physicians participate in PSLF. That's tens of thousands of health care workers making a decade-long commitment to public service, often in communities that desperately need them. Family physicians participate in PSLF in large numbers. In a survey sent to AAFP members just last month, over 75% of the respondents who participate in a loan repayment program are enrolled in PSLF. These physicians are choosing to sacrifice higher-paying positions so they can train and practice in areas where their impact will be even more pronounced. The very least we can offer them for this 10-year public service is the opportunity to be debt-free. This financial freedom will also give them greater ability to stay and practice in the rural and underserved communities they have dedicated years of their lives to serving.

PSLF is a crucial program for expanding access to care and supporting physicians who choose to work in areas of greatest need, but it is just one piece of the puzzle. Pieces of legislation such as the Resident Education Deferred Interest (REDI) Act, which allows medical residents to defer their student loans interest-free while they complete their training, and bills that exempt loan repayment programs from taxable income can also help to mitigate federal student debt.

These physicians are choosing to sacrifice higher-paying positions so they can train and practice in areas where their impact will be even more pronounced. The very least we can offer them for this 10-year public service is the opportunity to be debt-free.

These common-sense and bipartisan measures make family medicine and other lower-paying medical specialties more financially viable. Without them, interest continues to compound while residents earn modest stipends and physicians are subject to large tax bills after successfully completing a loan repayment program.

Further, we need to do more than maintain loan repayment programs such as PSLF — we need to expand them. That includes supporting the National Health Service Corps (NHSC), which offers scholarships and loan repayment in exchange for service in high-need areas, supporting rural track training programs and expanding eligibility and funding for all loan repayment programs for physicians who work in underserved communities. The federal government has a critical role to play. By expanding PSLF, passing the REDI Act and increasing investments in scholarship and loan repayment programs like the NHSC, policymakers can help eliminate the debt barrier that keeps too many talented young people from entering medicine — or drives them away from primary care.

These aren't just budgetary decisions. They're decisions about who gets to become a doctor and who gets to see one. Let's invest in a health care system that works for everyone — by investing in the health of America, today.

Jen Brull, MD, FAAFP, is a family physician in Fort Collins, Colorado and the president of the American Academy of Family Physicians.

America's Health is on the Line

The physician shortage is real. Family medicine is the answer.

America is aging, and the number of available doctors to care for our patient population is shrinking.

We need more physicians—**over 40,000 by 2040**—but the gap isn't just about numbers. It's about geography, with the greatest shortages in rural and underserved communities already lacking adequate access to care.

The **American Academy of Family Physicians** represents the family physicians who care for you, your patients and your communities. We're leading national efforts to **bolster the primary care physician workforce** by:

- Tackling steep medical student loan debt
- Expanding programs that help address physician shortages
- Advocating for policies that grow and support a diverse, well-distributed family medicine workforce

Now is the time to invest in the physician community—the one that delivers preventive and emergency care, serves families and responds to emerging health threats.

To Congress and our nation's health care leaders: Act now to secure the future of America's health.

Interested in learning more about the primary care workforce shortage?

Scan to view our 2025 Primary Care Scorecard.

Brought to you by the American Academy of Family Physicians.

SHUTTERSTOCK.COM

Make veterans healthy again

By U.S. Rep. Vern Buchanan, R-Fla.

America's veterans answered the call to serve their country. Now it's our turn to serve them — not just with words of gratitude, but with real solutions that improve their health, dignity and quality of life.

Throughout my time in Congress, I've worked to expand access to care and benefits for those who've worn the uniform. As vice chairman of the House Ways and Means Committee and chair of the Health Subcommittee, I've also long believed that prevention should be at the heart of our health care system. That's why I introduced the *Veterans Nutrition and Wellness Act of 2025*, bipartisan legislation to ensure our veterans receive the nutritional support they need to fight and recover from chronic illness.

This is more than good policy. It's a moral obligation to support those who sacrificed for us.

Veterans are more likely than the general population to suffer from serious and preventable health conditions. Studies show that veterans suffer from higher rates of obesity, diabetes, heart disease and stroke than non-veterans. In fact, 38.2% of low-income veterans meet the criteria for obesity. Other reports are even higher: in the years immediately following military discharge, approximately 75 to 84% of Operations Enduring and Iraqi Freedom veterans were considered overweight or obese.

These health challenges don't exist in a vacuum. Veterans with obesity are more likely to face foreclosure or eviction and less likely to use active coping mechanisms to manage stress. This leads to a cycle of poor health, financial hardship and declining wellbeing that dishonors the sacrifice they made for our country.

We can and must do better.

My Veterans Nutrition and Wellness Act would establish a pilot program within the Department of Veterans Affairs to provide medically tailored meals and groceries to eligible veterans. These are not ordinary meal services. They are scientifically designed, nutrient-rich meals prescribed by health professionals to help individuals recover from or manage specific chronic conditions.

This approach is known as "food is medicine," and it's gaining bipartisan support across the country. We know that nutrition plays a critical role in health outcomes. This is not an untested theory — it's backed by results.

Improving veteran health through nutrition is a cause we can all rally behind. It honors their service, strengthens our communities and helps transform our health care system from one that treats illness to one that prevents it.

At the Cleveland Clinic, a recent study found that patients who received medically tailored meals for just three months saved more than $12,000 per person in downstream medical costs over six months. Many Medicare Advantage plans are already embracing this model, offering healthy food as a covered benefit for those with chronic illnesses. These programs don't just reduce hospital visits; they empower patients, improve outcomes and save money.

