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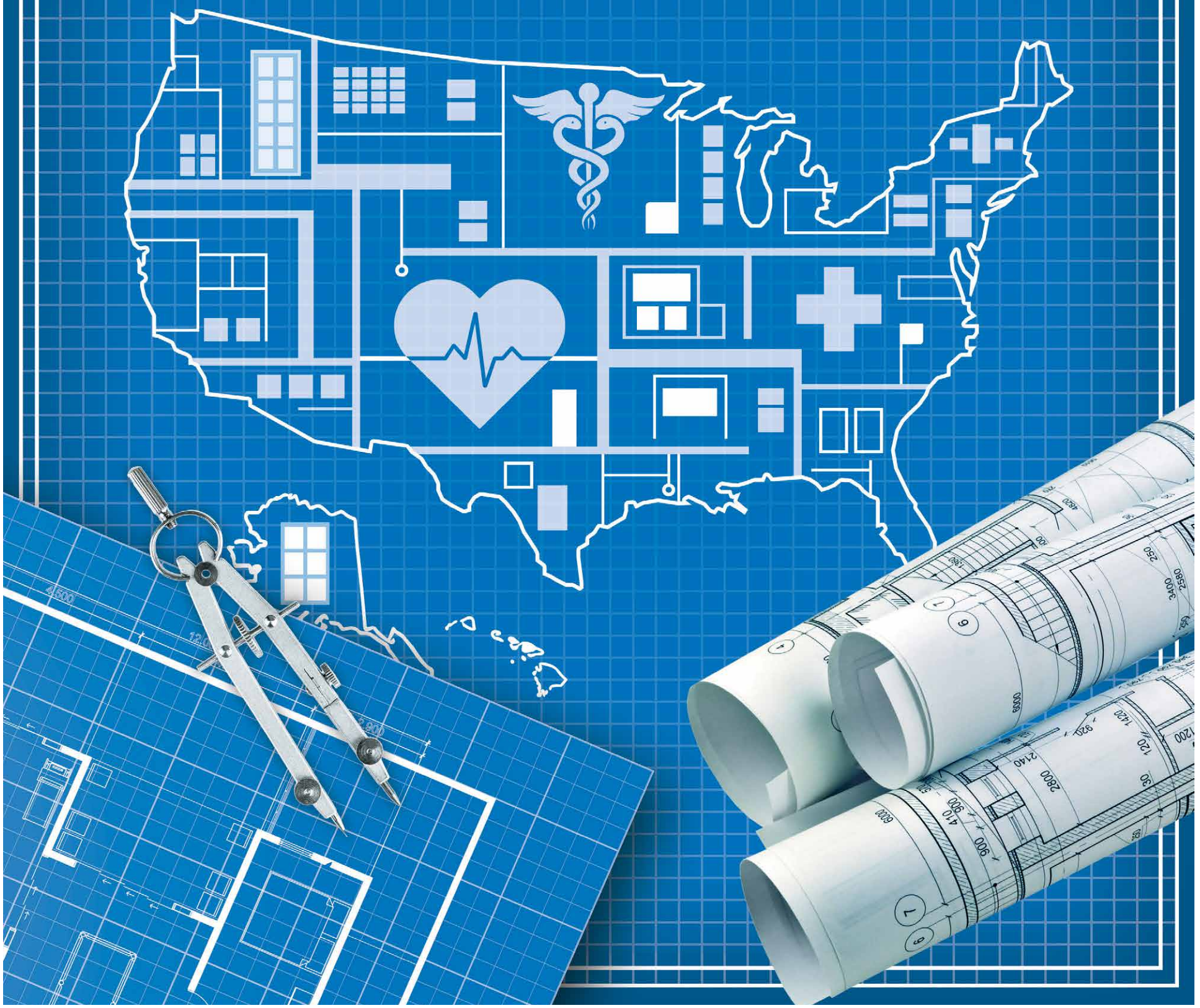

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Building the health care Americans deserve

CONTENTS

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We must deliver quality, affordable health care for rural families

By U.S. Sen. Jon Husted, R-Ohio

From serving Ohioans at the state level to doing so in the U.S. Senate, my mission has been simple: bring down costs and make life more affordable for working families. Health care is one of the biggest drivers of rising household expenses. When we reduce health care costs and expand access — especially in rural communities — families can spend less time worrying about bills and more time building healthy, stable lives.

I grew up in rural northwest Ohio, where a doctor's appointment could mean a long drive and a missed day of work. I understand the challenges families face when they live miles from the nearest provider. Too often, rural families are forced to choose between paying expensive out-of-network costs or traveling to urban centers just to receive in-network care.

When we reduce health care costs and expand access — especially in rural communities — families can spend less time worrying about bills and more time building healthy, stable lives.

As Ohio's lieutenant governor, I worked alongside Gov. Mike DeWine to establish school-based health centers located directly within rural schools. These centers provide physicals, immunizations, mental health services, vision and dental care and help students manage chronic conditions — all where these children live and learn. The results have been clear: healthier students, fewer missed school days and peace of mind for parents.

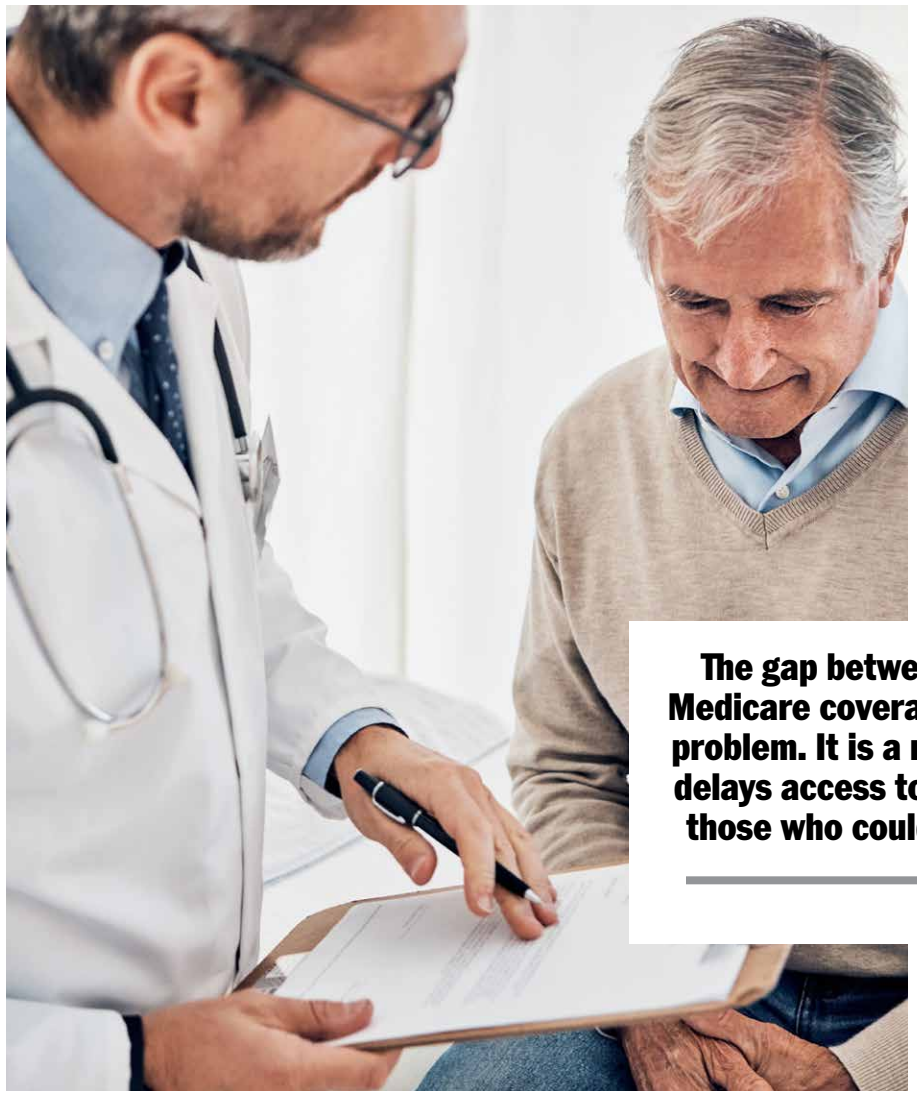
Building on that success, I fought to include the $50 billion Rural Health Transformation Fund in the Working Families Tax Cuts Act. This investment strengthens school-based health centers and protects rural hospitals that serve as lifelines for communities across Ohio and the country. Rural hospitals are often the largest employer in town and the only source of emergency care. This funding gives them the stability they need to continue delivering high-quality care close to home.

Lowering costs also means reforming how Americans access everyday medications. In my first year in the Senate, my SMART OTC Act was signed into law. It modernizes the FDA's process to safely dispense proven prescription drugs over the counter, lowering costs for families at the pharmacy counter. Every $1 spent on over-the-counter medicine saves the health system more than $7 — and saves families billions overall.

My work remains focused on lowering the cost of living and expanding opportunity for working families. The Rural Health Transformation Fund and the SMART OTC Act are meaningful steps toward ensuring that affordable, accessible health care is available to every American — no matter their ZIP code.

Sen. Jon Husted served Ohioans at the state level, most recently as lieutenant governor, until he was appointed to the U.S. Senate in January 2025. During his first year in office, three of Husted's bills centered on making life more affordable for Ohioans were signed into law. He serves on the Committee on Health, Education, Labor, and Pensions, the Committee on Small Business and Entrepreneurship, the Committee on Environment and Public Works, and the Special Committee on Aging. He considers his most important roles to be husband to his wife, Tina, father of three, and grandfather.

Medicare must keep pace with FDA-authorized breakthrough medical technologies



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By Scott Whitaker

Every day, doctors across America diagnose Medicare beneficiaries with life-threatening or debilitating conditions, then face a frustrating reality: much of the most promising medical technology available to help those patients is already authorized by the Food and Drug Administration for patient use, yet still unavailable because Medicare coverage has not caught up.

The gap between FDA authorization and Medicare coverage is not an abstract policy problem. It is a real, persistent barrier that delays access to medtech-enabled care for those who could benefit from it the most. Too often, Medicare beneficiaries are forced to wait years for coverage of technologies the FDA has already reviewed and determined to be safe and effective for patients with serious unmet medical needs.

Congress recognized the importance of speeding patient access to transformative technologies when it created the FDA's Breakthrough Devices Program in the 21st Century Cures Act. The program was designed to accelerate the review of medtech that provides more effective treatment or diagnosis for conditions than currently exist, while maintaining FDA's rigorous standards for safety and effectiveness.

But while FDA has delivered on its end of that bargain, Medicare coverage has not kept pace.

Growing evidence shows that for technologies requiring a new Medicare coverage pathway, nearly six years can pass between FDA market authorization and Medicare coverage. That means older Americans may wait the better part of a decade for access to innovations specifically designed to help patients like them. For those facing serious illness, that delay can mean fewer options, worse outcomes and missed opportunities for earlier intervention.

Some critics misunderstand the FDA's breakthrough program, suggesting it represents a shortcut to market or a weakening of evidentiary standards. That is not true. Breakthrough designation is not an approval, nor is it a waiver of FDA requirements. All breakthrough-designated devices must meet the same standards as any other medical technology — whether through the 510(k), de novo or premarket approval pathways. In fact, only a small fraction of breakthrough-designated devices ultimately receive FDA market authorization, underscoring the rigor of the process.

FDA evaluates compelling evidence — including clinical data, real-world evidence, and preclinical studies — to determine whether a device meets those criteria. Once authorized, these technologies are subject to ongoing post-market surveillance to ensure continued safety and effectiveness. Far from lowering the bar, FDA applies the global gold standard of scientific review.

Despite this rigorous process, Medicare patients still face long delays before they can benefit from these FDA-authorized innovations. These delays are especially challenging for small manufacturers and startups that drive much of America's medtech innovation and lack the resources to navigate years of uncertainty in coverage decisions.

At the end of President Donald Trump's first term, Medicare instituted the Medicare Coverage of Innovative Technologies (MCIT) policy, a tremendous step forward for Medicare patients in need of FDA-cleared breakthrough treatments. Unfortunately, the Biden administration repealed MCIT, leaving Medicare beneficiaries without access to these remarkable breakthrough medical technologies. Then, after repeal, they took three years to analyze the MCIT program. Finally, after years of delay, the Biden administration replaced MCIT with a watered-down Transitional Coverage for Emerging Technologies (TCET) pathway. While better than no policy at all, it is not adequate to ensure seniors see the promise of these amazing new technologies.

We are encouraged by the willingness of current CMS leadership, including Centers for Medicare and Medicaid Services Administrator Mehmet Oz, to revisit accelerated coverage pathways more akin to MCIT.

Lawmakers on both sides of the aisle have made encouraging progress with their introduction of the Ensuring Patient Access to Critical Breakthrough Products Act (H.R. 5343/S. 1717). This legislation would provide temporary Medicare coverage for FDA-cleared breakthrough technologies while CMS conducts a structured evaluation for permanent coverage. It preserves rigorous oversight, supports evidence development and ensures patients and physicians can access breakthrough innovations whenever needed.

The gap between FDA authorization and Medicare coverage is not an abstract policy problem. It is a real, persistent barrier that delays access to medtech-enabled care for those who could benefit from it the most.

AdvaMed, the leading trade association for medtech innovators, along with patient advocacy organizations and dozens of state medtech associations, are calling for passage of this legislation for a more predictable, timely Medicare coverage pathway for breakthrough medical technologies that have already been rigorously cleared by FDA. No one is asking for preferential treatment. AdvaMed, Medicare beneficiaries, and bipartisan leaders in the House and Senate are simply asking for Medicare to recognize FDA's scientific determination and to avoid duplicative, yearslong reviews that stand between patients and care.

The question is no longer whether Medicare should cover treatments involving these breakthrough technologies. The question is how quickly we can ensure that the coverage becomes a reality.

Patients shouldn't have to wait years to benefit from innovations the FDA has already determined to be safe and effective. Congress has an opportunity to fix this longstanding gap, strengthen America's leadership in medical technology and ensure Medicare policy keeps pace with modern medicine. We urge lawmakers to act because timely access can make all the difference for patients.

Scott Whitaker is president and CEO of AdvaMed, the medtech association.

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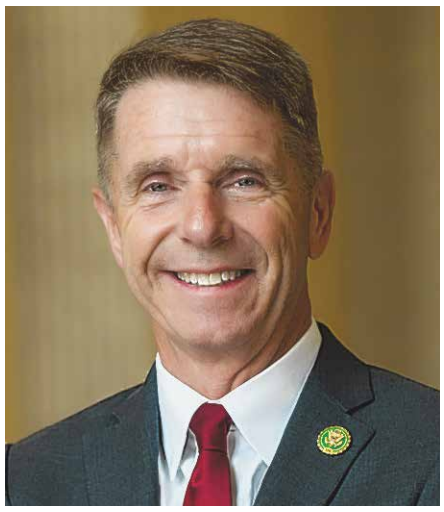
Rural health care requires local solutions



By U.S. Rep. Rob Wittman, R-Va.

In rural Virginia, access to health care is not guaranteed. It must be protected.

Across Virginia's First District and throughout our Commonwealth, rural communities face real challenges. Workforce shortages, aging facilities, thin operating margins and long travel distances all put pressure on local providers. When a rural hospital struggles, families notice. When access to specialists is limited, patients feel it immediately.

Rural America does not need more bureaucracy. It needs practical policies that respect local expertise, strengthen community-based providers, and encourage innovation.

