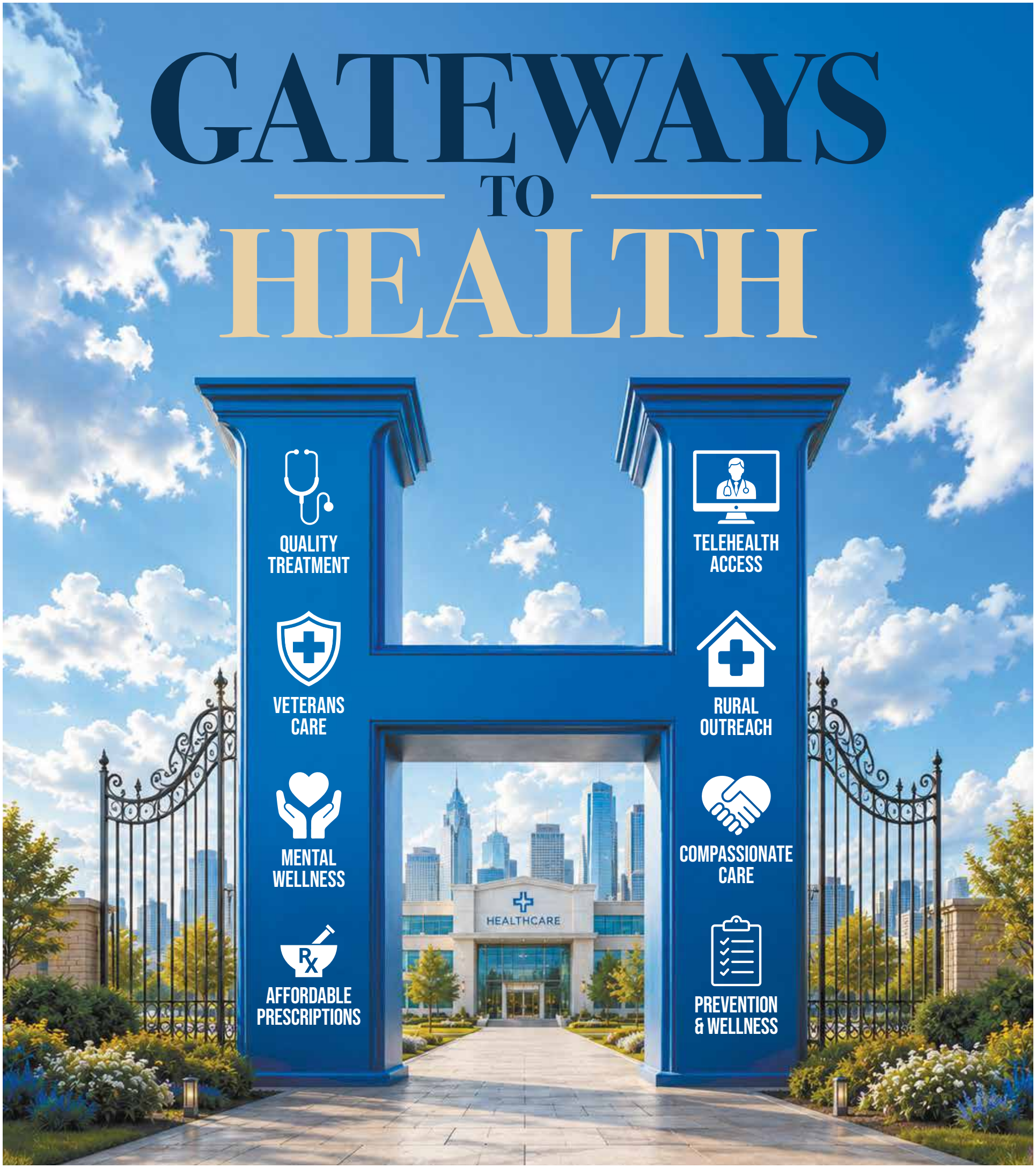
GATEWAYS TO HEALTH



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Gateways to Health

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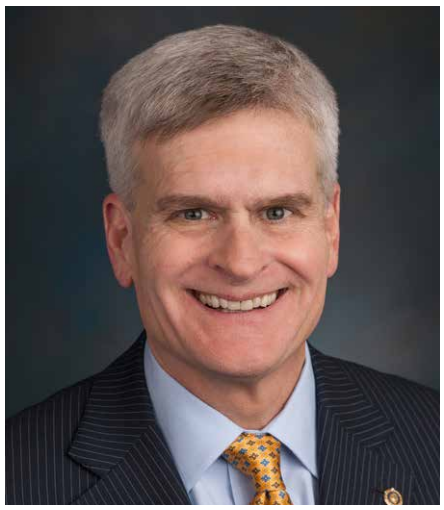
The families Washington health policy forgot



By U.S. Sen. Bill Cassidy, R-La.