In other words, this is compassionate care that's also fiscally responsible.

With over 1.43 million veterans in Florida and more than 64,000 in my district alone, this issue is critically important to me. I've heard directly from veterans in Manatee and Hillsborough Counties who personally know the power of proper nutrition. One veteran who recently underwent an amputation in my district told me that being able to heal at home with access to nutritious meals made all the difference in his recovery. Others were not as fortunate — unable to shop or cook for themselves, they were stuck in facilities longer than necessary, compromising their healing and independence.

Stories like these underscore what the data already tells us: veterans recover better when they have access to healthy food tailored to their needs. This pilot program will give more veterans that opportunity.

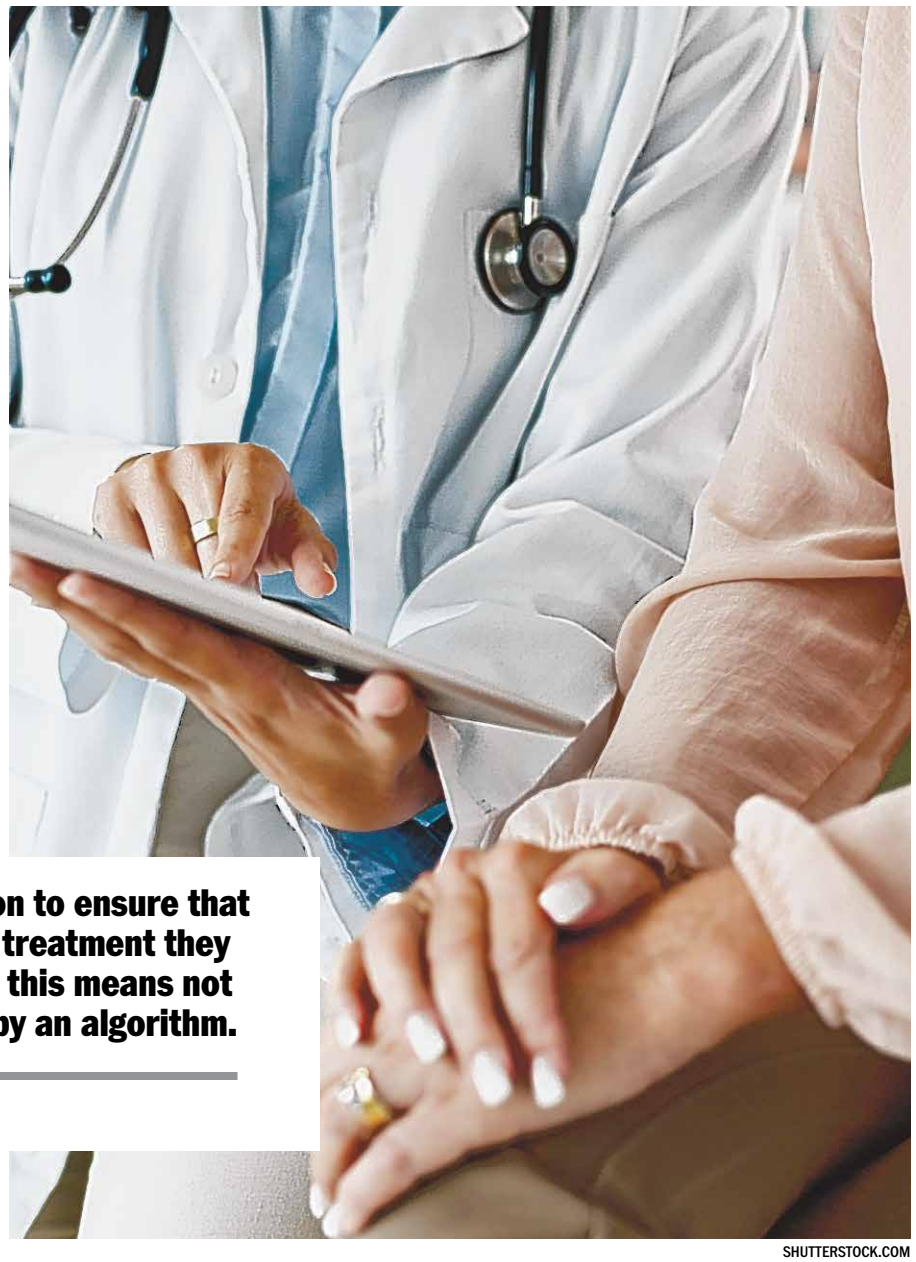
Improving veteran health through nutrition is a cause we can all rally behind. It honors their service, strengthens our communities and helps transform our health care system from one that treats illness to one that prevents it.

President Trump and Secretary Kennedy have been clear that one of this administration's top priorities is to "Make America Healthy Again." We can't make America healthy again if the heroes who defended it are left behind. Congress should pass the Veterans Nutrition and Wellness Act of 2025 and make "food is medicine" a cornerstone of veteran care.

Rep. Vern Buchanan, R-Fla., is the vice chairman of the Ways and Means Committee and the Chair of the Health Subcommittee. Prior to serving in Congress, Buchanan was in business for over 30 years and chaired both the Greater Sarasota Chamber of Commerce and Florida Chamber of Commerce. He served as a member of the board and the executive committee of the United States Chamber of Commerce. He also served in the Air National Guard for six years.

Reforming prior authorization: The next step to helping both sides of the stethoscope

By U.S. Rep. Mark Green, R-Tenn.