Before serving in Congress, I spent more than 26 years working for the Virginia Department of Health and earned a master's degree in public health. That experience shaped how I approach health policy. I have seen firsthand how federal decisions affect local providers, how one-size-fits-all mandates often miss the mark in rural America and how fragile rural health systems can be without thoughtful, targeted support.

That is why strengthening rural health care has remained one of my top priorities in Congress.

Last year, and with my support, Congress established the Rural Health Transformation Program, a $50 billion initiative designed specifically to stabilize and modernize rural health systems. Unlike top-down federal directives, this program gives states the flexibility to craft tailored plans that address their most pressing needs, whether that means preventing hospital closures, expanding mental health services, investing in updated equipment and technology or recruiting and retaining health professionals.

Just last month, the Centers for Medicare and Medicaid Services announced that Virginia would receive nearly $190 million in 2026 through this program. I was proud to advocate for the Commonwealth's application, and I will continue working to ensure these resources reach the communities that need them most.

This investment is not about expanding bureaucracy. It is about strengthening local health infrastructure so rural Virginians can access dependable, high-quality care close to home. Rural communities deserve solutions designed for their realities, not policies written with only urban systems in mind.

At the same time, we must recognize that simply expanding federal programs without structural reform does not guarantee long-term stability. Rural hospitals need predictable reimbursement, workforce support and regulatory flexibility — not layers of mandates that increase administrative burdens while failing to improve outcomes. Sustainable reform means empowering providers, not constraining them.

Technology is also central to expanding rural access. I have supported permanent telehealth access for families enrolled in high-deductible health plans and seniors covered by Medicare. Telehealth reduces travel burdens, connects patients to specialists and ensures timely care for those in remote areas. For rural communities, this is not a convenience; it is access.

I am also a cosponsor of the bipartisan Ensuring Access to Specialty Care Everywhere (EASE) Act, which would connect rural patients to specialists through a virtual provider network. For many families, seeing a specialist can require hours on the road. Leveraging telehealth bridges that gap and strengthens the rural health safety net.

Workforce development remains equally critical. Recruiting doctors, nurses and mental health professionals to rural communities requires sustained investment and smart policy. The Rural Health Transformation Program gives states the flexibility to address these shortages directly, helping ensure that rural providers have the support they need to serve their patients.

As we strengthen rural systems, we must also pursue reforms that lower costs and protect access more broadly. I have supported expanding health savings accounts (HSAs) to give families greater financial flexibility and recognizing direct primary care (DPC) arrangements that provide personalized, affordable care. These patient-centered solutions encourage innovation and expand options without increasing bureaucracy.

In addition, I continue working to protect vulnerable populations, including seniors, veterans and children facing rare diseases. Strong rural health systems depend on policies that support the full spectrum of care and ensure that no community is left behind.

Rural America does not need more bureaucracy. It needs practical policies that respect local expertise, strengthen community-based providers, and encourage innovation.

Geography should never determine whether a rural family can access quality care.

The future of rural health care will depend on our willingness to prioritize smart investment over political rhetoric — and to put patients and providers, not Washington, at the center of decision-making.

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An aerial perspective of Mechanicsville, Virginia, highlights the area's expanding commercial and residential development.

Rep. Rob Wittman serves as vice chairman of the House Armed Services Committee and the House Natural Resources Committee. Prior to his election in Congress, he spent 26 years working for the Virginia Department of Health's Division of Shellfish Sanitation and as an environmental health specialist for local health departments in Virginia's Northern Neck and Middle Peninsula regions.

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Making America healthy again starts with rural communities

By U.S. Rep. Morgan Griffith, R-Va.

Rural America is home to scores of working families trying to make ends meet, and hours-long trips to receive health care won't help pay the bills.

Much of President Donald Trump's domestic policy agenda is rooted in the blood, sweat and tears of rural America.

In our efforts to Make America Healthy Again, our agricultural industry is an integral partner.

Our farmers plant crops and stock grocery stores with fresh produce. Our cattle ranchers and poultry workers help feed American families. Rural America has a significant role in helping shield Americans from chronic disease and unhealthy foods.

And yet, health challenges threaten our reliance on its contributions.

Farmers work hard and long hours, at times under stressful conditions and often without much thanks. Their fitness and stamina are challenged as a result.

Communities in Appalachia, including those I represent, continue to reel from the devastating opioid epidemic.

Medical deserts in rural areas are growing.

Given these challenges, it would be a mistake for Congress to sit idly by. Because of this, I am helping lead the charge on ways to deliver meaningful health care solutions for rural America.

For example, in the Rural Health Transformation Program, Congress allocated $50 billion to support rural hospitals. We created this generational investment through the Working Families Tax Cuts Act. The program will help modernize health care infrastructure, supplement health care services and expand access to care in rural America.

The program empowered states to develop comprehensive plans to support the program's goals.

Right here in Virginia, Gov. Glenn Youngkin thoroughly considered a dozen rural communities when developing the Virginia plan, focusing on patient empowerment and preventative care to improve access, technology, and workforce development in rural Virginia.

The Rural Health Transformation Program is one part of the solution to provide financial support to our rural health care providers.

I am also focusing on strengthening community health centers (CHCs), which help address rural health care workforce shortages and fill gaps in our health system. CHCs play a critical role in delivering treatments and health care services in rural communities.

It is important that CHCs receive the assistance necessary for them to remain operational, which is why I was proud to support and see Congress recently pass a funding package which included health care extenders, part of which helps fund CHCs.

Rural America is home to scores of working families trying to make ends meet, and hours-long trips to receive health care won't help pay the bills. The ongoing expansion of rural medical deserts also creates lasting health care dilemmas for these patients, who contemplate forgoing care just because seeing an in-person provider is too far. Telehealth is a helpful alternative to in-person care for many.

The government funding package that included CHC funding also extended telehealth reimbursement for two years.

I believe Congress must embrace a comprehensive strategy that promotes telehealth and provides certainty to providers and patients utilizing its services. Telehealth has not only reduced travel time and health care costs, but has also improved access to certain services, especially mental and behavioral health services.

Telehealth is also prevalent in the Rural Health Transformation Program, with states recognizing mobile units and virtual care as tools for supporting rural providers and patients.

Technological progress presents opportunity for telehealth to flourish as a 21st-century health care alternative. As we move to close the digital divide, we can also move to close the health care divide.

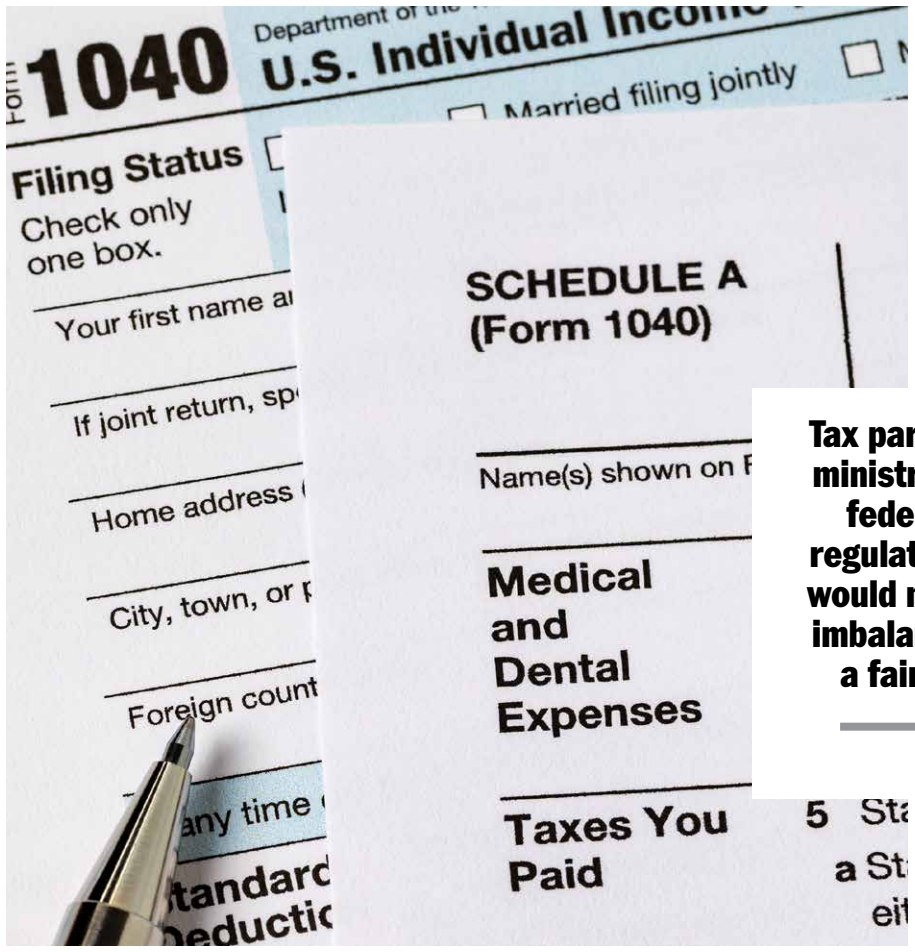
Taken together, these policies offer strong supports to rural health care well into the future. Much of America's growing success hinges on rural America's success.

And as a bedrock of the Trump coalition, we recognize that failing rural America is not an option.

As representative for Virginia's Ninth Congressional District, Rep. Morgan Griffith serves as chairman of the Subcommittee on Health for the House Committee on Energy and Commerce.

Tax code fairness: Why health care sharing ministries deserve equal treatment

By J. Craig Brown II



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When American families are straining under the weight of rising health care costs, public policy should expand responsible options, not quietly penalize them.

Nearly two million Americans participate in health care sharing ministries (HCSMs). These ministries are voluntary, faith-based communities in which members contribute monthly amounts to help meet one another's medical expenses. They are privately funded, rooted in religious conviction and have operated successfully for decades. Federal law expressly recognizes them.

Yet despite that recognition, participants in health care sharing ministries face unequal treatment under the federal tax code compared to Americans who purchase traditional health insurance.

That disparity is not about ideology. It is about fairness and neutrality.

Under Section 213(d) of the Internal Revenue Code, taxpayers who itemize may deduct qualifying medical expenses that exceed the statutory threshold. Families who purchase conventional insurance and incur eligible out-of-pocket costs can benefit from that deduction. Families who contribute comparable amounts through a health care sharing ministry generally cannot.

The economic reality is similar. The tax treatment is not.

Two families may devote $8,000, $10,000, or more each year to meeting medical needs. One family receives favorable tax treatment because its payments flow through an insurance company. The other does not because its payments flow through a faith-based sharing community. The distinction is structural, not substantive.

A neutral tax code should not privilege regulatory form over economic substance.

Health care sharing ministries are not new experiments. They have been serving members since long before the Affordable Care Act. They are structured, accountable organizations governed by published guidelines and clear eligibility standards. They operate without federal subsidies and without imposing taxpayer burdens. Members voluntarily agree to share responsibilities consistent with their religious beliefs.

Critics sometimes argue that, because HCSMs are not insurance, they should not receive comparable tax treatment. That observation misses the point. The issue is not whether ministries are insurance carriers. They are not, and do not claim to be. The issue is whether Americans who lawfully meet medical expenses through a federally recognized arrangement should be disadvantaged solely because their model reflects religious conviction and voluntary association rather than state insurance regulation.

Tax neutrality is a core conservative principle. Government should not use the tax code to steer citizens away from lawful private arrangements simply because those arrangements do not conform to a preferred structure.

The need for parity extends beyond individual taxpayers. Small businesses — especially those with fewer than 50 employees — are under extraordinary pressure as premiums continue to rise. According to federal data, average employer-sponsored family coverage now exceeds $20,000 annually. For a business with 15 or 20 employees, even incremental increases can determine whether health benefits remain sustainable.

Some employees prefer to participate in a health care sharing ministry because it is more affordable or better aligned with their faith. Yet current regulatory and tax barriers discourage employers from supporting those employees in the same way they support traditional insurance coverage.

Allowing employers to deduct contributions that assist employees participating in health care sharing ministries under Section 162 of the Internal Revenue Code would not create a new entitlement or expand federal spending. It would simply apply existing business deduction principles consistently.

Similarly, policymakers should ensure that participants in HCSMs are not excluded from meaningful access to consumer-directed tools such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs). These vehicles were designed to encourage personal responsibility and cost awareness. Restricting access based on structural distinctions serves no clear fiscal or policy objective.

Importantly, tax parity for health care sharing ministries would not require new federal outlays. It would not mandate participation. It would not alter the regulatory status of ministries. It would merely correct a structural imbalance and treat similarly situated taxpayers in a fair and consistent manner.

Tax parity for health care sharing ministries would not require new federal outlays [or] alter the regulatory status of ministries. It would merely correct a structural imbalance and treat taxpayers in a fair and consistent manner.

Congress has recognized the legitimacy of health care sharing ministries in federal statute. Executive Order 13877, "Improving Price and Quality Transparency in American Healthcare to Put Patients First," likewise reflected federal acknowledgment of alternative healthcare arrangements, although related regulatory efforts initiated in 2020 were not completed. Finalizing regulatory clarity under Section 213(d) and affirming consistent employer deductibility would align federal tax policy with those established legislative and executive actions.

America's health care landscape is diverse because the American people are diverse. Families make different choices based on cost, conscience, community and conviction. A pluralistic society should make room for those differences.

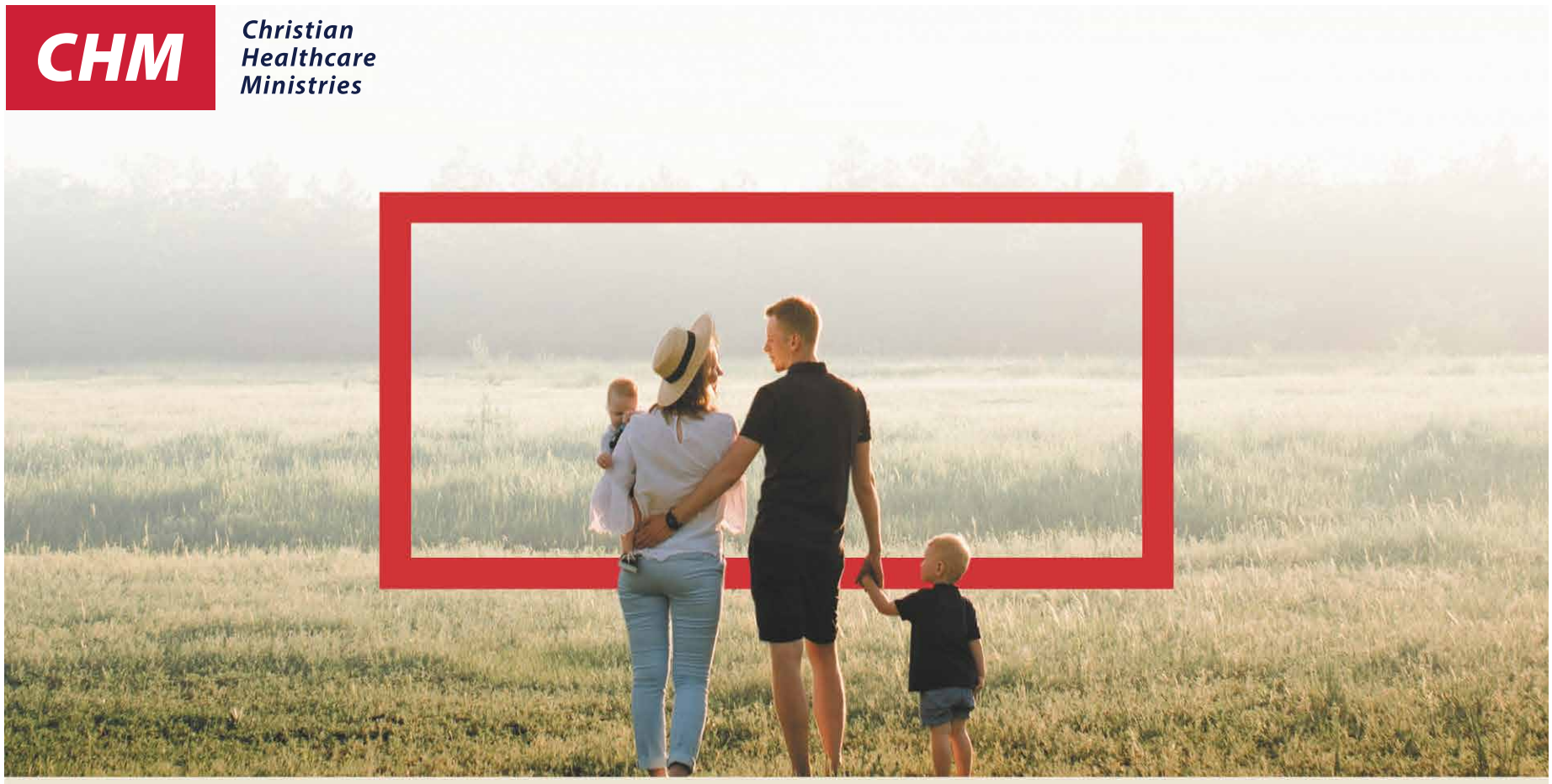
Public policy should not penalize citizens for choosing a lawful, faith-based model that helps them meet medical needs responsibly. Nor should the tax code quietly favor one form of private participation over another.