The most expensive day in many American families' lives isn't the day they buy a house or a car. It is the day they have a baby.

A young couple earning $100,000 or $125,000 a year may feel solidly middle class. They have jobs, they have health insurance through work and they are doing everything society expects of them. Yet when a child is born, they often discover that having insurance is not the same thing as being financially secure.

They may spend thousands of dollars on premiums before the baby arrives and thousands more on deductibles, copays, prescriptions, and other medical expenses afterward. By year's end, health care can consume more than 10% of household income. That makes health care one of the largest expenses in the household budget.

The MVP Plan — Money and Value for Patients — starts with a simple idea: if Washington is going to help Americans afford health care, it should help the families caught in the middle — those earning too much to qualify for full assistance yet still struggling to pay the bills.

If Washington is going to help Americans afford health care, it should help the families caught in the middle — those earning too much to qualify for full assistance yet still struggling to pay the bills.

The proposal does two things. First, it requires price transparency so that the patient has the power to make the best decision for their pocketbooks and their health. Second, it pre-funds health savings accounts for middle-income families with employer-sponsored coverage so that they have money in their pocket at the beginning of the year for their out-of-pocket costs.

The MVP plan focuses most on middle-income families because America's health-care subsidy system is upside-down. Most Americans assume federal health care assistance primarily helps lower-income families, but the reality is that the system provides its largest subsidies at both ends of the income spectrum.

At the lower end, Medicaid often covers nearly the entire cost of health insurance. Families purchasing coverage through the Affordable Care Act exchanges frequently receive subsidies covering 80%, 90%, or even more of the total cost of coverage. At the upper end, the tax code provides substantial assistance through the favorable treatment of employer-sponsored insurance.

Between those groups lies a vast population of working Americans who often receive comparatively less assistance than either group, despite carrying some of the largest health care burdens relative to income. The result is what might be called a subsidy valley.

Federal assistance is highest at the bottom of the income scale. It rises again near the top. And it falls in the middle, precisely where millions of working families are trying to pay mortgages, raise children, save for college and absorb rising medical costs.

If health policy were designed from scratch today, no one would intentionally build a system this way. That is why the MVP Plan focuses on middle-income families with employer-sponsored insurance.

The proposal does not attempt to replace Medicaid. It does not dismantle employer-sponsored coverage. It does not create a new entitlement. Rather, it fills the gap created by our current system.

Most families need protection from predictable costs, not million-dollar medical catastrophes. In fact, for most households, annual out-of-pocket spending is less than the proposed HSA contribution. In practical terms, that means many families would have little or no out-of-pocket medical spending during a typical year.

As an example, a parent taking a child to the pediatrician would not have to wonder how the bill would be paid. MVP provides financial certainty, ensuring families no longer see their deductible every January and hope no one gets sick.

That is why the most important measure is not the premium. It is the total cost of being insured.

A family paying $7,000 in premiums and another $4,000 in medical expenses experiences healthcare as an $11,000 annual obligation. Whether those dollars are labeled premiums, deductibles, copayments or coinsurance makes little difference to the family budget.

The MVP Plan attacks both sides of that equation.