SHUTTERSTOCK.COM

"You have cancer." Those three words bring time to a screeching halt. I know; it happened to me. Yet one thing I'm grateful for is that I was diagnosed early and treated quickly — none of that would have been possible if my colonoscopy had been denied because of prior authorization.

Congress has an obligation to ensure that patients can access the treatment they need and deserve – and this means not being denied treatment by an algorithm.

Prior authorization requires health insurance plan approval before a physician can act on a patient's next treatment or prescribe medication. For millions of Americans, prior authorization is a nightmare, and it isn't getting better.

As an emergency room physician, I know that time is one of a medical professional's most vital resources. You could have a great doctor and a solid treatment plan, and catch the disease at its very first symptom, and still have medical complications because an insurance company denied the prior authorization claim.

The way prior authorization works today adds an extra complication to the time-sensitive decision-making process. Too often, physicians in a different specialty make the final decision. Even worse, an algorithm might be doing it. In a Minnesota lawsuit titled Class Action v. UnitedHealth, insurance policyholders are claiming UnitedHealthcare is using an AI model with a 90% error rate to systematically deny claims to senior citizens.

The plaintiffs argue that UnitedHealth's AI model, known as "nH Predict," is incredibly flawed, setting unrealistically optimistic recovery timelines that give UnitedHealthcare the ability to severely curtail benefits. However, given the financial windfall UnitedHealth has enjoyed thanks to nH Predict's faulty predictions, the plaintiffs are concerned that UnitedHealth has no intention of improving nH Predict's diagnostic capabilities.

Congress has an obligation to ensure that patients can access the treatment they need and deserve — and this means not being denied treatment by an algorithm.

As a physician and survivor of thyroid and colon cancer, my *Reducing Medically Unnecessary Delays in Care Act of 2025* serves as a solution to bust through the red tape that often puts health insurance bureaucrats between patients and their doctors. The bill reforms prior authorization in Medicare and Medicare Advantage by requiring board-certified physicians in the same specialty to be the ones making these important decisions. Simply put, if a gastroenterologist deems a colonoscopy necessary due to a history of polyps, you get one. You get treated because a physician, in that specialty, considers it necessary — not health plan bureaucrats or an AI program. Screenings like colonoscopies save lives, and delays from insurance companies only place patients at greater risk.

Modern American health care is a maze of bureaucratic hurdles and payment issues. According to the American Medical Association, 23% of physicians report that prior authorization has led to a patient's hospitalization, while 18% report that it has led to a life-threatening event. In the same 2024 survey, 94% of physicians reported that prior authorization requirements negatively impacted patient care.

Insurance companies are also seeking to expand the procedures requiring prior authorization, meaning patients will need permission from an insurance representative to get coverage for more medical procedures. In a survey conducted by the Alliance of Specialty Medicine, more than 93% of respondents answered that prior authorization has increased for procedures; more than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and two-thirds (66%) agree that prior authorization has increased for prescription drugs. Physicians have noted that even many generic medications now require preapprovals. Every extra bureaucratic hurdle delays vital care, putting Americans at risk.

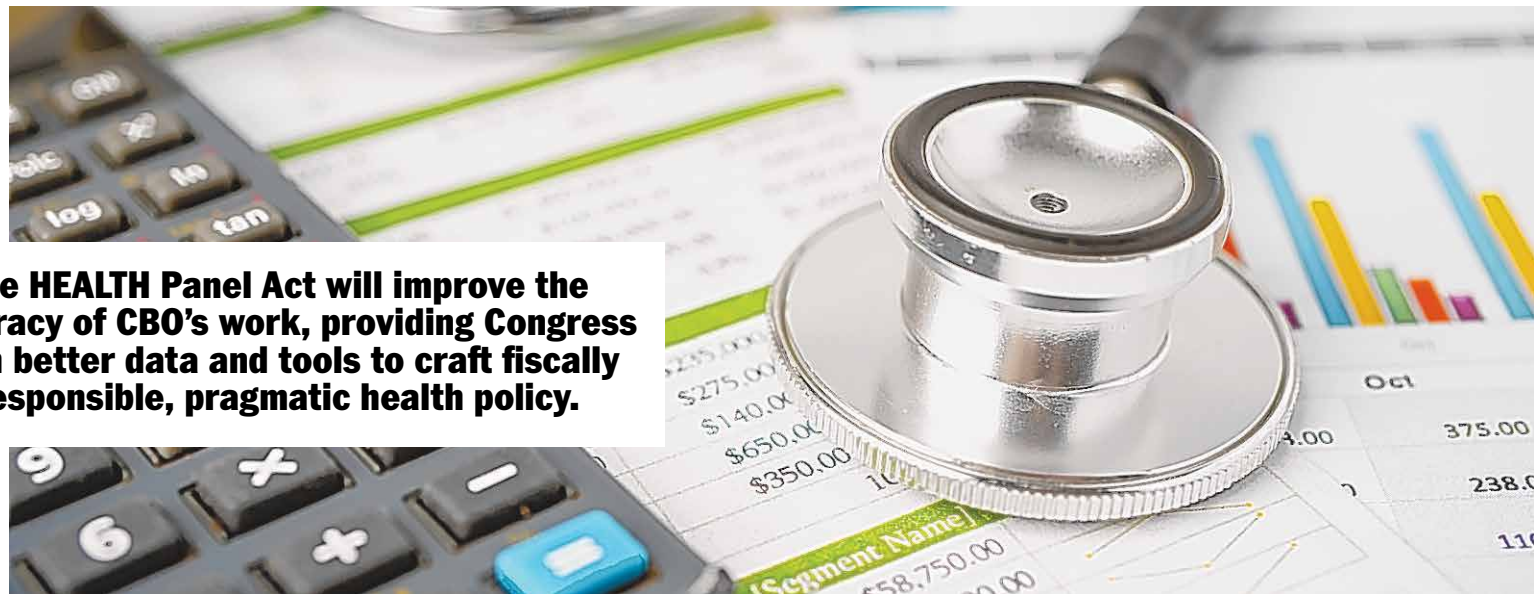
Burdening physicians with administrative paperwork, especially during a doctor shortage, exacerbates the challenges faced by Medicare and Medicare Advantage. When 94% of doctors believe that a process is harming patient care, it must be taken seriously.