Fairness does not require special treatment. It requires equal treatment.

Neutrality in the tax code strengthens freedom. And in matters of health care — where cost, conscience and personal responsibility intersect — neutrality is not merely good economics. It is sound public policy.

J. Craig Brown II is president and CEO of Christian Healthcare Ministries. To learn more, visit chministries.org or call 330-798-8052.

CHM Christian Healthcare Ministries



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The war on science is costing America its future

By U.S. Rep. Diana DeGette, D-Colo.

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For much of the past century, if you were a talented scientist anywhere in the world, you came to the United States. Our research institutions, stable funding and scientific independence created a gravitational pull for global talent. That pull has been recklessly reversed, and our adversaries are now exploiting that vulnerability.

The Trump administration has spent the past year systematically dismantling the research funding system that built American scientific dominance. Last year, political appointees at the National Institutes of Health (NIH) terminated or froze more than 5,800 research grants. Historically, NIH terminated fewer than 20 awards per year — and never for ideological reasons.

Researchers suddenly found themselves navigating a "banned words" list, where terms like "adolescent," "underserved," or "natural disasters" could put grants at risk. Multi-million dollar projects that took years to design could be canceled overnight, along with any cures they could have fueled.

The stakes strike at the heart of American health care. Nearly every new drug approved by the FDA between 2010 and 2019 relied on NIH-supported research. Billions in NIH investment have saved lives, seeded industries and made biomedical innovation a pillar of American power.

If the United States stops being the most reliable place to pursue discovery, the world's best minds will simply do their research somewhere else — perhaps even for our adversaries.

European governments have begun actively recruiting U.S.-based scientists. Austria, France, and Germany are snatching up researchers from Harvard, Columbia and Berkeley. China has recognized the opportunity as well. While the United States cancels grants over language, Beijing is investing heavily in the life sciences and offering U.S.-trained scientists the stability that American institutions once guaranteed.

We are not just losing talent. We are training our competitors' workforce.

The administration appears committed to this path, with Robert F. Kennedy Jr. leading the charge. He's elevated anti-science ideologues into power at our health agencies.

My state of Colorado felt this directly: we were one of four states that had $600 million in public health funding — including for HIV prevention — terminated overnight as political punishment.

But RFK Jr.'s ideological leadership hasn't just infected what gets cut; it has also infected what our country invests in. Meritless projects aligned with his ideology are greenlit, like the controversial Hepatitis B trials on newborns that the CDC wants to fund in Guinea-Bissau.

History offers a sobering warning about where this path leads. In the Soviet Union under Joseph Stalin, political leaders elevated ideologically approved pseudoscience, which led to Soviet agriculture falling disastrously behind the rest of the world. When political loyalty matters more than scientific evidence, nations suffer.

The United States became a scientific superpower by choosing a different model. Scientists, not politicians, decided which questions were worth asking. That principle helped produce the Human Genome Project, the biotechnology revolution and transformative advances in medicine that have saved millions of Americans.

If the United States stops being the most reliable place to pursue discovery, the world's best minds will simply do their research somewhere else — perhaps even for our adversaries.

One of my proudest achievements in Congress was passing the 21st Century Cures Act in 2016 — a bipartisan effort to accelerate lifesaving treatments and support Grand Challenge efforts like the Cancer Moonshot and the BRAIN Initiative. Its passage reflected a bipartisan consensus that American scientific leadership was bigger than partisan politics.

Whether due to disinterest or fear of crossing President Donald Trump or RFK Jr., the result is the same: bipartisan consensus has collapsed.

Polling shows more than 70% of Americans support public health investments, yet political leaders are ignoring what the people want.

Research funding is now entangled in ideological battles, and the idea that science should be insulated from politics is under attack.

The damage will not be easy to reverse. Even if every canceled grant were restored tomorrow, the global scientific community has already received a powerful message: American research funding can swing dramatically with each election.

That is why structural reform is urgently needed to permanently protect science from political interference. The Follow the Science Act, which I recently introduced, would cap the number of political appointees at the NIH, keep them out of grant review and prevent political cancellations. This is good policy regardless of administration, but up until now, we didn't need it. The fact that we do now tells you how far we've fallen.

Our country's scientific leadership is not permanent, as the current administration has proven.

As our allies and adversaries quickly attract the scientists who once came here automatically, we are at a crossroads.

We can choose science — and recapture our role as the global leader in health research — or we can choose politics. We cannot choose both.

Rep. Diana DeGette is the ranking member of the House Energy and Commerce Subcommittee on Health. She is one of Congress's leading experts on cutting-edge scientific research and is a recognized leader on human embryonic stem cell research. She represents Colorado's First Congressional District, including Denver.

The doctor will see you later

By U.S. Rep. Bob Onder, R-Mo.

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Do you remember the name of your childhood doctor? He remembered your allergies without checking a screen. Your mom would call the office, and the doctor would see you the same day. His office was probably a few rooms tucked into a brick building, and he ran it himself. You weren't a "case." You were a patient.

Today, that kind of doctor is quietly disappearing — replaced by an impersonal system where you repeat your medical history to someone new and brace yourself for the bill that follows. Nearly 74% of doctors are now employed by hospitals, and some are employed by health insurance companies. This shift isn't just eroding the doctor-patient relationship; it has created regional monopolies and driven up costs.

I've treated patients in my allergy and asthma practice for over 30 years. When my patients needed a sinus CT scan, if I referred them to a private doctor-owned radiology practice, the patient paid around $300 for the scan. If I referred them to a hospital-owned practice, an identical scan cost $2,500 or more.

Once a hospital acquires a medical practice, prices increase an average of 45%. Patients typically see the same doctor with the same equipment, yet they are paying more for it.

Hospital prices are also not uniform; rather the variation between prices is staggering. In one case, a Wisconsin patient saved $1,095 simply by choosing between two hospitals located 30 minutes apart.

Hospitals are not necessarily villains in this story. Most struggling private practices sell because they are drowning in debt and administrative burden. Doctors now spend two hours on administrative tasks for every hour they spend with patients. Arguing with insurers about the care patients need has become a second job. But there is no question that it is difficult or impossible to compete when one's competitor is paid dramatically more for the same service. And patients are the real losers in this dysfunctional system.

Once a hospital acquires a medical practice, prices increase an average of 45%. Patients typically see the same doctor with the same equipment, yet they are paying more for it.

And lack of transparency is an enormous problem. While you're sitting in the exam room, your doctor often cannot see in real time which prescriptions or procedures your insurance will actually cover. If he could, he could discuss your options with you, and you could decide on your care plan together. Instead, doctors are forced into lengthy phone calls with insurers or slow "fax-only" processes that are designed to stall rather than deliver care — while patients often get worse while they wait. This administrative burden pushes private practices to the brink and has driven many of them into hospital employment or early retirement.

For many small practices, selling to a hospital feels like the only way to survive. And when competition disappears, prices skyrocket.

Patients deserve access to care when they need it: without delays, and without having to choose between medical treatment and groceries or childcare.

During his first term, President Donald Trump began tackling unreasonable administrative hurdles that drive consolidation. Since returning to office, he has pressured insurers to provide clear, timely information about drug and procedure denials so patients can access care without unnecessary delays. To make this progress permanent, Congress must pass the Improving Seniors' Timely Access to Care Act. This bipartisan bill would require insurers to communicate claim issues electronically, reducing approval delays and allowing doctors to focus on care instead of paperwork.

But reducing administrative burden is only half the solution. Because consolidation has already reduced competition in many communities, price transparency can restore some competition and empower patients to shop around for the best price.

Also during his first term, President Trump signed the No Surprises Act into law, which required hospitals to post clear, upfront prices so patients could compare costs for non-emergency care. Unfortunately, President Joe Biden refused to enforce Trump's price transparency law, and 45% of hospitals didn't comply. If the price transparency rules had been fully enforced, analysts estimate that it could have saved patients, employers and insurers up to $80 billion by 2025.

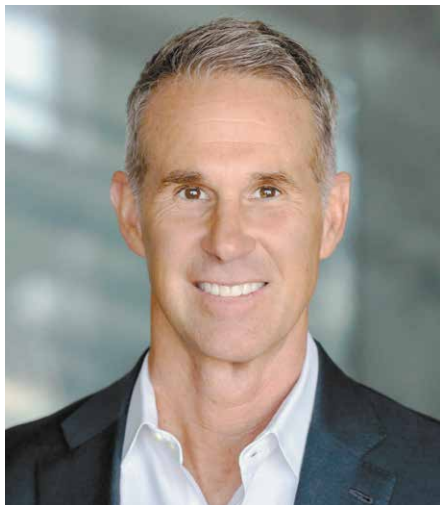
After returning to office, President Trump signed an Executive Order directing stronger enforcement of his price transparency law. In January, Congress passed stronger price transparency reforms, led by my colleagues on the GOP Doctors Caucus.

We cannot undo consolidation overnight, but we can insist on policies that restore competition, demand transparency and reduce the administrative overload that is suffocating private practices and driving up costs.

It's not too late to return to a system where moms don't hesitate to call the doctor out of fear of a devastating medical bill — and one in which the doctor remembers your name.

Rep. Bob Onder has represented Missouri's 3rd Congressional District since 2025. He is vice chair of the House Education and Workforce Committee's Subcommittee on Health, Employment, Labor, and Pensions and is a member of the GOP Doctors Caucus.

The healthcare reform that pays for itself: Why HSA expansion reduces costs



By Scott Cutler

Washington rarely sees healthcare reform that doesn't rely on massive new federal spending or expanded entitlements. Health Savings Accounts (HSAs) are a notable exception.

As an administrator of HSAs for more than 10 million Americans, we have direct visibility into how consumers use and manage their healthcare dollars and we set out to better understand their experiences and decision-making. Our survey of over 600 employed Americans reveals something budget models consistently miss: when people control their own healthcare dollars, they spend smarter and waste less. The downstream savings can exceed the upfront tax expenditure over time.

Expanded HSA contributions reduce near-term tax revenue. But that cost is outweighed by measurable, recurring savings when consumers have real financial skin in the game. This isn't theory — it's measurable behavior we observe daily across millions of transactions.

The Behavioral Economics Are Clear

HSA holders demonstrate fundamentally different consumption patterns. They comparison-shop, ask pricing questions before procedures, choose higher-value care and avoid unnecessary utilization.

We also found that HSA holders are 12.5% more likely to be prepared for routine healthcare costs and 16% more likely to have significant emergency savings. Most tellingly, they're markedly less likely to skip preventive services when facing financial pressure — behavior that drives up long-term costs.

The reason is straightforward: it's their money. HSA dollars don't disappear at year-end or belong to someone else. When consumers know they benefit directly from smart decisions today, they protect their own financial future. The data illustrates that HSA-holders are more likely to be prepared for routine medical bills and less likely to cut back on essential preventive care and treatment.

The Fiscal Math Washington Needs to See

Healthcare costs are projected to jump 9% in 2026, among the steepest increases in more than a decade. Middle-income families, along with their employers, already spend nearly $27,000 annually on healthcare, while half of American adults can't cover a $500 medical bill. At the same time, 31 million Americans report they had to borrow an estimated total of $74 billion to pay for healthcare for themselves or a household member.

HSAs are already helping address this gap. Americans now hold more than $159 billion in HSAs across over 40 million accounts. Last year alone, HSA members spent $42 billion on medical expenses using their own saved dollars. Roughly 4 million accounts invest their HSA funds, giving them balances nearly 9 times larger than non-investing accounts and far greater capacity to absorb future healthcare costs without public assistance.

What's more difficult to capture is behavior. When consumers ask about pricing, providers are incentivized to compete. Unnecessary tests are declined. Generic drugs get chosen when clinically appropriate. Urgent care replaces expensive ER visits. Preventive care increases, allowing health problems to be caught before they require hospitalization.

These are not marginal effects. They compound over time.

The CBO Scoring Problem

The standard budget scoring misses this dynamic entirely. The Congressional Budget Office excels at estimating federal expenditures, but it has limited tools for projecting multi-year behavioral changes that unfold gradually. As a result, models tend to capture the immediate tax revenue impact of HSA expansion but miss the long-term savings driven by consumer behavior.

We saw this dynamic with Medicare Part D. While not perfectly analogous, it offers a cautionary example: the program ultimately came in substantially below ten-year cost projections, as competition and consumer choice reduced spending far more than models anticipated.

A more complete HSA score would weigh tax revenue reduction against decreased Medicare and Medicaid spending as empowered consumers reduce system-wide costs. It would also factor in reduced disability claims and productivity gains when workers aren't distracted by medical financial stress. Our survey found that people who understand their benefits are 45% less likely to report that financial concerns interfere with their work.

When consumers know they benefit directly from smart decisions today, they protect their own financial future. The data illustrates that HSA-holders are more likely to be prepared for routine medical bills and less likely to cut back on essential preventive care and treatment.

Proper accounting would materially narrow — and could potentially eliminate — the projected revenue gap over the long term.

Real Evidence from America's Largest HSA Platform

Despite economic anxiety affecting 79% of employed Americans, survey respondents with HSAs report building emergency medical savings at substantially higher rates. When finances tighten, Americans often skip preventive care, delay prescriptions, or postpone mental health services. HSA holders are significantly more likely to protect these essential services because they understand long-term value.

They are also 46% more likely to thoroughly understand their employee benefits — knowledge that translates into more confident, cost-aware healthcare decisions across their entire experience. This did not require new government programs or bureaucracy. It is happening because Americans were given ownership and control.

Empower, Don't Subsidize

HSA expansion puts individuals in charge, rewards personal responsibility, relies on markets rather than mandates, and scales without expanding federal programs. Unlike most healthcare reforms, it reduces reliance on subsidies by helping Americans save for their own needs.