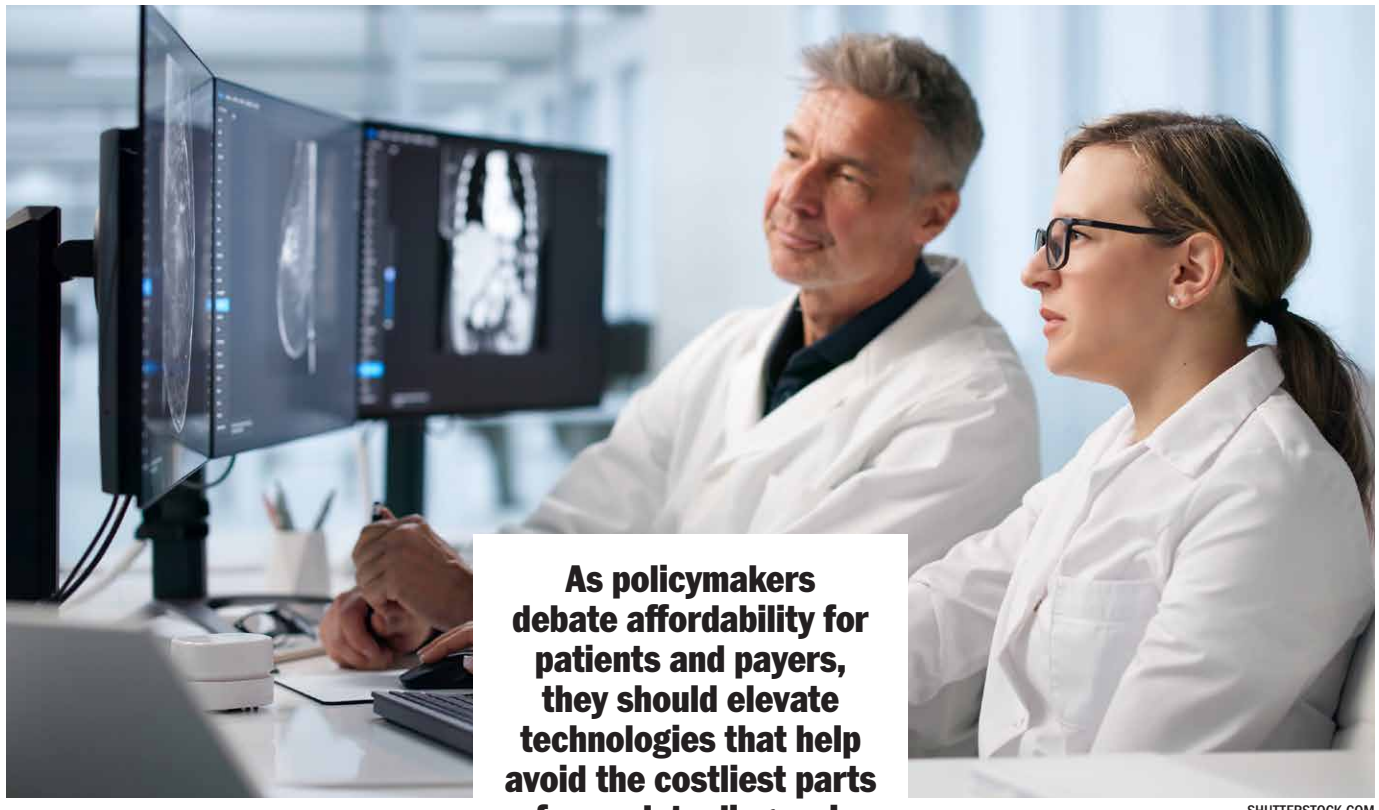
Premiums fall because the system becomes more transparent and competitive. Out-of-pocket spending falls because families receive resources before medical bills arrive. The result is a health-care system that directs assistance where affordability problems are greatest.

For decades, health-care reform has focused on expanding coverage. The next challenge is making coverage affordable once families have it.

Middle-income Americans should not be the forgotten families of health policy; they should be its central focus. That is what the MVP Plan seeks to achieve.

Sen. Bill Cassidy, M.D., is Chairman of the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee.

Medtech: A great value in American healthcare



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By Scott Whitaker

There is a lot of talk in Washington about "value" in healthcare. Some suggest the best way to create value is to simply lower costs by limiting the procedures and products available to patients. But what this misses is the long-term value these procedures and technologies provide both to patients themselves and the healthcare system overall. The medtech industry has a powerful story to tell here: The cost of the medical technologies, devices, and equipment that fill hospitals, clinics, and home healthcare settings has remained very steady for decades. Not only is medtech not a cost driver; it is actually a cost saver. Here's how.

The diagnostic tests, technologies, implants, wearables and digital tools developed by medtech innovators help doctors find disease earlier, treat it more precisely and manage it before a crisis requires far more expensive, invasive, and possibly even less effective treatment. Increasingly, AI-enabled medtech, for example, has the potential to extend that value.