In the wake of the COVID-19 pandemic, patients want a more active role in their care. This is a golden opportunity to reinforce the doctor-patient relationship, increase patient care satisfaction, and improve treatment quality. We must ensure that the patient remains central to the healthcare decision-making process, with specialists in the same field making the final decisions. If AI has a role to play in future healthcare, it should expand patient access and treatment options, not limit them.

When an expectant mother needs a fetal echocardiogram due to an abnormal ultrasound, or a firefighter requires a knee replacement, they should be able to take comfort knowing their prior authorization reviewer is also a physician of that same specialty. Everyone can agree that an orthopedic surgeon shouldn't be making decisions about an oncology treatment plan, because their training doesn't align.

Physicians are trained to make the medical decisions they deem necessary. Patients deserve swift medical care without the red tape. My bill ensures both sides of the stethoscope are taken care of.

Rep. Mark Green is chairman of the House Homeland Security Committee and serves on the House Foreign Affairs Committee. He is a member of the GOP Doctors Caucus and the Congressional Bipartisan Rural Health Caucus.



The HEALTH Panel Act will improve the accuracy of CBO's work, providing Congress with better data and tools to craft fiscally responsible, pragmatic health policy.

SHUTTERSTOCK.COM

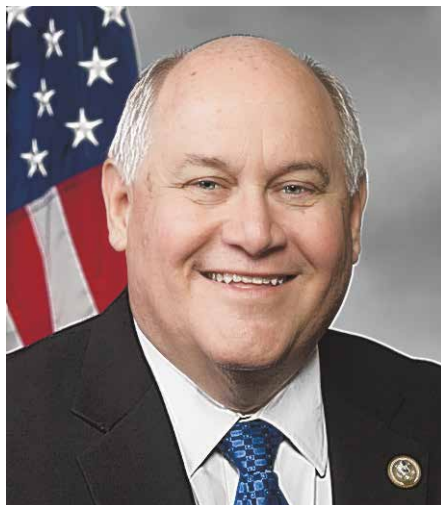
Congress must ensure health care cost estimates are accurate

By U.S. Reps. Buddy Carter, R-Ga., and Ron Estes, R-Kansas

Congress relies on cost estimates from the Congressional Budget Office (CBO) to determine the financial impact of proposed health care legislation. When CBO's projections are off the mark, inaccurate cost estimates lead to unexpected deficits, programmatic instability, and unintended consequences for taxpayers, patients, providers, and lawmakers.

That's why we, members of the House Committee on the Budget, introduced the Healthy Equipping and Lending Technical Help Panel (HEALTH Panel) Act, which contains a commonsense reform to ensure that Congress receives the most accurate and up-to-date health care policy analysis from CBO. CBO's estimates shape everything from health insurance regulations to Medicare and Medicaid reforms; for the sake of our parents, children, and elderly members of society we must get this right.

For much of CBO's history, its health care projections have missed the mark, significantly affecting legislative decision making. CBO is tasked with producing impartial, objective cost estimates; but the direction of its inaccuracies over the past two decades, combined with the opaque "black-box" nature of its work, has raised questions about whether CBO's estimates tend to skew in favor of government-run programs and against pro-patient, market-based solutions. Erosion of trust in CBO estimates has real-world impacts, and our legislation aims to put those questions to rest by strengthening confidence in CBO and its vitally important work.



Inaccuracies in CBO's estimates on Medicare Part D, and the contrasting inaccuracies in its estimates for the Affordable Care Act (ACA), illustrate the need for reform. More than 20 years ago, CBO overestimated the cost of President Bush's signature health policy achievement – the creation of the Medicare Prescription Drug Benefit – by 100%. In the first 10 years of the program, Medicare Part D, which relies on plan competition to keep expenses down, cost $353 billion less than CBO's original estimate.

This same pattern of inaccuracies holds true for more detailed CBO cost estimates. For example, when the so-called Center for Medicare & Medicaid Innovation (CMMI) was set up under the ACA, CBO originally projected that it would reduce spending by $2.8 billion. In 2023, CBO updated its estimate to recognize that the CMMI actually increased spending by more than $5.4 billion. Other technocratic policy proposals, such as expanding drug price controls in Medicare, have been given overly optimistic savings projections that don't fully account for how entrepreneurs, large pharmaceutical product developers, and markets adapt to new regulations, while likely underestimating negative innovation impacts.

Health care accounts for one-quarter of federal spending. Any miscalculations in cost estimates result in billions of unintended federal government expenses. Without proper oversight and expert review, budgetary miscalculations will worsen an already strained fiscal environment.