Yet arbitrary restrictions still block more than 140 million Americans from opening HSAs simply because they have the "wrong" insurance type. Congress doesn't restrict IRA eligibility based on your employer's pension plan. Why maintain barriers that prevent families from saving for healthcare?

The Reforms Congress Should Enact

First, decouple HSA eligibility from plan type, allowing every American to save regardless of insurance structure.

Second, allow HSA funds for insurance premiums. Today, Americans can use HSA dollars for nearly every medical expense except their monthly premium — often their largest healthcare cost. Removing this restriction would allow individuals to pay premiums with pre-tax dollars, reducing the after-tax cost of premiums by roughly 25-30% for many middle-income families, depending on marginal tax rate and individual circumstances.

Third, raise contribution limits to reflect real healthcare inflation. Any adjustment would help families keep pace while strengthening long-term savings.

These reforms require no new spending authority, create no new entitlement and impose no mandates. They simply remove barriers that prevent Americans from helping themselves.

Healthcare consumes over $5 trillion annually — nearly 18% of our economy. We can continue layering regulation and subsidies on top of a broken system, or we can trust Americans to make better decisions when they control the dollars and see the prices.

The evidence is clear. People with skin in the game spend smarter, save more, and achieve better outcomes. Expanding HSA access isn't a cost; it's an investment in a healthcare system that is more affordable, more resilient, and more accountable to the people it serves.

Scott Cutler is CEO and President of HealthEquity, the nation's largest Health Savings Account administrator.

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A toothache should never ground a warfighter

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

I learned early in life that pain doesn't wait. As a captain in the United States Air Force serving as a dentist, and later in more than 30 years of civilian practice, I've seen firsthand that a severe toothache strikes without regard for time, place, or circumstance. Whether you're sitting in a state-of-the-art clinic or marching with a rucksack halfway across the globe, pain is the same. In uniform, there is no convenient moment for a medical problem. Every day and every minute counts.

For our service members, oral health is not a minor issue. It is a matter of readiness. Military commanders have long understood this reality. Dental emergencies are among the most common preventable reasons for medical evacuations from deployed environments. Every year, thousands of duty hours are lost to conditions that could have been prevented with timely care. Class 3 designations — those with significant untreated conditions — render troops non-deployable, and roughly half of them will face a painful emergency within weeks.

We have seen needless vulnerabilities in military health care for years, which is why Congress enacted legislation in 2021 that mandated accreditation standards to reduce risk and strengthen care across military dental facilities. Yet, years later, gaps remain. Some clinics still lack the independent verification to ensure consistent, high-quality treatment, and staffing shortages continue to strain the system. Accreditation is not mere box-checking; it is the gold standard for patient safety, clinical consistency, and accountability. At the same time, recruiting and retaining dentists and specialists has become increasingly difficult, leaving clinics understaffed and service members waiting longer for the care required to remain deployable.

These are real problems. They lead to lost training days, diverted medical evacuations, and reduced combat effectiveness when every minute and every Marine, soldier, sailor or airman matters.

That's exactly why I submitted the dental provisions as an amendment, now part of the Fiscal Year 2026 National Defense Authorization Act. My amendment requires the Department of Defense Inspector General to conduct a thorough review of every military dental facility: how many are still unaccredited, what obstacles remain, what resources and funding are truly needed and what specific actions Congress should take to complete the process. The report is due one year after passage, so we can act quickly and deliberately.

In uniform, there is no convenient moment for a medical problem. Every day and every minute counts.

We also directed the Pentagon to develop clear plans for prioritizing active-duty dental personnel assignments to the facilities that need them most, with annual reports to Congress starting next year. No more guesswork. No more hoping the problem will resolve itself.

These measures are simple, commonsense and long overdue. Fully accredited clinics with well-staffed teams mean fewer emergencies on the battlefield, more warfighters ready when the nation needs them, and greater confidence that the care our troops and their families receive is the care they deserve.

Our military exists to deter conflict and win decisively when needed. That requires a force that is healthy, trained and lethal. Dental readiness is part of that equation, and I am proud that the FY2026 NDAA finally recognizes the importance of dental readiness. Our service members have already sacrificed enough for this country; the least we can do is ensure their health does not become another obstacle to mission success.

America's strength begins with the readiness of every individual who wears the uniform, and readiness includes their health, their care, and yes, even their teeth. With my amendment in this year's NDAA, we are taking a practical, commonsense step to sustain that strength and keep America's military, the strongest fighting force in the world, fully deployable.

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

America needs to address our health care crisis head-on

By Rep. Andy Harris, M.D. (R-MD), and Dr. Renee Desmarais

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National comprehensive health care and health care insurance reform are needed both to improve quality and to decrease rising insurance costs. The Affordable Care Act (ACA) failed these goals because it lacked five interrelated foundational requirements for success: adequate quality health insurance choice, improved drug safety and competitive drug costs, fostering of health literacy, full realization of electronic health record (EHR) and IT potential and correcting the problems of behavioral health delivery.

Limited health insurance choice causes high costs for families and employers, causing increases in the number of uninsured and underinsured patients. Options other than large insurers with large profit margins are needed to lower overhead and give more control to the consumer. "Association" health plans could provide alternative accounts to small businesses, sole proprietors, the self-employed and individuals. We could also increase the number of consumer operated and oriented plans (CO-OPs) in the entire country and ensure universal access to membership. Offering insurance terms longer than one year would incentivize insurers to promote preventive care and to consider long-term effects of benefit denials. Finally, Medicaid needs reform as it offers little choice, its administration by private insurers threatens access to care, and loopholes in state payment schemes create inefficiency and inflate cost.

President Donald Trump has successfully lowered many drug prices, but we should legislate permanent drug and medical device price negotiations for all health insurance plans that are funded in any manner by the federal government – so that future presidential administrations do not reverse these gains. "Big Pharma" has argued fallaciously that such reduction would lead to less research and innovation, but other countries could be asked to pay more and thus maintain some, if not all, of any given drug's profitability. Furthermore, drug companies would be incentivized to increase efficiency and innovation. The scrutiny of pharmacy benefit managers (PBM) must continue, including transparency of drug "rebates" and allowing patients to reap the gains of PBM negotiations. For enhanced drug safety, we must rein in the wild west show of snake oil salesmen plaguing our over-the-counter medicines and supplement industry.

Higher health literacy correlates with better outcomes. Patient engagement with providers and the management of all aspects of one's own health care depend on health literacy. In turn, power mismatches in both patient/physician and patient/health system relationships are lessened, fostering better resource use. Inadequate health literacy costs up to half a trillion dollars per year but is relatively cheap to improve — especially with social media. Improving health literacy perhaps offers the best return on investment. Health literacy includes understanding smart food choices, and further work in this space is sorely needed — such as what is being done as part of the Make America Healthy Again (MAHA) movement. Studies have shown dietary education in elementary school children improves both their food choices and their families' choices. More states should limit the use of SNAP and child nutrition money on sugary soft drinks and junk food, which account for over 10% of SNAP spending. The benefits of reducing youth overweight and obesity cannot be overstated.

Limited health insurance choice causes high costs for families and employers, causing increases in the number of uninsured and underinsured patients. Options other than large insurers with large profit margins are needed to lower overhead and give more control to the consumer.

IT needs to encompass communication and data mining. We should improve interoperability of electric health records (EHR), use social media and digital messaging to enhance health maintenance, screening and literacy and smooth communication among all those involved in patient care delivery. EHRs contain enormous amounts of data that should be used to conduct virtual clinical trials and comparative effectiveness research, develop better quality metrics and screening tools, improve diagnostic accuracy and increase the yield of public health research. For example, minors could be screened for risk of behavioral health disorders and linked dietary vulnerabilities, allowing for crucial earlier intervention.

Finally, behavioral health is likely the area that needs the most work and contains the most potential for increasing value. Problems include a critical lack of access to health care practitioners, insufficient inpatient psychiatry beds, inadequate payment for hospital admissions and practitioner care, poor regional behavioral health coordination and weak patient referral and treatment algorithms. The result is increased homelessness, rising suicide rates, behavioral health problems in our youth and unnecessary and counterproductive incarceration of the mentally ill. Opioid overdose and opioid use disorder alone cost an estimated $1 trillion annually, and the cost of other untreated mental health disease is another $500 billion. We must both grow and improve the efficiency of the behavioral health workforce and increase treatment capacity. As a nation, we are at least 36,000 inpatient beds short of the minimum required for adequate coverage. Building 50 to 100 large behavioral health treatment complexes containing the full range of inpatient and outpatient services would bring together local communities, create needed research centers and help alleviate our mental health crisis.

As physicians, we feel reforming and improving health and health care can be the unifying force so badly needed in our country.

Rep. Andy Harris has represented Maryland's First Congressional District since 2011. An anesthesiologist and veteran who served in the U.S. Navy Medical Corps, he chairs the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies subcommittee of the House Appropriations Committee.

Dr. Renee Desmarais has practiced cardiology for the past 33 years in Salisbury. He is president of the Wicomico County Medical Society and on the Board of Trustees of MedChi, the Maryland State Medical Society.

From compliance to intelligence: A smarter path for state reform

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By Taylor Justice

As state legislatures convene across the country, the implications of H.R. 1, the "One Big Beautiful Bill Act," are no longer theoretical. Rural Health Transformation (RHT) funding is moving from promise to implementation. Medicaid community engagement requirements are shifting from debate to operational reality. Expectations around measurable outcomes and program integrity are rising.

For state leaders, this is not simply a funding cycle. It is a defining infrastructure moment.

The decisions made this year will determine whether time-limited federal dollars deliver a short-term boost to fragmented systems or establish the foundation for long-term fiscal discipline, stronger communities and durable self-sufficiency.

Too often, RHT funding and Medicaid mandates are treated as separate challenges requiring separate tools. One platform for compliance; another for care coordination; and another for reporting. This approach reinforces the very fragmentation that drives waste, inefficiency and poor outcomes in the first place.

The real opportunity is bigger.

Repairing fragmentation in rural health

States can use this moment to build not only connected systems but also intelligent infrastructure: a shared digital ecosystem that unites agencies, providers and community organizations around a single, accountable source of truth.

For decades, rural health and human services have operated in silos. Medicaid agencies, workforce departments, housing authorities, clinics and community-based organizations often serve the same residents without visibility into one another's efforts. Even when organizations sit in the same building, their systems do not communicate.

This is a failure of technology, but it leads to a failure of care.

When systems cannot see across programs, states cannot allocate resources strategically. Service gaps go undetected until they escalate into high-cost crises. Verification processes become manual and duplicative. Return on investment is estimated, not demonstrated.

RHT funding offers a rare chance to correct this structural weakness. When used to build shared infrastructure, states can connect health care providers, workforce partners and social service organizations into a coordinated network. We have already seen what happens when sectors align around common data and accountability.

In communities that have implemented coordinated referral networks, emergency department utilization drops, preventable costs decline and residents receive the services they need faster. Addressing nonmedical barriers to health – including housing instability, food insecurity and transportation – produces measurable clinical and financial results. These are not abstract social theories. They are operational realities backed by data.

But the next chapter goes further.

One infrastructure, multiple mandates

We are entering a phase in which public infrastructure does more than store and transmit data. Modern platforms can reason across it. With the responsible application of artificial intelligence, states can move from reactive administration to predictive governance.

This shift is especially relevant in Medicaid. Instead of discovering after the fact that a resident lost coverage due to incomplete engagement documentation, intelligent systems can flag likely verification gaps in advance and coordinate with workforce or community partners to resolve them. Rather than waiting for housing instability to manifest in repeated emergency department visits, predictive analytics can identify high-risk individuals earlier and prioritize intervention.

This is not about replacing public servants. It is about equipping them.

Agentic AI systems capable of orchestrating multistep processes within defined guardrails can reduce administrative burden by automating verification workflows, cross-referencing trusted data sources and surfacing inconsistencies in real time. Compliance becomes embedded in the design of the system rather than layered on through audits and manual checks.

For states, that means stronger program integrity, lower improper payment risk and reduced overhead.

For residents, it means fewer redundant forms, fewer delays and clearer pathways to stability.

The same intelligent infrastructure that supports care coordination can also support Medicaid community engagement requirements. Verification should not require a new procurement cycle every time federal policy shifts. When workforce participation, education enrollment, volunteer service and health care engagement data flow through a shared ecosystem, reporting becomes a byproduct of normal operations rather than a parallel bureaucracy.

Just as importantly, intelligent infrastructure allows leaders to see across programs.

Medicaid spending does not exist in isolation from housing instability. Workforce participation is not disconnected from access to transportation or child care. When agencies operate within one coordinated network, states can analyze how interventions in one program affect costs in another. Budget decisions become informed by longitudinal evidence rather than annual snapshots.

That is the difference between managing programs and governing outcomes.

Governing for durability, not the moment

Some states will use RHT dollars to purchase point solutions tailored to current requirements. Those systems may satisfy immediate mandates, but they will need to be replaced when policies evolve.

Others will treat this as a structural inflection point.

They will invest in adaptable infrastructure that can support health care coordination today, community engagement verification tomorrow, and future federal priorities yet to be defined. They will embed accountability directly into workflows. They will reduce fragmentation across vendors and agencies. And they will position themselves to measure and prove the return on public investment.

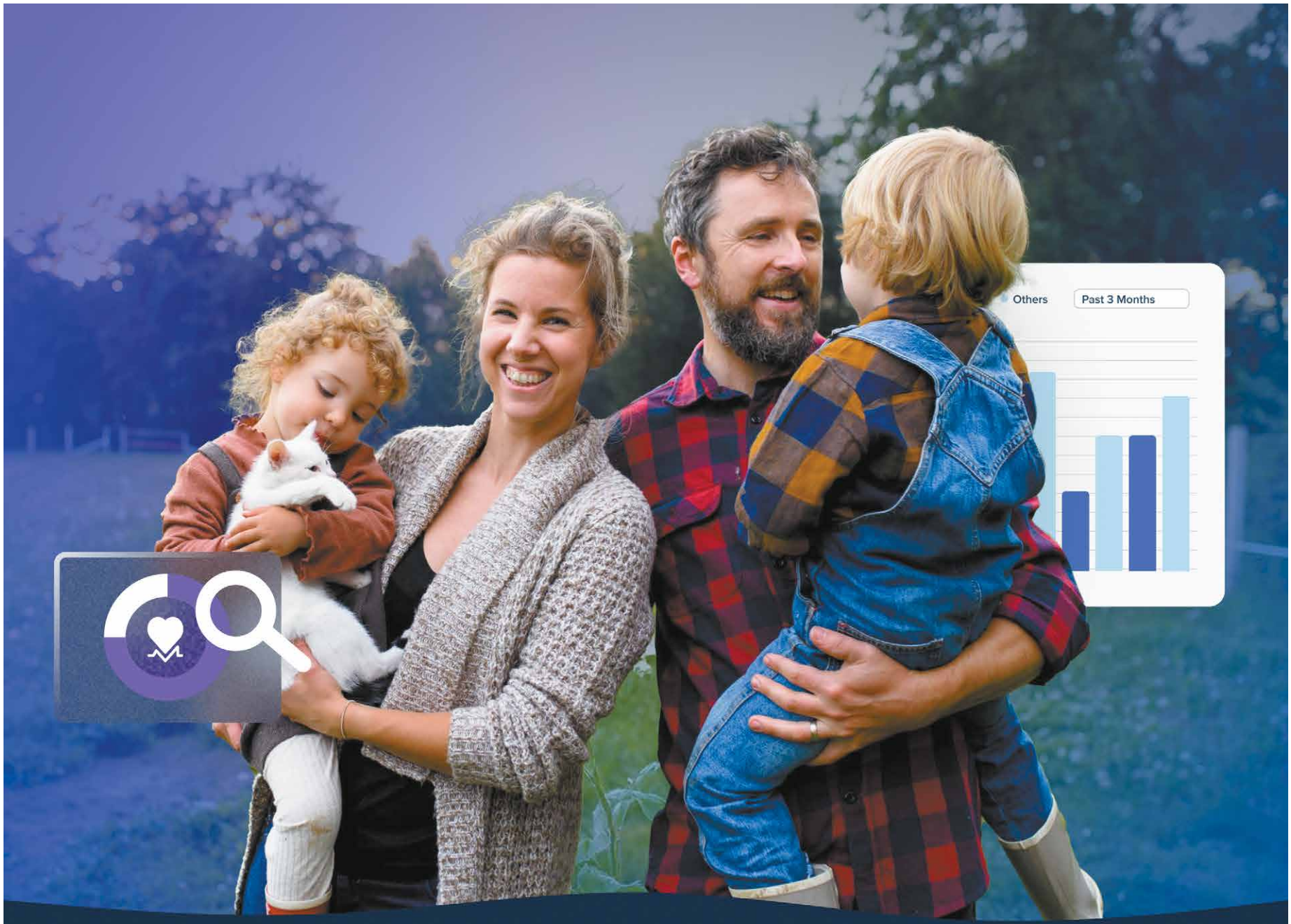
The goal for 2026 should not be compliance alone. It should be durability.