Consider breast cancer screening. A prominent study found that AI-assisted mammography helped doctors detect 29% more breast cancer instances than radiologist review alone, without increasing false positives. It also reduced doctors' reading workload by 44% and found 51% more in situ cancers, often described as non-invasive.

The stakes are clear. When breast cancer is found before it has spread, about 99% of patients are alive five years later. When it is found after spreading to other parts of the body, that rate falls to roughly 30%. The financial stakes move in the same direction. Early treatment can take weeks; late treatment can mean years of surgery, chemotherapy, medicines, repeat scans, emergency visits and other care. By one analysis, breast cancer treatment costs were roughly twice as high for later-stage disease as for earlier-stage disease.

Those potential savings are not abstract. They are hospital days not needed, procedures avoided, complications prevented, and costs Medicare, Medicaid, employers and families may not have to absorb. Across the roughly 288,000 women diagnosed with breast cancer each year, even a modest shift from late diagnosis to early diagnosis could save lives and reduce spending.

That same value proposition appears across many areas of healthcare, including diabetes, which cost the United States $412.9 billion in 2022. Some of the most expensive episodes are dangerous blood sugar emergencies that send patients to the emergency room or ICU. Continuous glucose monitors help patients see problems earlier and act sooner.

One large real-world study found that starting a flash glucose monitor was associated with reductions in hospitalizations for serious diabetes emergencies in both Type 1 and Type 2 diabetes, with the improvement lasting two years. Every avoided admission can mean fewer emergency visits, inpatient stays, and related costs.

Cardiac care tells the same story. For a patient having a heart attack, a stent can reopen a blocked artery before the heart is badly damaged. One widely cited economic analysis found that reopening blocked arteries after a heart attack adds more than a full year of life expectancy at a cost near $40,000 — a strong value by commonly used medical cost-effectiveness standards.

Outcomes keep improving: one recent analysis found that deaths within a year after emergency artery-opening procedures for the most serious heart attacks fell by roughly 30%. Without timely treatment, patients face greater risk of heart failure, repeat hospital stays, disability and higher long-term costs.

As policymakers debate affordability for patients and payers, they should elevate technologies that help avoid the costliest parts of care: late diagnosis, preventable hospital stays, complications, disability and worsening disease.

Medical technology, alongside advances in prevention, treatment and care delivery, has contributed to major public health gains. Since 1950, death rates from heart disease have fallen by roughly three-quarters. Across five major cancers, prevention and screening helped avoid 4.75 million deaths over 45 years. Another analysis estimated that cancer screening generated $6.5 trillion in value and 12 million years of life over 25 years.

This should matter to budget hawks. Medtech is a part of healthcare where competition and iterative innovation can improve products while helping hold prices in check. It accounts for less than 6% of national health spending. Since 2000, overall medical prices have risen much higher than the prices for medical equipment made by manufacturers.

Part of the reason is that medtech is fast-moving and highly competitive. Companies invest more than $20 billion each year in research and development, and improved products often reach patients every one to two years. Each new version aims to do more for patients while reducing burdens on doctors, hospitals, and payers. That value is not theoretical. It is realized every day in operating rooms, heart procedure rooms, imaging centers, clinics, and homes across America.

It is also an American strength. U.S.-made technologies supply about 70% of the domestic market, generating more than $250 billion in annual output and nearly three million direct and indirect jobs across 16,000 facilities in all 50 states. The industry exported $80 billion in 2024 — more than automobiles or semiconductors. America is a global leader in medical innovation, supporting patients, workers, and communities at home.

At the same time, the federal government is now the largest payer of the nation's $5.3 trillion healthcare bill. As policymakers debate affordability for patients and payers, they should elevate technologies that help avoid the costliest parts of care: late diagnosis, preventable hospital stays, complications, disability and worsening disease.

Those are just the kinds of results we all want: earlier answers, earlier treatment, and better use of a strained healthcare workforce.

For the woman whose cancer is caught early, the man with diabetes who avoids the ICU, and the heart attack patient who walks out of the hospital alive, the value of medtech is concrete. By helping deliver earlier diagnoses, better outcomes, and avoided downstream costs, medtech should be a headline, never a footnote, in healthcare policy debates.

Scott Whitaker is President and CEO of AdvaMed.

AdvaMed
The Medtech Association

The Value of Medical Technology

Medical technology is helping doctors detect disease earlier, treat it more precisely, and improve patient outcomes. From advanced cancer screening to continuous glucose monitoring and lifesaving cardiac interventions, medtech is changing what's possible in health care every day.