We recognize that CBO's task of producing neutral and objective cost estimates is made even more difficult due to the complexity of the health care system. Unlike other policy areas, health care involves a web of economic, regulatory, and behavioral factors that interact in complicated ways, impacting the accuracy of spending projections.

That is why we are offering a commonsense solution in the HEALTH Panel Act, which creates a formal structure through which a wider range of external experts would continuously inform CBO's process with the best available data and analysis, while simultaneously requiring basic transparency in CBO's methods and output.

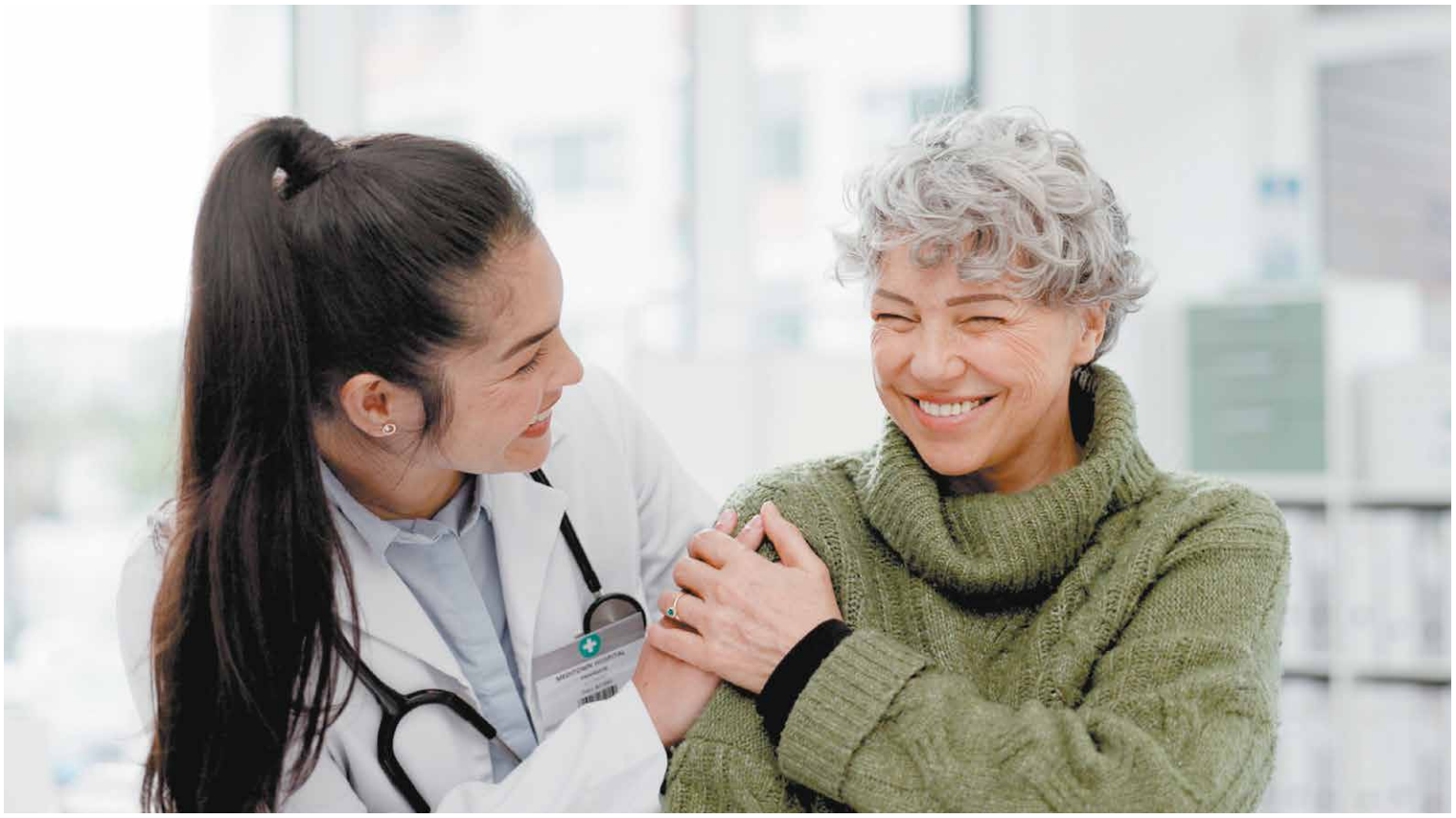
The HEALTH Panel Act takes the existing, albeit informal, CBO Panel of Health Advisers and codifies it into law, aiming to bring greater transparency and broad expertise to CBO's estimates. By implementing these reforms, the HEALTH Panel Act will improve the accuracy of CBO's work, providing Congress with better data and tools to craft fiscally responsible, pragmatic health policy.

At a time when the national debt exceeds $36 trillion, ensuring the accuracy of federal health care spending projections is critical. When CBO underestimates costs, taxpayers are left footing the surprise bill. When it overestimates savings, Congress may enact policies based on unrealistic expectations. This affects access to care, affordability, and the sustainability of government health programs.

The HEALTH Panel Act is a necessary step toward greater accountability in how Congress evaluates health care policy. By ensuring that lawmakers have the most accurate fiscal data at their disposal, members of Congress can better safeguard taxpayer dollars while improving health care policymaking.

Rep. Buddy Carter represents Georgia's 1st District and chairs the House Energy and Commerce Subcommittee on Health. He is a career pharmacist.