If states seize this moment, they can move beyond managing crises and toward engineering pathways to self-sufficiency. They can reduce waste while strengthening support for those who truly need it. They can connect government agencies and community partners into a unified, accountable system designed to help residents stabilize, work and thrive.

The next generation of public infrastructure will not merely connect systems; it will think across them.

States that recognize this and build accordingly will comply with federal mandates; but what's more, they will own their outcomes.

Taylor Justice is co-founder and CEO of Unite Us.



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Obamacare's broken promise: Affordability

By U.S. Rep. Mike Kennedy, R-Utah

As a family physician with over 25 years of experience, I have seen firsthand how my patients struggle with the cost of health care. To make the American Dream affordable again, we need to examine the broken promise of Obamacare.

When the Affordable Care Act was passed in 2010, the American people were promised one thing above all else: affordability. It was a goal so central it was written into the name of the legislation. Yet, over 15 years later, we find ourselves in a system that is far from affordable.

What we have today is a subsidy-fueled illusion with spiraling costs hidden by taxpayer dollars and deficit spending. Premiums continue rising, and the subsidies keep increasing. Since Obamacare passed, premiums in the individual market have more than doubled, far outpacing both medical inflation, at 51%, and overall inflation, at 49%.

The politically convenient path is to maintain the status quo and dodge the unpopular necessity of reforms. But this ignores the harsh reality that our health care programs are ballooning beyond our means. By making promises we cannot afford, we aren't just delaying the problem; we are sabotaging our country's future. I refuse to stand by while these programs risk failing the very people they were created to protect.

By making promises we cannot afford, we aren't just delaying the problem; we are sabotaging our country's future. I refuse to stand by while these programs risk failing the very people they were created to protect.

Last summer, I joined my Republican colleagues to pass the landmark Working Families Tax Cuts Act. This legislation delivered historic relief to American families while reining in the unsustainable Obamacare provisions and strengthening core programs like Medicaid.

Obamacare was sold as a solution for health care affordability and accessibility, but its incentive structure has created a system reliant on unsustainable federal spending. Medicaid was originally established in 1965 as a lifeline for vulnerable populations: low-income families and children, individuals with disabilities, seniors whose expenses aren't fully covered by Medicare, and pregnant women.

However, the 2010 expansion extended Medicaid coverage to include able-bodied adults earning up to 138% of the Federal Poverty Level, a shift forcing the program to move away from its core mission. To incentivize this change, the law provided states with a higher federal match rate for the expansion population than for the vulnerable groups the program was originally designed to serve. This upside-down incentive structure prioritizes expansion at the expense of those who need the program most.

It is false to say that Republicans "cut" Medicaid through the Working Families Tax Cuts. In fact, Medicaid funding will still grow significantly over the next decade. The non-partisan Congressional Budget Office projects that Medicaid spending will add up to $8.6 trillion over the next ten years. Because Medicaid's federal matching rates favored expansion enrollees under Obamacare, many states underinvested in their traditional Medicaid populations. The real question is one of prioritization. When states added able-bodied adults to Medicaid, they left individuals with disabilities stuck on waiting lists. Republican reforms adjust funding formulas and policies to direct attention back to core populations.

The Congressional Budget Office warned early on that these Medicaid expansions and subsidy phase-outs would discourage work, leading some to reduce their hours or leave the labor force entirely just to retain their benefits.

To address this perverse incentive, we have established a national Medicaid work requirement for able-bodied adults aged 19 to 64. Participants will be required to work or engage in community service for 80 hours a month, with mandatory exemptions for those with medical issues, caregiving responsibilities, or other hardships. This reform does not rip away coverage, as some claim; instead, it restores the dignity of work as a path to independence while continuing to support those truly in need.

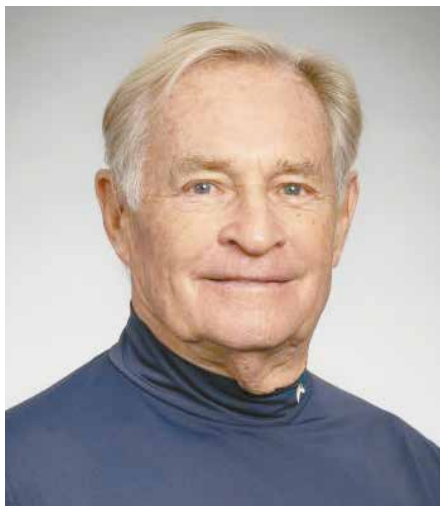
Obamacare promised lower costs and broader access, but delivered a system where affordability is an illusion propped up by trillions in debt. To achieve sustainable reform, we must look toward solutions that prioritize patients. This includes establishing a parallel marketplace for lower-premium insurance, empowering individuals by redirecting spending into Health Savings Accounts (HSAs), and enacting rigorous measures to eliminate waste, fraud, and abuse. I urge readers to explore the provisions within House Republican's "Making the American Dream Affordable Again" plan as we work to build health care systems that deliver.

As a physician, I took an oath to "do no harm." As your representative, I apply that same principle to a health care system that is clearly hurting. Americans deserve a government that doesn't just manage the status quo, but also protects and stabilizes our future.

Rep. Mike Kennedy, M.D., has represented Utah's 3rd Congressional District since January 2025. He co-chairs the Biomedical Research Caucus and serves on the GOP Doctors' Caucus.

FDA drew a line on illegal drug copycats. Now it must enforce it

By Philip J. Schneider and Ronald P. Jordan



The Food and Drug Administration has taken an important and overdue step to rein in the mass marketing of compounded drugs that have never been reviewed or approved by the agency.

In a Feb. 6 statement, the FDA made clear that it would take steps to limit importation of API for mass compounded copycat drugs and that companies cannot sell unapproved products as substitutes for FDA-approved medicines. That clarity matters, because it reaffirms a basic expectation patients have when they take a prescription drug: that it has been tested for safety and effectiveness, manufactured under appropriate quality standards and independently reviewed before reaching the market.

For FDA-approved medicines, that expectation is well founded. But a growing number of Americans are now taking compounded drugs that never went through that process — often without realizing it.

Compounding serves and important but limited role in medicine when it is used to meet individualized patient needs that cannot be met by FDA-approved drugs, such as when a patient has a documented allergy to an inactive ingredient in an approved drug. But what has emerged in recent years is something very different. Under the guise of compounding, some companies have moved far beyond individualized care — particularly for high-demand therapies like weight-loss and diabetes drugs, hormone treatments and other popular medications.

These actors are mass-producing unapproved drug copies with API from foreign sources – some of which are selling illicit ingredients that cannot legally be used in drugs intended for humans. They then sell these substandard products nationwide through telehealth platforms and med spas and promoting them directly to consumers through social media and digital advertising. The products are often described as "the same as" or "just like" FDA-approved medicines but the truth is they are not remotely the same thing.

Let's be clear: this isn't customization for a unique patient need. It's industrial-scale unapproved drug production marketed as "personalized" to evade the rules.

Unlike FDA-approved drugs, these compounded products have not been independently reviewed to confirm that they contain the correct amount of active ingredient, are sterile and uncontaminated, will work as intended, or are produced, stored, and shipped under appropriate quality standards. Many compounded GLP-1 products also include added ingredients — such as vitamins, amino acids, or other substances — that have never been clinically tested in combination with these drugs. That means patients are effectively participating in an uncontrolled experiment, with no reliable data on safety, effectiveness, interactions or long-term risks. Instead of FDA oversight, patients are left to rely on compounders' claims alone.

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The result is a two-track marketplace: one set of rules for FDA-approved medicines, and another for products operating outside FDA review while being marketed as equivalent alternatives. This uneven system undermines patient confidence and erodes trust in the drug supply.

The risks are not theoretical. Investigations and reports have documented compounded drugs with incorrect dosing, contamination and ingredients that do not match their labels. Some patients have experienced serious side effects while others have paid for medicines that simply did not work. FDA also recently cited one of the largest suppliers of API for compounding, noting that it imported illicit API, destroyed the original label and then resold it to compounders.

Confusion is further fueled by marketing practices that obscure whether a product is FDA-approved. Phrases like "contains semaglutide" can give patients the impression they are receiving the same treatment as an approved GLP-1 medication, even when they are not. Clinicians, too, can struggle to track what their patients are taking when products are shipped directly to homes without clear disclosure.

The FDA's Feb. 6 action — including its plan to restrict access to certain active pharmaceutical ingredients used for mass-marketed, non-approved compounded drugs and to address misleading promotional claims — was both necessary and appropriate. It reinforces a simple principle: companies cannot sidestep FDA review while making the same claims as approved manufacturers.

Clarity, however, must be followed by consistent enforcement. The FDA has a range of tools at its disposal — from inspections and warning letters to seizures, injunctions and referrals when warranted. Those tools exist to ensure that regulatory exceptions are not exploited as commercial loopholes and that the law applies equally to all.

Congress has begun to recognize the consequences of regulatory drift as well. Bipartisan proposals introduced by lawmakers reflect growing concern that compounding exceptions have been stretched far beyond their intended scope and that clearer guardrails are needed to protect patients.

Let's be clear: this isn't customization for a unique patient need. It's industrial-scale unapproved drug production marketed as "personalized" to evade the rules.

America's drug approval system is respected around the world because it is grounded in science, safety, and regulatory rigor. That system works only if its standards are applied consistently. The FDA has drawn an important line. The task now is to ensure it is enforced — for patients, for providers, and for the integrity of the U.S. drug supply.

Philip J. Schneider, MS FASHP FFIP, is a professor at Ohio State University College of Pharmacy and past president of the American Society of Health-system Pharmacists (ASHP). Ronald P. Jordan, RPh is the Founding and Emeritus Dean at Chapman University School of Pharmacy and former president of the American Pharmacists Association (APhA).

Americans fighting rare diseases deserve effective solutions

By U.S. Rep. Gus Bilirakis, R-Fla.

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Every patient deserves a fair shot at a healthy life, especially those battling the most devastating and life-threatening illnesses. Yet for the millions of Americans living with rare diseases, that promise remains too often out of reach. Today, more than 10,000 rare diseases have been identified, but only about 5% have an FDA-approved treatment. For families confronting these diagnoses, this is not only a fight against illness. It is a fight against a system that has historically overlooked their needs. The consequences are profound and heartbreaking. Nearly 30% of children diagnosed with a rare disease will not live to see their fifth birthday. These are not abstract statistics. These are children, families and futures cut tragically short. And this reality is unacceptable.

That is why Congress must continue to act with urgency and why bipartisan, patient-focused policies matter so deeply.

One of the most effective tools we have had in this fight is the Rare Pediatric Disease Priority Review Voucher program. This proven incentive has helped bring more than 50 treatments to market for children facing devastating conditions such as spinal muscular atrophy, cystic fibrosis, and Friedreich's ataxia. Of those treatments, 36 addressed diseases that previously had no approved options at all. These breakthroughs have saved lives, restored hope and given families something priceless: more time with their children.

I am proud that Congress has now united to reauthorize this critical program and that it has been signed into law. By providing either an accelerated FDA review or a transferable voucher that can support continued research, the program continues to drive investment into rare pediatric disease research — some of the most complex, costly, and high-risk clinical trials in medicine. It does so at zero cost to taxpayers. As chair of the Congressional Rare Disease Caucus, I was proud to help lead this bipartisan effort. This achievement is about more than drug development. It reflects our values and our commitment to stand up for the most vulnerable among us and to say clearly that every child matters.

Nearly 30% of children diagnosed with a rare disease will not live to see their fifth birthday. These are not abstract statistics. These are children, families and futures cut tragically short. And this reality is unacceptable.

We have also made important progress in recent months to strengthen the pediatric research pipeline. Just this month, the Give Kids a Chance Act was also signed into law. I co-authored this comprehensive legislation to accelerate the development of pediatric cancer treatments and expand access to lifesaving therapies for children with rare diseases. This package strengthens incentives for pediatric drug development, improves patient outcomes, and addresses longstanding gaps in research for rare childhood diseases.

The urgency could not be clearer. Each year, more than 1,500 children in the United States die from cancer. That represents more than 1,500 families devastated by loss and a call to action for policymakers. The Give Kids a Chance Act builds on proven successes and includes a key reform that codifies orphan drug exclusivity based on an FDA-approved indication rather than a broader disease category. This change ensures that companies continue developing targeted therapies for small patient populations, even when market incentives alone fall short.

Equally important is ensuring children receive answers as early as possible. Too many families endure what is often called a diagnostic odyssey: a journey that can last years and involve repeated misdiagnoses, unnecessary tests, and overwhelming emotional and financial strain. That is why I am proud to sponsor the Genomic Answers for Children's Health Act. This legislation clarifies that children enrolled in Medicaid who have a suspected rare disease or genetic disorder can access advanced genomic sequencing, a diagnostic tool that has quickly become the standard of care.

Whole genome and whole exome sequencing can dramatically shorten the time it takes to reach a diagnosis, sometimes from years to weeks, or even days. The bill clarifies coverage under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit for eligible children in both inpatient and outpatient settings and supports access in hospital environments. Studies show this approach is not only clinically effective but also cost-efficient, and it is recommended by major medical organizations. This legislation also builds on important momentum from states like Florida, which passed the Sunshine Genetics Act to expand access to genomic tools and improve outcomes for children with rare diseases.

More broadly, early diagnosis remains a cornerstone of my work. Expanding newborn screening is a critical part of ensuring that no child suffers because a disease was not detected in time. This year, two rare diseases, metachromatic leukodystrophy and Duchenne muscular dystrophy, were added to the newborn screening process. Identifying rare diseases early can dramatically improve outcomes by enabling timely treatment, more effective therapies, and, in some cases, cures. Early diagnosis also benefits our whole healthcare system by preventing complications, reducing years of misdiagnosis and lowering long-term costs.

I am currently working with a constituent, Mattie, whose rare disease, biliary atresia, was not recognized at birth even though a simple blood test could have made all the difference. Stories like Mattie's reinforce why this work matters. I will continue working with Secretary of Health and Human Services Robert F. Kennedy Jr. and his team to expand newborn screening even further and ensure more children get the early care they need.