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Put patients back in charge of their healthcare

By U.S. Reps. Andy Harris, R-Md., and Eric Burlison, R-Mo.

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In 2000, the average family paid about $6,000 a year for health insurance. Today, that figure has climbed to nearly $27,000, rising at more than twice the rate of inflation over the same period. It's no surprise that healthcare affordability remains a top concern among Americans. As costs continue to climb, more working adults are choosing to go without health insurance altogether.

Democrats, responsible for the inception of Obamacare and our current crisis, tell you that the solution is more government spending and intervention in the free market.

But the United States already spends more on healthcare than any other nation, and the government finances more than half of this spending. Propping up a broken system with more taxpayer cash is a guarantee for failure — leaving patients and providers feeling stuck and powerless in a system devoid of choice.

Americans need real solutions, not more government subsidies, control and free market intervention.

In a departure from most of our nation's past, big government, big Pharma and insurance companies are now deeply entrenched in the American healthcare system. Invariably, insurers like the federal government, private insurance companies or large employers are fronting costs that would otherwise be paid by the patient. Providers, free from accountability to the patient and in short supply, have no incentive to reduce or even communicate prices when the patient is not directly involved in decision-making.

Imagine walking into a grocery store where nothing has a price tag, you don't know what your total cost will be for weeks or months later and someone else decides which products you are allowed to purchase.

No one should tolerate this experience. Yet, this is how America's healthcare system functions.

It's past time Congress puts patients — not insurance companies or bureaucrats — first, and empowers Americans to take control of their own healthcare decisions.

But talk is cheap. Americans want action. Your favorite Republican in Congress probably frequently opines on the failure of Obamacare and will happily lecture Americans on the pitfalls of socialized medicine. But what good is any of that without offering an alternative?

Right now, House Republicans hold the majority. We have a president demanding action, and we even have proposed legislation that offers a path forward. What remains is the political will to pass it.

Earlier this year, Rep. Eric Burlison introduced the Great American Healthcare Plan, built largely around President Trump's call to "give the money to the people," and give Americans control over their own healthcare dollars. At the center of the legislation is an expansion of Health Savings Accounts (HSAs), empowering individuals to save and spend tax-free dollars on qualified medical expenses that they feel is right for them and their family.

When patients spend their own money, they become active participants in their own healthcare. With an HSA, and the freedom to choose the insurance plan that best fits their needs, consumers can research providers, compare prices, evaluate quality and make informed decisions about their care. Providers, in turn, must compete on both cost and quality, rather than aiming their practices to maximize reimbursements from the federal government or insurance companies.

It's no surprise that in our current system, where insurers are insulated from competition and negotiate in secret, price transparency is nowhere to be found. In virtually every other sector of the economy, consumers can compare prices and quality before making a purchase. Healthcare should be no different.

Patients deserve to know what a procedure will cost before they receive care, not months later when an uninterpretable insurance statement or bill arrives.

To help make that possible, the Great American Healthcare Plan requires hospitals and other providers to publicly post their prices every month in a standardized, searchable format. Insurance companies must also regularly report what they pay for medical services to federal and state regulators, increasing transparency across the healthcare system. Quality metrics are already available through Medicare, and other systems should be created.

Throwing more money at insurance companies and providers via subsidies (especially Obamacare) and Medicaid isn't the solution to America's healthcare crisis, as Democrats so often suggest. Our system suffers from a lack of transparency, government and insurance company intervention that insulates costs from consumers and perverse incentives that create a government-backed race to the bottom. By expanding HSAs, enforcing price transparency, encouraging robust competition and putting patients back in control of their healthcare dollars, we can build a system that delivers better care at a lower cost while promoting quality. It really is that simple.

It is long past time for conservatives to do what President Donald Trump has called for and what Americans have demanded since we took back the White House. Give the money to the people. Trust and empower Americans to make their own healthcare decisions. Give them the tools to succeed in a market driven by patients, instead of by government mandates, large insurance companies, and distorted incentives.

Democrats are counting on Republicans to maintain the failing status quo. If the faulty Obamacare scheme continues to implode through premium growth that is not sustainable, it will only fuel their cries for a government-run healthcare system, rivaling Canada and the United Kingdom, where patients die waiting in line for care.

Failure is a choice.