Rep. Ron Estes represents Kansas' 4th District and chairs the House Ways and Means Social Security Subcommittee.



SHUTTERSTOCK.COM

Fixing our health care workforce doesn't have to break the bank

By U.S. Rep. Mike Lawler, R-N.Y.

One of the driving motivators for my legislative priorities in Congress is supporting middle-class families and working families, many of whom are getting crushed by our national affordability crisis and high taxes. The Doctors in Our Borders Act is precisely the kind of targeted, cost-effective reform conservatives should be championing.

In Washington, the answer to every problem is often to spend more of your hard-earned dollars. But when it comes to one of the most significant issues facing our health care system, we have a common-sense solution that does not cost taxpayers a dime.

Right now, we are heading toward a massive shortfall of physicians over the next decade. According to a March 2024 report from the Association of American Medical Colleges, the United States could be short as many as 86,000 doctors by 2036. That includes up to 40,000 fewer primary care physicians and nearly 20,000 fewer surgeons than we will need. And if underserved communities had the same level of access to care as everyone else, we would need up to 200,000 more doctors today just to meet the need.

But we do not have to start from scratch. We already have a group of highly trained, U.S.-educated physicians who are here legally and ready to step in. These are international medical graduates who have completed their training in our hospitals. They know the system, they want to stay, and they are eager to serve the communities where they have trained.

Today, our immigration system requires medical students in the U.S., here on J-1 student visas, to leave the country after they graduate for a period of two years. The Conrad 30 program allows the waiver of this requirement for up to 30 physicians in each state annually, provided they work in underserved communities. The cap has not changed since 1994, and now, three decades later, it is time to modernize this program. That is why I introduced the Doctors in Our Borders Act, a bipartisan bill that expands the program by lifting the cap to 100.

The need is urgent. The same AAMC report shows that 42% of the physician workforce was over 55 in 2021. Many of these doctors will retire in the coming decade. At the same time, the population over age 65 is expected to grow by more than 34%. That means more people who need care, and we'll have fewer doctors available to provide it.

That is why the Doctors in Our Borders Act has strong bipartisan support and is endorsed by leading health care organizations, including American Medical Colleges, National Rural Health Association (NRHA), Associated Medical Schools of New York (AMSNY), Community Health Care Association of New York State (CHCANYS), College of American Pathologists (CAP), and so many more stakeholders who know the good this change will bring.

One of the driving motivators for my legislative priorities in Congress is supporting middle-class families and working families, many of whom are getting crushed by our national affordability crisis and high taxes. The Doctors in Our Borders Act is precisely the kind of targeted, cost-effective reform conservatives should be championing. It strengthens our workforce, reduces strain on our health care system, improves access to care, and does it without asking taxpayers for more.

We have an opportunity to solve part of the doctor shortage by using talent already here. It's a smart policy, fiscally responsible, and is urgently needed.

Rep. Mike Lawler is one of the most bipartisan members of Congress and represents New York's 17th Congressional District, which is just north of New York City and contains all or parts of Rockland, Putnam, Dutchess, and Westchester Counties. He was rated the most effective freshman lawmaker in the 118th Congress, 8th overall, surpassing dozens of committee chairs.

SHUTTERSTOCK.COM

We must strengthen America's health care workforce

By U.S. Rep. Brian Babin, R-Texas, D.D.S.

As both a dentist and a member of Congress, I have dedicated my life to improving the health and wellbeing of the American people. Throughout my career, I have witnessed firsthand the challenges our nation's health care system faces, from overwhelmed providers to lack of access to care in rural areas. Among the most pressing issues we must address are the skyrocketing costs of education and the growing shortage of health care providers across the country. These problems are deeply intertwined, and they demand a serious, solutions-oriented response.

To help confront these challenges, I introduced H.R. 2028, the Resident Education Deferred Interest (REDI) Act. This bill delivers a straightforward yet powerful fix to a financial burden that is uniquely placed on the shoulders of our future health care providers: the accrual of student loan interest during medical and dental residencies.

Right now, under current federal law, medical and dental school graduates are required to begin paying off their student loans and accruing interest, even while they are still in residency training. These individuals work long hours in high-stress environments, serve patients, and earn only modest stipends during these critical years of postgraduate education. Despite their service and dedication, these men and women are penalized financially before they've even had a chance to fully enter their profession.

This system serves as a deterrent for many aspiring providers. It discourages many bright and compassionate students from entering medical or dental school at all, and it drives others away from pursuing vital careers in primary care, pediatrics, and rural medicine — areas where we face serious shortages.

By easing this financial burden, the REDI Act empowers new graduates to make career choices based on passion and need, not on how quickly they can pay down debt.

The REDI Act combats this by allowing medical and dental residents to defer interest payments on their federal student loans until after they complete their training. This simple adjustment will save these future health care professionals thousands, and sometimes tens of thousands, of dollars in accrued interest. More importantly, it makes the path to becoming a physician or specialist more accessible and affordable, especially for students from low- and middle-income families.

By easing this financial burden, the REDI Act empowers new graduates to make career choices based on passion and need, not on how quickly they can pay down debt. That means more young professionals choosing to serve in communities that need care the most, more educators training the next generation of providers, and more researchers advancing the science that keeps Americans healthy.

Our nation's health care system depends on a steady pipeline of well-trained, compassionate professionals. But that pipeline is under pressure. We must act now to ensure we have enough health care providers to meet the demands of an aging population and an evolving health care landscape.