During Rare Disease Week (Feb. 24-26), we celebrate progress, but we must also acknowledge how much work remains. Far too many Americans are still lost to rare diseases. I am proud to help lead this charge with urgency, accountability and compassion. Together, we can deliver real solutions, better outcomes and the brighter future that every child, family and patient deserves.

Rep. Gus Bilirakis serves Florida's 12th Congressional District. He serves on the Energy and Commerce Committee, where he chairs the Innovation, Data and Commerce Subcommittee and is also a senior member of the Health Subcommittee and the Communications and Technology Subcommittee. He also chairs the Congressional Rare Disease Caucus.

Health care isn't a Left-wing or Right-wing issue: It's an American one

By U.S. Rep. Bruce Westerman, R-Ark.

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Democrats want to expand federal policy and spending, while Republicans want to cut regulation and spending. But what we really need to understand is that health care policy is not about one partisan philosophy or the other.

It is about creating an accessible, functioning system where a working family does not have to choose between health insurance and putting food on the table. Where health care costs, which are also the largest expenditures of the federal government and biggest driver of our federal debt, don't continue to escalate. A system where a young, healthy college graduate does not have to pay enormous out of pocket costs that subsidizes a broken system, instead of saving to buy a home.

Health care policy is an American issue that is currently broken and not getting better. Your cancer diagnosis and your child's broken arm do not care who you voted for. For a health care system where Americans spend over $5 trillion annually (most in the world) and 18% and rising of our GDP, we cannot afford to let partisan politics stand in the way of common sense and quality care.

The Fair Care Act is an overarching solution that increases the number of people with health insurance coverage, decreases patient costs, and lowers long-term government spending. It makes care more economical, straight forward, and accessible to all Americans. Here are its four pillars.

Modernizing Health Savings Accounts

Right now, your health account may be an HSA, FSA, HRA, etc. The average American loses hundreds of dollars annually in unused FSA funds due to use-it-or-lose-it rules. This bill eliminates that waste by merging these health care accounts into one simple Health Savings Account (HSA). With this change, anyone with Medicare, Medicaid, employer plans, or individual plans would qualify.

Additionally, pre-tax money would be available to go toward prescription costs, doctor visits, premiums, and more. Under the Fair Care Act, employees could choose to use HSA funds to buy their own insurance so that health insurance would be portable and no longer tied to employment.

Creating Changes to the Insurance Market

Under the Fair Care Act, preexisting conditions will not send your rates into the stratosphere. If you do not want to commit to long-term coverage, this bill makes it easier to access cheaper health plans, including short-term insurance. Also, expanding options like Association Health Plans allows small businesses and individuals to join for group discounts and rates.

The approximately eight million federal workers currently enrolled in the costly Federal Health Employees Benefit Plan would be moved into the individual marketplace. Placing millions of bureaucrats on the very plan many of them manage will ensure a better functioning system while increasing competition and lowering prices in the marketplace.

The Fair Care Act also makes COVID-era telehealth expansions permanent, protecting a vital lifeline for rural communities to receive emergency services and primary care.

For a health care system where Americans spend over $5 trillion annually (most in the world) and 18% and rising of our GDP, we cannot afford to let partisan politics stand in the way of common sense and quality care.

Promoting Price Transparency and Competition

The enemy of the free market and principal driver of rising health care costs is consolidation and vertical integration (monopolies) within the hospital, insurance, and pharmaceuticals industries.

According to the U.S. Department of Health and Human Services, hospital mergers have the potential to raise costs from 6% to 65%. By encouraging competition in the marketplace and reducing the monopoly power of these industries, the Fair Care Act creates a competitive market to drive down the costs of drugs and services.

Creating Reforms to Medicare and Medicaid.

The Fair Care Act offers states more flexibility to adjust their Medicaid programs and offers help for those who may not qualify for the program but still struggle to afford insurance.

By allowing Medicare to negotiate drug prices and help our senior citizens compare insurance plans to choose what best meets their needs, our elderly are empowered instead of being stuck in a one-size-fits-all system. Limiting how much Medicare premiums can increase each year will give our seniors more freedom and flexibility with their fixed income.

The Fair Care Act takes politics out of the equation and introduces common sense and competition to the health care marketplace. It covers pre-existing conditions, lowers costs, and increases consumer choice by incorporating bipartisan proposals, proven academic research, and scientific data. But most importantly, it is legislation that will give Americans fair coverage at a fair price.

Americans deserve real solutions to their health care issues that the Fair Care Act provides, not partisan talking points and inaction.

Rep. Bruce Westerman represents Arkansas' Fourth Congressional District in the U.S. House of Representatives, where he serves on the Committee on Transportation and Infrastructure and as chairman of the Committee on Natural Resources.

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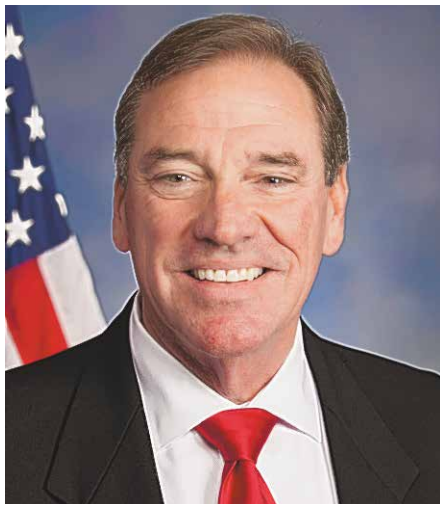
Congress must step up and strengthen health care preparedness



By U.S. Rep. Neal Dunn, R-Fla.

The 21st century has repeatedly exposed the vulnerabilities in America's healthcare system. From the Sept. 11, 2001, attacks to the 2008 financial crisis to the COVID-19 pandemic, unforeseen events have tested the resilience of our national institutions. Few systems were tested more severely than healthcare.

Leaders in Washington have the responsibility to plan for the unexpected. Congress must act now to modernize America's pandemic preparedness laws and strengthen our healthcare system before the next crisis. That is why I am advancing the Protecting Americans from All-Hazards Preparedness Act, to reauthorize and improve the Pandemic and All-Hazards Preparedness Act (PAHPA) and ensure our nation is ready for future threats.

The COVID-19 pandemic revealed both the strengths and weaknesses of the United States' public health and healthcare infrastructure. Fortunately, when the pandemic hit, the authorities granted by PAHPA enabled us to respond to the challenge. PAHPA governed our use of effective personal protective equipment (PPE) and coronavirus treatments.

Preparedness is not an abstract policy goal; it is the difference between order and chaos in an emergency room.

PAHPA also played a key role in authorizing elements of President Trump's ground-breaking Operation Warp Speed, which ended the pandemic and led to the lifting of the lockdowns.

Originally enacted by Congress in 2006, PAHPA sunsets every five years to provide Congress with the opportunity to update and improve the law. Despite proven effectiveness, President Joe Biden let PAHPA expire in 2023. Since then, Congress has used temporary extensions that leave our nation's public health workers in limbo, preventing healthcare leaders from effectively planning for future crises.

We learned in 2020 that the threat of a pandemic remains real despite medical advances. In fact, scientific advances have made the threat of bioterrorism even greater. In 2017, Canadian scientists proved that they could make a genetic copy of an extinct form of smallpox in a lab. The DNA for smallpox, among other viruses, is public knowledge and could be used by anyone, with any motivation, whether a government or a terrorist group.

Other viruses could also be replicated in a lab and then released in a major metropolis, setting off another pandemic. This isn't science fiction; this is reality. For example, the Soviet Union maintained a significant biological warfare capability and planned to use it on the United States in case of war. Russia inherited this program, and North Korea maintains bioweapon capabilities today. China had a bioweapons program until at least the 1980s, and evidence suggests they do to this day. Iran has conducted research that could be used to make bioweapons. Our adversaries have even come onto our own soil, creating illegal biolabs under our noses in California and Nevada.

As a former Army doctor, I spent time at the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID), where I learned the seriousness of the threats we are facing. I saw firsthand how adversaries think about threats and how critical readiness is to national security. As a physician with more than five decades of experience, serving soldiers overseas and later building and running the largest urology practice in the country, I have witnessed the strengths and weaknesses of our healthcare system up close. Preparedness is not an abstract policy goal; it is the difference between order and chaos in an emergency room.

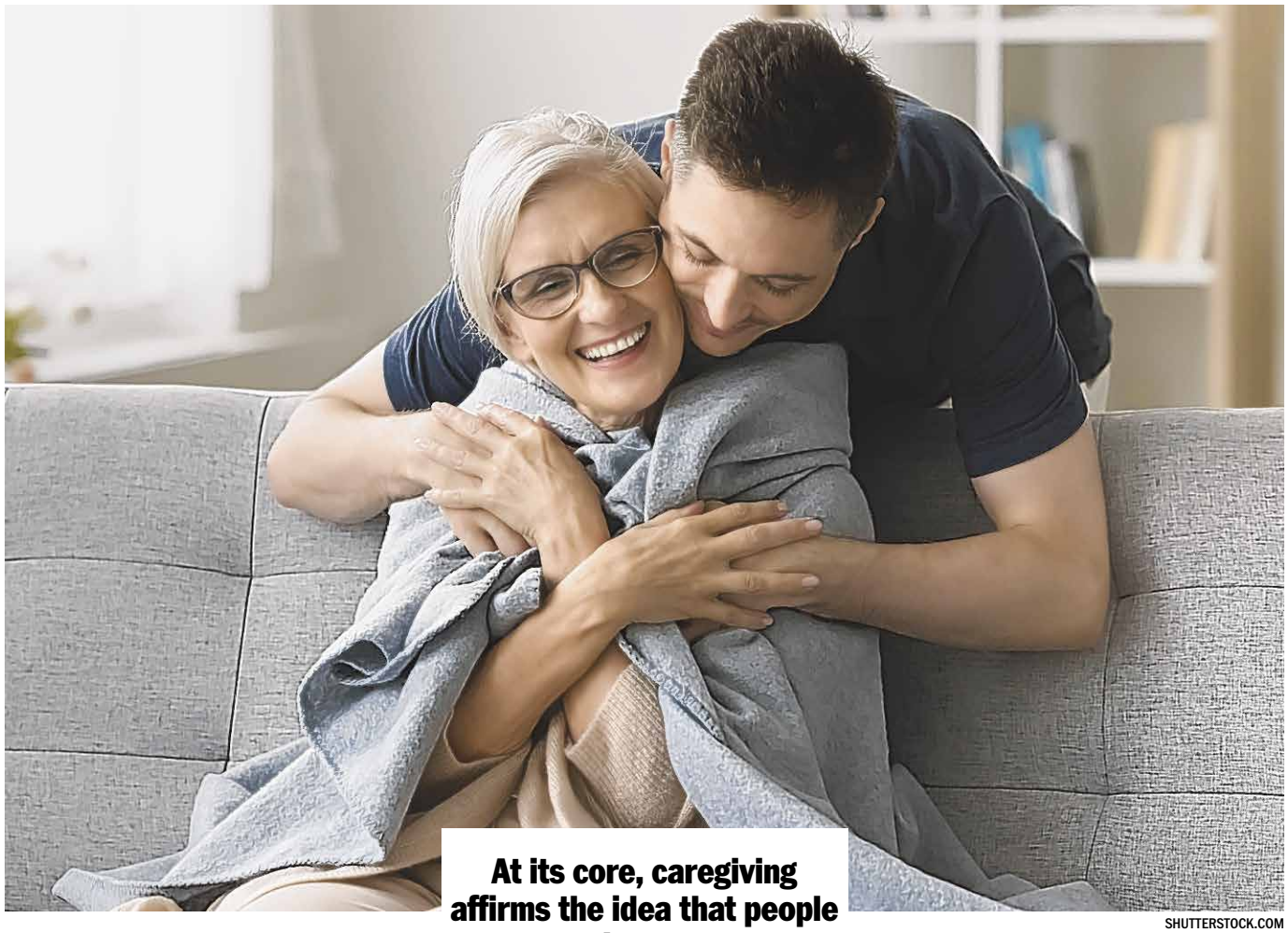
During the COVID-19 pandemic, the United States found itself reliant on China — our principal strategic competitor — for basic personal protective equipment such as masks. We should never again allow such vulnerability. Updating our pandemic preparedness laws also presents an opportunity to reshore critical manufacturing and secure an all-American supply chain for essential goods.

Viruses and bacteria are always evolving, and we must take biological threats seriously. After nearly three years of uncertainty, it's time for Congress to update America's healthcare preparedness laws and reauthorize PAHPA.

Rep. Neal Dunn, M.D. proudly represents Florida's Second Congressional District. Formerly a U.S. Army surgeon for over 10 years, Dr. Dunn serves as the Vice Chair of the House Energy & Commerce Committee. Additionally, he is on the House Select Committee on the CCP. A lifelong public servant, Dr. Dunn practiced medicine in Panama City for 25 years before coming to Congress.

Supporting caregivers is critical to a strong American workforce

By U.S. Rep. Debbie Dingell, D-Mich.



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Caregiving makes all other work possible. Yet too many people don't understand how essential it truly is. Care allows children to grow, older adults to age with dignity, people with disabilities to live independently and families to stay intact during illness or crisis. Nearly everyone will need care at some point in their lives, and most people will either provide it or depend on someone who does.

Caregiving does not stop–someone, somewhere, is always providing care. A parent is packing lunches and tying shoes. An adult daughter is making sure her father took his medication. A neighbor is checking in on a veteran down the street. This work — often unpaid and unseen — is the invisible infrastructure of America, the glue that holds everything else together. While roads, bridges and broadband are essential for economic growth, none of them thrive if families cannot count on safe child care, support for aging parents, or help for a loved one with disabilities.

This is not a partisan issue. It touches families in rural communities and big cities, affecting Democrats and Republicans alike. Most people agree that parents and seniors deserve dignity, our children deserve safety and families deserve support.

Millions of people are juggling jobs and caring for a loved one, often without support. When support is missing, businesses lose experienced employees, and families face impossible choices — like whether to cut back hours, leave a job they love or drain their savings because there is no other option. And this challenge is often carried by women. Regardless of ideology, no one benefits from an economy that quietly pushes capable people out of the workforce simply because they stepped up for their family. According to the Caregiver Action Network, 63 million U.S adults care for a spouse, elderly parent or relative, or special-needs child. Almost half the adults in the so-called sandwich generation, aged 40 to 59, find themselves caring for both their aging parents and for their children.

Caregiving is also about values — who we are as a nation. Do we honor the contributions of older Americans by ensuring they can age with dignity? Do we recognize the sacrifices of family caregivers who manage medications, attend doctor appointments, and balance work with responsibility at home? Investing in care is not charity — it is smart economic policy. When caregiving systems are strong, the entire economy benefits. Workers are more reliable. Employers retain talent. Children enter school ready to learn. Seniors avoid costly hospital stays. The return on investment is not abstract; it shows up in stronger families, healthier communities and a more stable workforce. For too long, we have treated caregiving as an individual problem instead of a shared priority.

It is time to change that. Recognizing caregiving as essential infrastructure means supporting family caregivers, strengthening home- and community-based services, and ensuring child care is affordable and accessible. It means understanding that care work — whether paid or unpaid — has real economic value. That is why I look forward to reintroducing two landmark pieces of legislation, the Home and Community-Based Services (HCBS) Access Act to make HCBS a mandatory benefit, and the Long-Term Care Workforce Support Act to improve caregiver compensation, benefits, and support systems.