But we have the necessary legislation to avoid continued failure, and the American people are waiting.

Rep. Andy Harris, M.D., represents Maryland's 1st Congressional District. He serves as Chairman of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies subcommittee on the House Appropriations Committee and active member of the GOP Doctors Caucus.

Rep. Eric Burlison represents Missouri's 7th Congressional District and chairs the Economic Growth, Energy Policy, and Regulatory Affairs subcommittee in the House Committee on Oversight and Government Reform.

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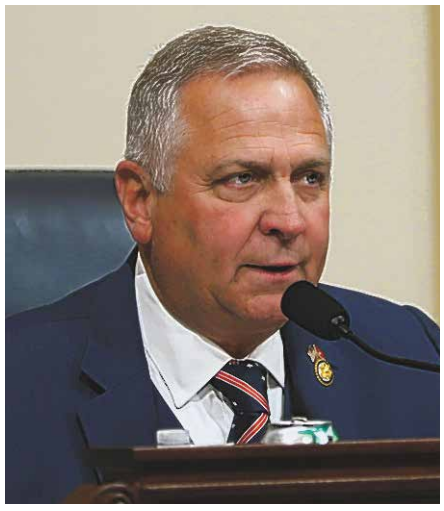
More healthcare, less red tape for veterans nationwide



By U.S. Rep. Mike Bost, R-Ill.

The Department of Veterans Affairs (VA) is the largest integrated healthcare system in the United States. Together with community doctors, millions of veterans receive the healthcare benefits they are eligible for, whether it's specialized treatment for a chronic back injury from long days working on aircraft carriers or care from their local doctor for a routine physical that's close to home and on time — not three hours away at the nearest VA hospital. Our men and women who have served deserve a big-tent VA healthcare system that meets them where they are.

But during the Biden administration's management of VA, hand-picked bureaucrats prioritized protecting VA's healthcare bureaucracy over the veteran patient's choice in care. That goes against the intent of President Barack Obama's CHOICE Act and President Donald Trump's MISSION Act. Both laws promised veterans that the wait-times scandals like the one in Phoenix over ten years ago — where veterans were placed on a fake wait list for healthcare appointments — would never happen again and that, when VA could not provide timely care, a private doctor would step in. Biden administration officials directed VA employees to "not make VA community care an easy button." For me, that's unacceptable. That's not what veterans deserve. And it reaffirmed that we must cement more in law to ensure that veterans across the country — and its territories — can get the quality, timely healthcare they need.

The Take Care of America's Veterans Act takes another step to build on that pledge. This sweeping veterans' package includes major provisions to continue to expand – and protect – healthcare access. The bill includes the Veterans' ACCESS Act, which safeguards veterans' healthcare choice eligibility so that no one — no matter who is in charge of VA — can restrict community care appointments. Those community care appointments save lives, point blank. And because it can be the difference between life and death for a veteran to get the care they need close to home, House Republicans' bill will increase access for veterans who are struggling with substance abuse and addiction and expand eligibility so they can use their VA healthcare benefits at treatment facilities closer to home and near their families.

For a veteran who has tried three times to go to rehab but is either paying out of pocket, missing their kids, or unable to afford to take the time off work to go to the outpatient facility that's included in their coverage but is hours away, the status quo isn't cutting it.

The bill also includes major advancements for veterans living with traumatic brain injuries, mTBIs, and the effects of exposures to blasts during time in service, especially the effects these injuries can have on a veteran's mental health. By advancing research, treatment and understanding of these injuries, we will be able to propel VA forward so that it can continue to develop modern care and get veterans the right neurorehabilitation treatment and support so that they can live comfortably with these injuries.

A lot of times in Washington, we can get caught up in the details, because it's easier to stick to the status quo. But for a veteran who has tried three times to go to rehab but is either paying out of pocket, missing their kids or unable to afford to take the time off work to go to the outpatient facility that's included in their coverage but is hours away, the status quo isn't cutting it.

As Rep. Dr. Mariannette Miller-Meeks' rightly named No Wrong Doors Act, which is included in the package, suggests, House Republicans believe that we should be opening more doors than ever for rural and urban healthcare access. That's exactly what the Take Care of America's Veterans Act does. Whether it's keeping that door open for a primary care appointment or continuing to provide grants to community-based mental health organizations or opening up a new door for a veteran struggling with substance abuse, my bill would advance those promises to make a difference in veterans' day-to-day lives, and I'm proud to lead this effort.