The REDI Act is a commonsense, bipartisan solution that strengthens our health care workforce, expands access to care, and ensures the long-term sustainability of the American health care system.

I am proud to lead this effort in Congress and urge my colleagues — on both sides of the aisle — to join me in supporting the REDI Act. Together, we can lift an unnecessary burden from those who dedicate their lives to healing others and help secure a healthier future for all Americans.

Rep. Brian Babin has represented Texas' 36th congressional district since 2015. was sworn into the 114th Congress on January 6, 2015. Babin serves as the Chairman of the Science, Space, and Technology Committee.

Fighting a deadly illness is brutal. You shouldn't have to fight your insurance too

By U.S. Rep. Suzan DelBene, D-Wash.

When Maryville, Wash., resident Robin Sparks was diagnosed with Stage 3 non-Hodgkin lymphoma, she and her doctor quickly came up with a care plan. But midway through her chemotherapy, when her doctors needed a CT scan to determine whether the treatment was working, her health insurer said no. The routine test was denied multiple times. Their reason? It wasn't necessary for Robin, despite her doctor ordering it.

Unfortunately, Robin's story is not unique. Across the country, patients are facing dangerous delays due to an antiquated paperwork practice known as prior authorization, wherein insurance companies require patients to get advance approval before delivering treatments or medications.

Prior authorization was designed to be a tool to keep health care costs in check, but it has become a pervasive barrier to care. It's a feeling that is familiar to many Americans: calling your doctor's office multiple times, filling out the same form and then faxing it over to your insurance provider, then waiting days or even weeks to get a decision.

I've met with patients, their families, and their providers from across Washington state about the harms this practice can have for many types of illnesses and conditions. Delays are not only frustrating; they can also make conditions worse. Rick Timmins from Whidbey Island told me how his insurer delayed granting prior authorization to allow his dermatologist to assess a small, painful lump on his ear. During that months-long delay, the tumor tripled in size and was diagnosed as a malignant melanoma that had a high risk of spreading, requiring surgery and immunotherapy.

These stories are heartbreaking and infuriating.

Doctors report spending 13 hours each week on average trying to get prior authorization requests approved. In many cases, they're forced to defend decisions already based on widely accepted standards of care. The American Medical Association says that 94% of prior authorization delays result in worse health outcomes.

Reforming this antiquated practice has significant bipartisan support in Congress. I recently reintroduced the Improving Seniors' Timely Access to Care Act with a bipartisan coalition of members. This commonsense legislation modernizes and streamlines the prior authorization process for Medicare Advantage plans, which serve over 33 million seniors.

The bill would help get faster decisions on routine services, create a standardized electronic form across Medicare Advantage, and require information reporting from insurance companies about what they're approving and denying.

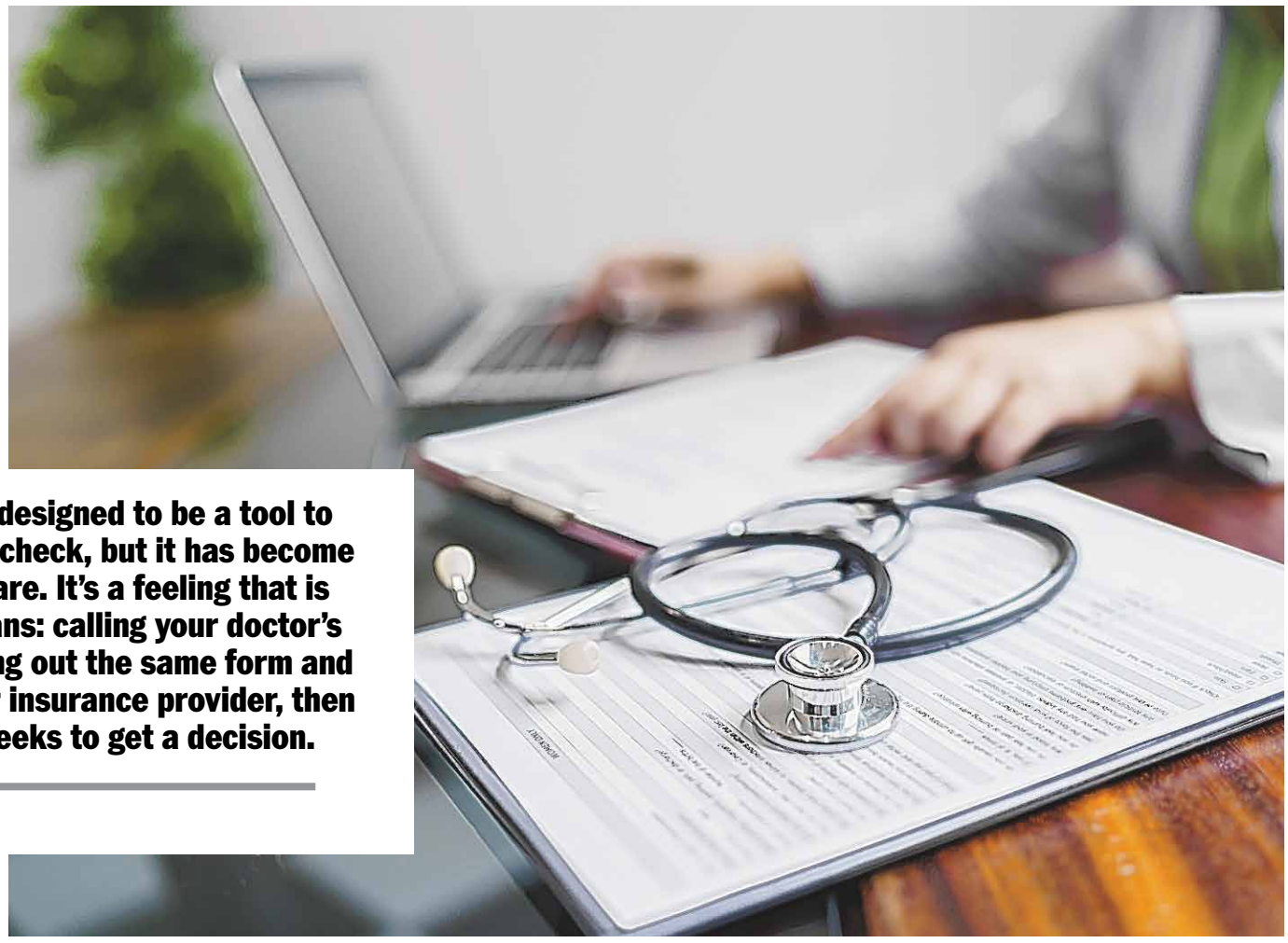
Last year, the Biden administration took a critical step forward by announcing new regulations to limit unnecessary prior authorization requests that mirror many aspects of our legislation. While this was progress, we must still pass legislation to improve care for seniors and give providers certainty about the process going forward.