At its core, caregiving affirms the idea that people are not disposable once they become vulnerable — and that families should not be punished for doing the right thing.

In Congress we have established the bipartisan Assisting Caregivers Today (ACT) Caucus, which I co-chair with Rep. Jen Kiggans, R-Va. We have introduced a number of pieces of legislation to address shortages in the caregiving workforce and support the mental wellbeing of providers. We will also shortly be introducing legislation to bolster the financial wellbeing of unpaid family caregivers.

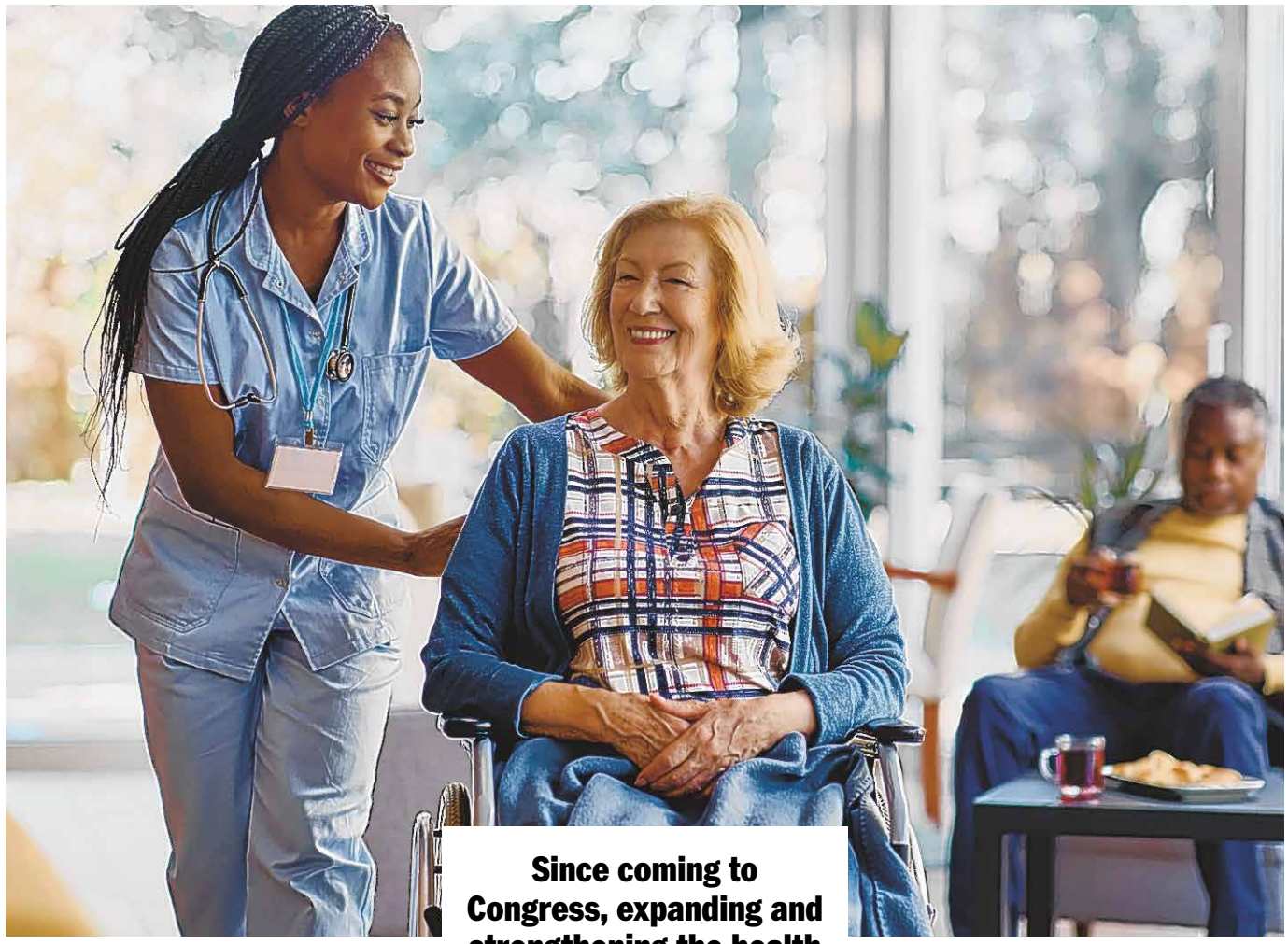
If we want to strengthen America's workforce and support families, supporting caregivers must be at the center of that effort. It matters to communities and states because the demographics are unavoidable. The debate is often about the how, not the need.

At its core, caregiving affirms the idea that people are not disposable once they become vulnerable — and that families should not be punished for doing the right thing. Ultimately, everyone cares about caregiving, because it is personal. It is a phone call in the middle of the night, a parent who can no longer drive, a child who needs extra help, a spouse facing illness. These moments cut through ideology and partisan politics and remind us that strong families and a strong economy depend on care being possible, sustainable and respected. When caregiving is supported, everyone benefits; when it is ignored, everyone is impacted in some way.

Rep. Debbie Dingell represents Michigan's 6th Congressional District. She serves on the House Energy and Commerce Committee's Subcommittee on Health and co-chairs the Assisting Caregivers Today Caucus.

Nursing home reform begins with safe staffing, stronger caregiver support

By U.S. Rep. Jen Kiggans, R-Va.



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Before serving in the halls of Congress, I walked the halls of primary care clinics and nursing homes, caring for our nation's Greatest Generation. From routine checkups to treating patients living with dementia and complex chronic conditions, I had the privilege of serving seniors at every stage of health. That experience is one of the many reasons I entered public service. I saw firsthand how our seniors are directly impacted by the lack of older adult advocacy on the federal level — and I knew we could do better.

During my time in the Virginia State Senate, I introduced Senate Bill 1149 to establish minimum staffing ratios for certified nursing assistants (CNAs) and licensed practical nurses (LPNs), and to require a registered nurse (RN) to be onsite 24 hours a day in nursing homes. The evidence is clear: staffing levels matter. A National Academies of Sciences, Engineering and Medicine study on nursing staff in hospitals and nursing homes found that higher RN hours per patient were consistently and significantly associated with better outcomes — including lower mortality rates, improved patient capacity for self-care and a greater likelihood of timely discharge.

Additional research reinforces this conclusion. A study published in the National Institutes of Health National Library of Medicine in August 2025 examined state variations in staffing ratios following implementation of the federal minimum staffing rule. It found that stronger state staffing standards correlated with higher nursing home quality ratings. However, the study also highlighted that many facilities across the country struggled to meet the new federal requirements — underscoring the serious workforce shortages facing our health care system.

The shortage of health care professionals is deeply concerning, especially as America's aging population continues to grow. Since coming to Congress, expanding and strengthening the health care workforce has been one of my top priorities. We must make the profession more accessible for young people entering the workforce while easing the burden on the nurses currently delivering care.

That's why I supported the Dr. Lorna Breen Health Care Provider Protection Reauthorization Act, which funds programs to address burnout and support the mental health and wellbeing of health care providers nationwide. I was proud to see this legislation included in this year's consolidated appropriations bill so that health care workers receive the support they deserve.

I have also supported legislation to expand workforce capacity and reduce unnecessary barriers to care. H.R. 1317, the ICAN Act, would allow nurse practitioners and physician assistants to practice to the full extent of their training under Medicare and Medicaid. H.R. 392, the PRECEPT Nurses Act, would provide up to a $2,000 tax credit for nurse preceptors who train the next generation of nurses, thus helping strengthen the workforce pipeline.

Since coming to Congress, expanding and strengthening the health care workforce has been one of my top priorities. We must make the profession more accessible for young people entering the workforce while easing the burden on the nurses currently delivering care.

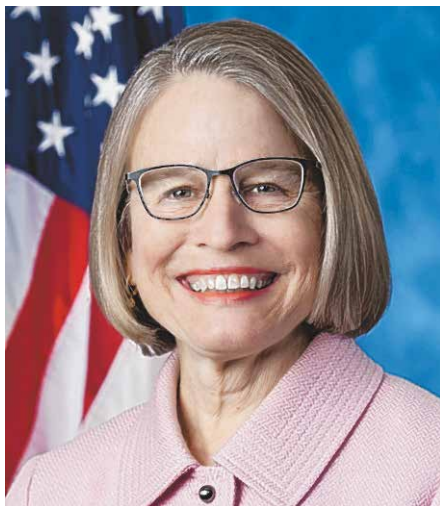
Additionally, I have made it a priority to advocate for recognizing post-baccalaureate nursing programs as professional degrees. I have sent multiple letters to the Department of Education expressing concern about the exclusion of advanced practice nurses from this designation and the long-term consequences it could have on workforce recruitment. If we are serious about addressing staffing shortages and meeting growing patient demand, we must encourage Americans to enter the nursing profession — not create additional barriers.

Nursing home reform begins with supporting the people who provide the care. Nurses are the backbone of our health care system. If we want better outcomes for seniors and patients, we must ensure there are enough well-trained professionals on the floor to provide timely, compassionate care. That means strengthening the workforce pipeline, supporting provider well-being and reducing unnecessary administrative burdens that pull nurses away from their patients.

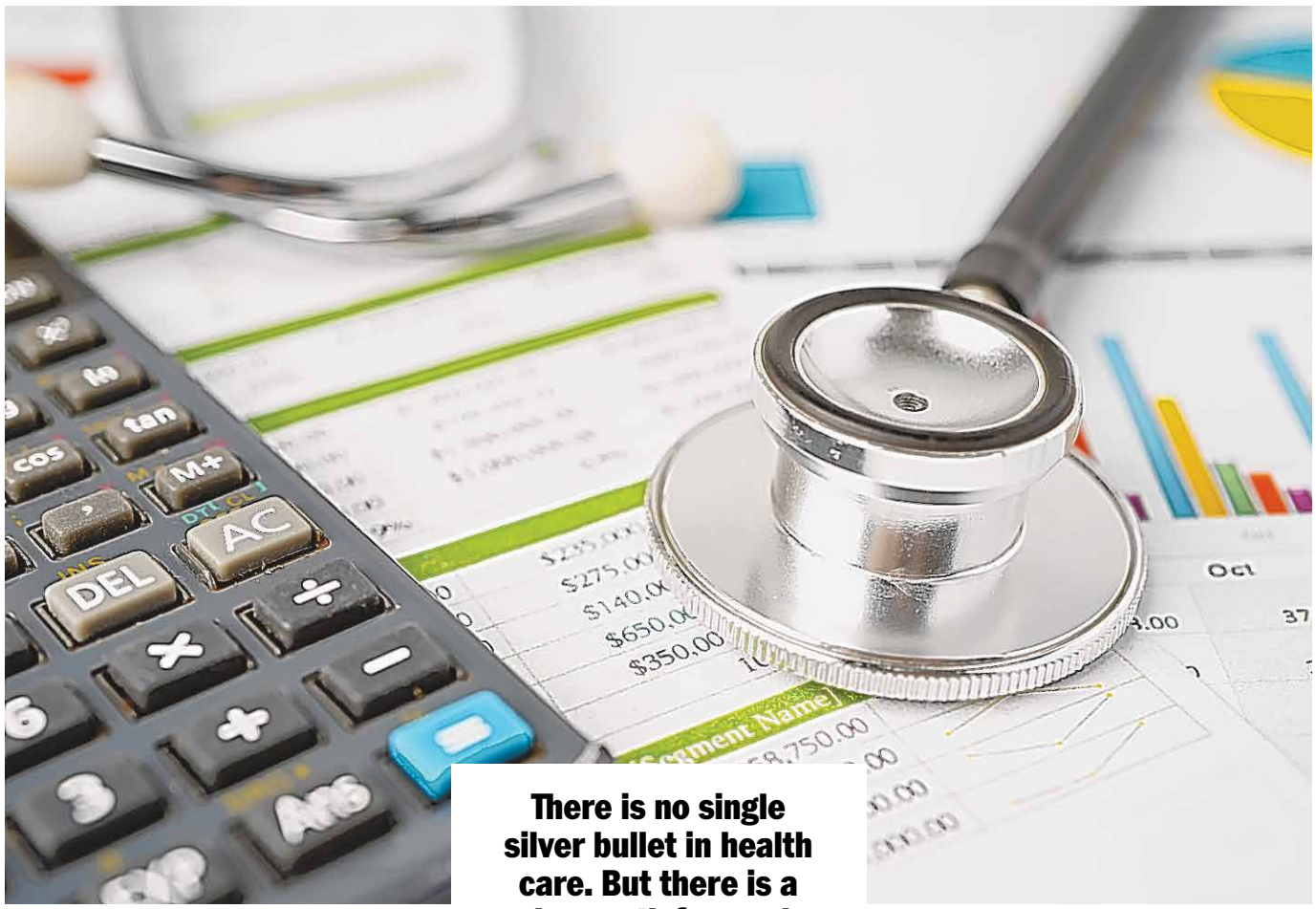
We can protect seniors, support nurses, and be responsible stewards of taxpayer dollars, all at the same time — but only if we build a system that puts patient care first. Our seniors deserve nothing less.

Rep. Jen Kiggans, a Republican, represents Virginia's 2nd Congressional District in the U.S. House of Representatives. She serves on the House Armed Services, Veterans' Affairs and Natural Resources committees. Prior to public office, she served 10 years as a U.S. Navy helicopter pilot, flying H-46 and H-3 helicopters and completing two deployments to the Persian Gulf, and then worked in the health care system as a geriatric nurse practitioner.

Lowering health care costs for ALL Americans



By U.S. Rep. Mariannette Miller-Meeks, R-Iowa



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As a physician, a 24-year Army veteran, and a former director of the Iowa Department of Public Health, I have spent my life caring for patients. In Congress, my mission is just as clear: lower health care costs and expand access to high-quality care for every American.

Health care reform does not have to mean bigger government. In fact, Washington's habit of layering on mandates, micromanagement and bureaucracy has too often driven costs higher, not lower. A conservative approach starts with a simple principle: empower patients, increase transparency, strengthen competition, and hold middlemen accountable.

Costs remain the top concern I hear from families across Iowa. Premiums, deductibles and out-of-pocket expenses strain household budgets. Small businesses struggle to provide coverage to employees. Seniors on fixed incomes are forced to choose between prescriptions and groceries. We can, and must, do better.

That is why I have continued to lead on the Lower Health Care Premiums for All Americans Act, legislation focused on tackling one of the biggest drivers of rising costs: the lack of competition and transparency in our system. When insurers, hospital systems, or other entities consolidate and operate without meaningful market pressure, patients pay the price. My bill strengthens oversight, promotes competition, and helps ensure that savings are passed along to consumers, not absorbed by bureaucracy.

Another area demanding urgent reform is prescription drug pricing.

Across Iowa, I have met with independent pharmacists who are fighting to survive under a system increasingly dominated by Pharmacy Benefit Managers, or PBMs. These middlemen were originally intended to help negotiate lower drug prices. Instead, in many cases, they have become opaque gatekeepers who determine which medications are covered, how much pharmacies are reimbursed, and how much patients pay at the counter.

I have worked with Jane and John Nicholson, owners of Mahaska Drug, a Main Street Pharmacy in Oskaloosa for years now, and they have shared firsthand how PBM practices threaten the viability of community pharmacies. John and Jane are not faceless bureaucrats. They are trusted local health care providers who know their patients by name. When PBMs reimburse pharmacies below cost or steer patients toward preferred networks, it is Main Street that suffers, and patients ultimately lose access and choice.