Rep. Mike Bost is a Marine veteran and represents Illinois' 12th congressional district and serves as chairman of the House Committee on Veterans' Affairs in Congress.

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America's edge begins with its aviators

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

Military aviation has always been deeply personal to me. Military aviators operate at the tip of the spear. They launch from aircraft carriers in darkness, navigate rapidly changing conditions and make split-second decisions in some of the world's most unforgiving environments. These missions require exceptional skill, physical endurance, sound judgment and unwavering dedication.

American military aviation is second to none, not simply because we operate the world's most advanced aircraft, but because of the exceptional patriots who fly them. Their professionalism, sacrifice and commitment to the mission embody the very best of America.

Our national security depends on their ability to succeed. Whether they are defending American forces, deterring our adversaries, delivering humanitarian assistance or supporting operations around the world, military aviators are always ready to accomplish the mission.

We owe them the same level of commitment.

Protecting aviator health is essential to maintaining military readiness. Our aviators are among our nation's most highly trained and valuable assets. We invest years and significant resources preparing them to operate sophisticated aircraft under demanding conditions. Our military has made tremendous advancements in aircraft safety, protective equipment, medical care and human-performance programs. However, we still have more to learn about the unique conditions of military aviation including altitude, pressure changes, repeated acceleration, high-G forces and demanding operational schedules. To answer these questions, we must use research and innovation to make our world-class aviation force even stronger.

Whether they are defending American forces, deterring our adversaries, delivering humanitarian assistance or supporting operations around the world, military aviators are always ready to accomplish the mission. We owe them the same level of commitment.

As both a former Navy helicopter pilot and a nurse practitioner, I believe good healthcare policy must be guided by evidence. That is why I introduced the *Warrior Impact from Neurological and G-Force Stress (WINGS) Act*.

The *WINGS Act* directs the secretary of Veterans Affairs to conduct a long-term study of military aviation veterans. By examining flight histories, operational exposures and long-term health outcomes, this research will help military leaders and medical professionals strengthen aviator health, sustain peak performance and preserve operational readiness throughout an aviator's career.

That knowledge can help us enhance preventive care and ensure aviators remain healthy, capable and mission ready. It can also help defense officials improve protective equipment, training practices and health-monitoring programs for the next generation of aviators.

I am encouraged that a version of the *WINGS* Act focused on late-career military aviators was included in the Fiscal Year 2027 *National Defense Authorization Act*. Together, these efforts can help the Departments of Veterans Affairs and War better support aviators across the entire span of their service.

Our nation is free because generations of patriots have answered the call to serve. Today's military aviators carry that proud legacy forward with unmatched skill, courage and devotion to duty, ensuring America remains strong, secure and ready to confront any threat.

Our aviators will always answer the call and accomplish the mission. Our responsibility is to demonstrate that same unwavering commitment by protecting their health, supporting their readiness and honoring their service — not only while they are in the cockpit, but throughout their lives.

Rep. Jen Kiggans 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 healthcare system as a geriatric nurse practitioner.

Compounding must not become a drug-approval shortcut for Big Wellness

By Philip J. Schneider and Ronald P. Jordan

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Patients deserve innovation, but they also deserve evidence. FDA should not allow pharmacy compounding to become a shortcut around safety and efficacy standards that protect the public. If compounding becomes an entry point for every substance that attracts an online following, the distinction between individualized patient care and mass production of unapproved, untested drugs begins to disappear.

The outcome of the FDA's recent Pharmacy Compounding Advisory Committee (PCAC) meeting is about far more than a handful of peptides. It is about whether the country still has a functioning line between regulated medicine and unaccountable experimentation. At stake is whether pharmacy compounding will be reined back in as the narrow pathway for individual patient care it was designed to be — or whether the mass compounding of GLP-1s becomes the template, with peptides opening the next front in a scalable commercial pathway for selling experimental drugs that have never demonstrated they are safe or effective.

The gray market is already moving faster than the science. Peptides promising faster recovery, weight loss, better sleep, improved endurance and even slower aging are promoted widely across social media, podcasts, telehealth platforms, and wellness clinics. As The Atlantic recently reported, thousands of Americans are using BPC-157 and other peptides despite limited human-safety data and no FDA approval. Vendors sell untested peptides labeled "for research use only" — which, it must be mentioned, are not manufactured to be safe for human use — while influencers and clinics tout their supposed benefits.