The health care community largely agrees. More than 500 national and state organizations, including patient advocacy groups, hospitals, and provider groups, back our bill. In 2022, the legislation passed the House with overwhelming bipartisan support, but it wasn't taken up in the Senate. We know we only help people when we get legislation to the president's desk. That's why we must finish the job and get this bill all the way there.

Robin Sparks survived cancer. After months of uncertainty and repeated denials, she finally got the scan she needed and completed her treatment. But she knows others may not be as lucky. I'm fighting alongside Robin and thousands of others to make sure no one else has to delay or abandon care because of outdated red tape. If we want a health system that puts patients first, we must fix prior authorization now.

Congress can make a real difference in the lives of millions of seniors. Let's deliver the care patients deserve when they need it most.

U.S. Rep. Suzan DelBene represents Washington's 1st Congressional District. She serves on the House Ways and Means Committee, which is at the forefront of creating a more equitable tax code, health care reform, trade deals, and lasting retirement security.



SHUTTERSTOCK.COM

Prior authorization was designed to be a tool to keep health care costs in check, but it has become a pervasive barrier to care. It's a feeling that is familiar to many Americans: calling your doctor's office multiple times, filling out the same form and then faxing it over to your insurance provider, then waiting days or even weeks to get a decision.

UNITED STATES SENATE FEDERAL CREDIT UNION®

Celebrating 90 Years of Service to our Members.

NEW MEMBERS EARN $300*

Join USSFCU now and unlock $300 in just a few simple steps!

When you join the United States Senate Federal Credit Union, you get more than just an account—you get a partner in your financial journey. As a member, you'll enjoy personalized service, lower fees, better rates, and a financial institution that's focused on your long-term success. And as a special offer, you can earn $300 by becoming a member and meeting all promotion requirements within 6 months of membership!*

1

Use Promo Code: 'BONUS25'

Apply for membership using Promo Code '**BONUS25**'

2

Open A Senate Checking Account

Establish a free Senate Checking Account with a Visa® Debit Card

3

Make 20 Purchases

Use your new Visa Debit Card to make 20 purchases (minimum $10 each) within the first six months of opening your account.

4

Setup & Receive Direct Deposit

Enroll in direct deposit and receive at least $500 per month for six consecutive months.

*Limited Time Offer! Must use Promo Code: '**BONUS25**'*

USSFCU.ORG/JoinUs | In-Branch | 800.374.2758

*Limited Time Offer. This offer is valid from January 1 to December 31, 2025. To qualify for the $300 bonus, you must establish membership by opening a Primary Savings Account with a minimum balance of $5, paying a one-time $1 membership fee, and opening a free Senate Checking Account with a Visa® Debit Card. To complete the offer, you must use your USSFCU Visa® Debit Card to make at least 20 transactions of $10 or more within six months of membership, excluding ATM withdrawals and electronic transfers, and all transactions must be completed within 60 days of joining. Additionally, set up qualifying direct deposits of at least $500 per month for six consecutive months into your USSFCU account, with deposits made by your employer or another payer using your USSFCU account number. Non-qualifying deposits include teller deposits, wire transfers, ATM transactions, and transfers from external accounts. The $300 bonus will be deposited into your USSFCU Primary Savings Account within 30-60 days after all requirements are met. This offer is only available to new members, limited to one $300 bonus per member, and cannot be combined with other promotions. Taxes on the bonus are the recipient's responsibility. To participate, use promo code BONUS25. USSFCU employees, managers, and board members are not eligible. Terms are subject to change and may be modified, suspended, or terminated at any time. Savings Accounts earn 0.10% annual percentage yield (APY). Must maintain a minimum balance of $5.00 to earn disclosed APY. Yield and dividend rates as of January 01, 2025, and subject to change without notice. View current rates at ussfcu.org/rates. Fees may reduce earnings. View our fee schedule at ussfcu.org/fees or call 800.374.2758. Membership eligibility is required. Eligibility does not guarantee membership. This credit union is federally insured by the NCUA.