That is why I was proud to support and help advance the most consequential PBM reforms in years. These reforms increase transparency, curb abusive practices and begin restoring fairness to a system that too often works against patients and independent pharmacies alike. Conservative reform does not mean abandoning oversight. It means ensuring markets function honestly and competitively.

There is no single silver bullet in health care. But there is a clear path forward: transparency over secrecy, competition over consolidation, innovation over stagnation and patients over special interests.

Lowering health care costs also requires addressing chronic disease, expanding preventative care, and embracing innovation. Early detection technologies, value-based payment models and telehealth expansion all offer pathways to improve outcomes while reducing long-term costs. A healthier population is not only a moral imperative, but also an economic one.

We must also ensure that federal health programs are sustainable and focused on those they were designed to serve. That means rooting out fraud, waste, and abuse, strengthening program integrity, and resisting policies that expand bureaucracy without improving care.

There is no single silver bullet in health care. But there is a clear path forward: transparency over secrecy, competition over consolidation, innovation over stagnation and patients over special interests.

Conservatives believe in empowering individuals, not systems. We believe families, doctors and patients, not Washington bureaucrats, should drive health care decisions. And we believe that real reform means delivering measurable relief to the people who pay the bills.

As we look ahead to 2026, my focus remains where it has always been: lowering costs, protecting patient choice, strengthening local providers and ensuring that every American can access quality care without financial ruin.

Health care is personal. It is about peace of mind. It is about dignity. And it is about keeping our promises to the people we serve.

That is the standard I will continue to fight for in Congress.

Rep. Mariannette Miller-Meeks, M.D., has represented Iowa since 2021. A retired Army officer and ophthalmologist, she is a member of the House Committee on Energy and Commerce, where she sits on the subcommittees on Health, Energy and Environment. She's also a member of the House Committee on Veterans' Affairs, where she serves as chairwoman of the Subcommittee on Health.

Keeping pace with innovation: Empowering Americans in the age of wearables

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By U.S. Rep. Troy Balderson, R-Ohio

Americans are paying more attention to their health than ever before. From scrutinizing ingredient lists to prioritizing sleep and recovery, people across the country are becoming more engaged in their own well-being.

At the center of this movement are wearable health devices.

Products like smartwatches, fitness bands and rings now offer insights that once required a visit to a doctor or specialist. They help answer everyday questions that matter: Did that late-afternoon coffee affect my sleep? Has increasing my activity lowered my resting heart rate? Am I recovering well, or should I take it easy today?

I've seen this evolution firsthand. Decades ago, wearable health tech was bulky, expensive, and mostly limited to elite athletes. Today, it fits on your wrist — or even your finger — and it's being used by people of all ages. My own mother, now in her 80s, can track her steps and better understand how she's feeling from one day to the next.

I'm an early adopter myself. I've worn a smartwatch for years. It tracks my workouts, heart rate, sleep, respiration and VO2 max, and even estimates a "fitness age" compared to my actual one. These tools don't replace a doctor — but they make me a more informed, engaged patient.

In fact, when I go in for my annual physical, I can hand my phone to my physician and review trends together. Having this data already in hand sparks better conversations, better questions and better decisions.

But as exciting as this progress is, innovation is now moving faster than our regulatory system.

Wearable companies are packing more sensors, features and capabilities into consumer devices at a rapid pace. But Washington's regulatory framework wasn't built to keep up with health-focused technology that evolves this quickly.

Technology has a long history of outpacing the federal government. But when regulation lags too far behind, it can delay access to safe, low-risk innovations — and discourage the very breakthroughs that have made American products competitive globally.

This is where Congress needs to act.

In the coming weeks, I will introduce legislation to modernize how certain low-risk digital health screening functions on wearables are reviewed and approved. The goal is simple: create a streamlined, tailored regulatory pathway that protects consumers without bogging down innovation.

My bill provides the Food and Drug Administration with clear legislative guidance on how to approach these emerging tools. It encourages collaboration between regulators and device manufacturers, rather than forcing innovators into outdated, one-size-fits-all processes designed for traditional medical devices.

Safety and accuracy remain front and center. But we also need a system that recognizes the difference between high-risk medical interventions and low-risk digital health screeners that help people better understand their own bodies.

Safety and accuracy remain front and center. But we also need a system that recognizes the difference between high-risk medical interventions and low-risk digital health screeners that help people better understand their own bodies.

This matters not just for patients, but also for the entire health care system. When individuals are more engaged in their health, outcomes improve—and costs can come down.

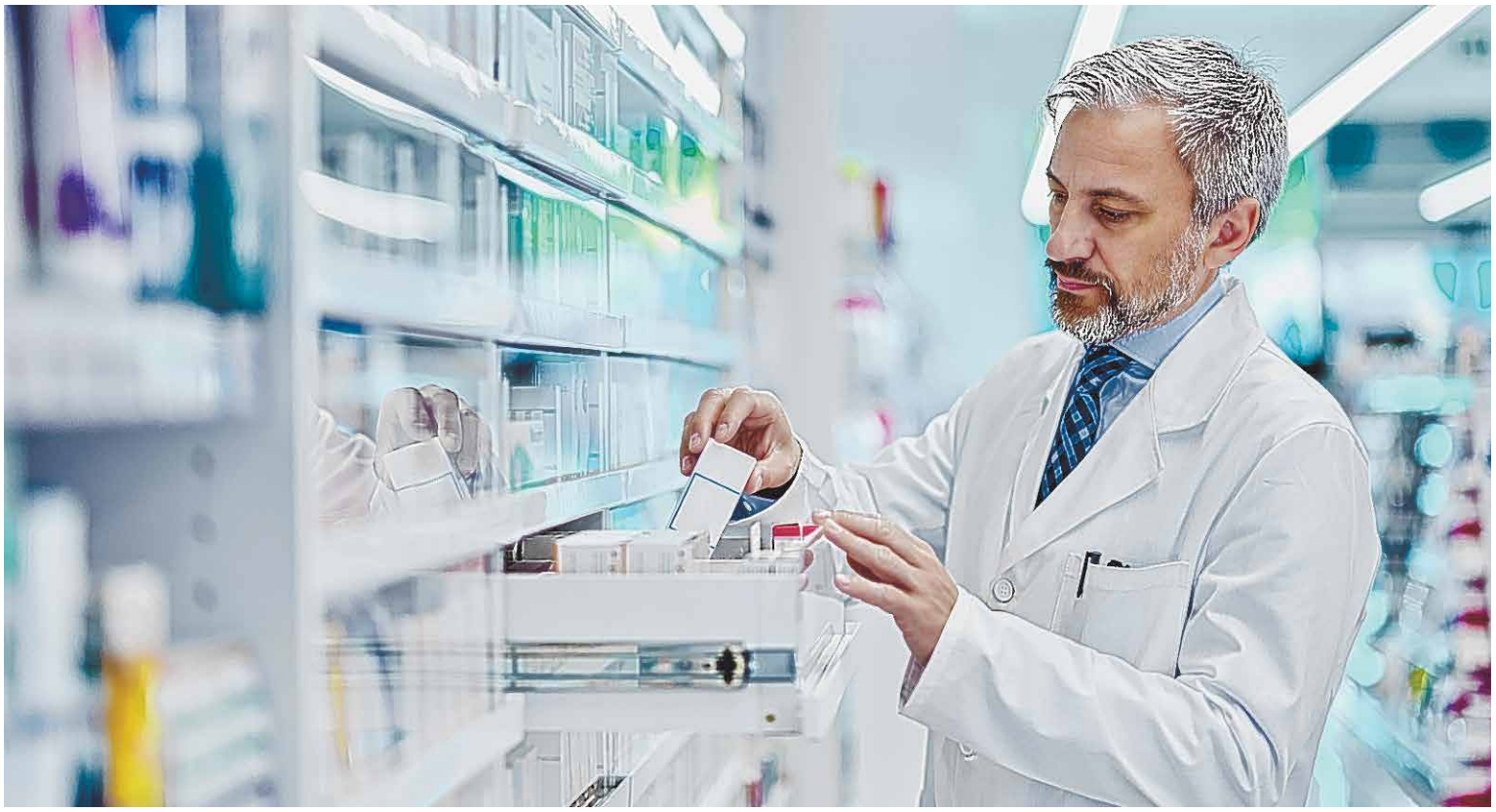
There's also a bigger picture to consider. The United States leads the world in health innovation, but that leadership isn't guaranteed. If we fail to modernize our regulatory approach, we risk falling behind while other countries race ahead.

Just as important as innovation is protecting Americans' personal health information. Consumers deserve confidence that the data generated by their devices is secure, transparent and used responsibly. As this discussion unfolds on Capitol Hill, I will be committed to establishing strong privacy safeguards and clear accountability.

Republican or Democrat, we all want healthier lives for ourselves and our families. Modernizing regulations to keep pace with innovation shouldn't be controversial; it should be expected. And in 2026, learning more about your health shouldn't be limited to the four walls of a doctor's office.

As co-chair of the Congressional Digital Health Caucus, I believe we should use every tool at our disposal to bring care directly to patients, wherever they are, and whenever they need it. With thoughtful, modern regulations, we can empower consumers, support innovators and ensure America remains the global leader in digital health.

Rep. Troy Balderson represents Ohio's 12th Congressional District. He serves on the House Energy and Commerce Committee.



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Congress reduced prescription drug costs. Let's do it again

By U.S. Rep. Buddy Carter, R-Ga.

Shannon, a pharmacy technician, describes the challenges Americans have been facing with the high cost of prescription medications: "I cannot even count the number of times I have heard someone walk away saying, 'I can't afford this.'"

This is unacceptable, and under President Donald Trump, Congress agreed: Something must change.

That's why we passed my PBM Reform Act as part of the Consolidated Appropriations Act, 2026.

The PBM Reform Act, which I introduced earlier this year with a bipartisan group of colleagues, reins in pharmacy benefit managers (PBMs). The top three PBMs process nearly 80% of all prescription drugs dispensed by pharmacies. These PBMs have been manipulating drug prices and restricting access to affordable medication for their own financial benefit for decades. With this legislation, we took measurable steps to address the root causes of predatory practices that are negatively affecting Americans' health and bank accounts.

PBMs have strayed far from their original purpose, which was using their buying power to achieve lower prescription drug costs for employers and consumers.

PBMs have strayed far from their original purpose, which was using their buying power to achieve lower prescription drug costs for employers and consumers. Today, by contrast, PBMs, owned by insurers in vertically integrated conglomerates, drive up prices by controlling drug formularies and steering patients toward higher-priced drugs. PBMs often prefer high list price medicines that enable them to collect larger rebates from manufacturers while at the same time restricting patient access to less expensive drugs like generics and biosimilars.

The PBM Reform Act corrects this bad practice by delinking PBM compensation from drug costs. Paying PBMs a fair, flat, market-based fee for their services eliminates this perverse incentive and ends the practice of these middlemen getting between patients and their physicians by deciding which medications a patient can or cannot take.

This bill also protects community pharmacies by requiring the Centers for Medicare and Medicaid Services to define and enforce "reasonable and relevant" contract terms in Medicare Part D pharmacy contracts. This means PBMs can no longer run roughshod over the small businesses that serve patients every day.

Additionally, the bill mandates a long-overdue higher level of transparency from the PBMs so employers and patients will be able to see how PBMs structure drug costs and determine formularies. For too long, these massively profitable companies have hidden their practices behind an opaque shield to prevent patients and pharmacists from understanding how the money flows. Under President Trump, those days are over.

Let me be clear: This is not the end of the road. Congress still must focus on banning the practice of "spread pricing" in which PBMs reimburse pharmacies less than what they charge health plans for the same medications, pocketing the spread as profit. This practice is pushing too many community pharmacies, often the most accessible or only health care providers for many patients in rural or underserved areas, out of business.

When a pharmacy closes, a community loses a vital health care resource. We need to use every available tool to bring an end to PBM practices that are forcing these small business owners to close their doors for good.

By passing the PBM Reform Act, we are shifting power back to patients and consumers and making an immediate impact on lowering their prescription drug costs.

Patients fought long and hard for this change. There is still a lot more work to be done, but I'm proud that under unified Republican leadership, we are building a health care system that puts patients ahead of profits.

Rep. Buddy Carter is a Republican representing the First Congressional District of Georgia. As a former small businessowner and pharmacist, he ran and operated his own chain of retail pharmacies for more than 30 years.

Americans Want Medicare to Cover Dental, Vision, and Hearing

58% of Seniors Skip Medical Procedures, With Dental, Vision and Hearing Care Most Affected

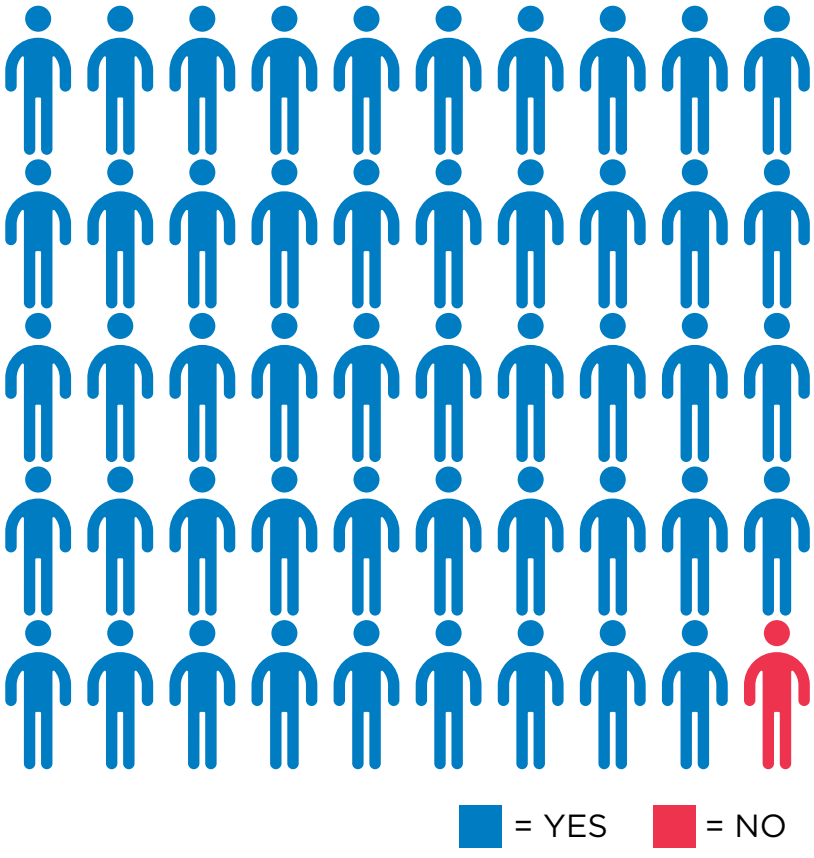
A recent national poll shows overwhelming support for strengthening Medicare: **98% of respondents said Medicare should provide basic dental, vision, and hearing coverage**, while only 2% opposed.

These essential services are critical to maintaining seniors' health, independence, and quality of life, yet traditional Medicare still does not cover them. As Congress considers **H.R. 2045**, legislation that would add dental, vision, and hearing benefits to Medicare, **the message from older Americans is clear:** it is time to modernize Medicare to reflect today's healthcare needs.

Ensuring access to these fundamental services would help millions of seniors stay healthier, detect medical issues earlier, and avoid more costly health complications later.

THE SENIOR CITIZENS LEAGUE
An Affiliate of TREA The Enlisted Association

Should Medicare provide basic Dental, Vision & Hearing coverage?



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