This is not a fringe trend. It is part of the rise of "Big Wellness," a commercial ecosystem connecting influencers, clinics, telehealth companies, compounders, investors and overseas suppliers. According to the Global Wellness Institute, the U.S. wellness economy reached $2.1 trillion in 2024 and the global market reached $6.8 trillion. This scale creates enormous incentive to turn each viral health claim into a product and each experimental compound into a recurring revenue stream, regardless of merit. With PCAC recommending that the compounding of certain peptides be permitted, the peptide marketplace could have a powerful new distribution channel. The result could be a peptide gold rush in which commercial demand, not reliable clinical evidence, determines which experimental treatments reach patients.

That distinction matters because compounded products are not FDA approved, which means that FDA does not evaluate their safety, effectiveness, or quality before they are given to patients. Traditional compounding pharmacies are not required to comply with current good manufacturing practice requirements or report adverse events. Compounding simply does not provide the same safeguards as the drug-approval process, which is why FDA warns that compounded products "can be risky for patients."

None of this diminishes the value of traditional pharmacy compounding, which has long served an important and respected role in patient care by preparing individualized medications when a patient's medical needs cannot be met by an FDA-approved product or when shortages arise. But that respect is undermined if compounding becomes merely a way to commercially distribute unapproved and experimental drugs without FDA oversight.

Supporters argue that patients already buy these substances online and that compounding would offer a safer alternative. The concern about the underground market is legitimate—but a compounding pharmacy does not establish that a substance works, identify a safe dose, or resolve unknown long-term risks any more than this emerging unsafe pathway does.

Worse, it may lend a false veneer of legitimacy to these experimental products: patients understandably assume a prescription filled by a licensed pharmacy has been FDA-reviewed, even when it hasn't.

We've learned this lesson before. Thalidomide was marketed in Europe in the late 1950s and 1960s before its catastrophic effects on fetal development were understood — a catastrophe the U.S. largely avoided only because FDA withheld approval pending stronger evidence. The episode led Congress to require proof of both safety and efficacy before any drug reaches the market. In 2012, the New England Compounding Center shipped contaminated steroid injections across the country, causing more than 750 infections and more than 60 deaths in 20 states. This tragedy prompted Congress to pass the Drug Quality and Security Act, strengthening federal oversight and drawing a clearer line between small-scale pharmacy compounding and large-scale drug manufacturing conducted under the guise of compounding.

Thalidomide and NECC point to the same underlying lesson: individualized, evidence-based medicine breaks down when either approval standards or manufacturing oversight are skipped in the name of speed or access. In the specific case of compounding, the risk changes dramatically when a narrow pharmacy practice becomes mass compounding at a national scale. Today's combination of direct-to-consumer advertising and social-media promotion, rapid telehealth prescribing, centralized fulfillment and foreign-sourced ingredients lets mass compounding scale a product far faster than the compounding market of 2012. The regulatory framework must account for that reality.

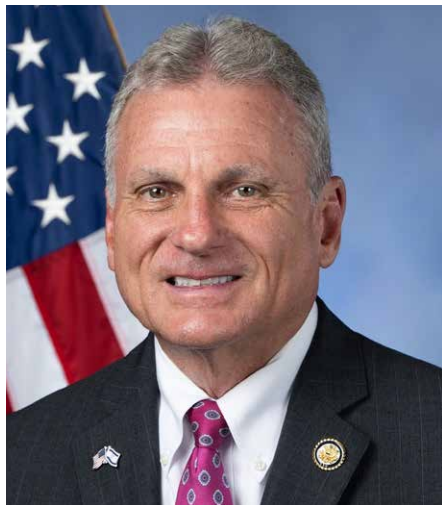
Research into peptides should continue, and some may prove valuable. But scientific promise is not clinical proof, and popularity is not evidence. The proper response to a promising experimental treatment is rigorous research — not broad commercial distribution before the necessary trials are complete.

FDA's decision will therefore reach beyond any specific peptide recommended by the PCAC. If compounding becomes an entry point for every substance that attracts an online following, the agency will lose any meaningful distinction between individualized patient care and mass production of unapproved and untested drugs. That distinction is what separates safe medicine from guesswork, and patients pay the price when it disappears.

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).

Fraudsters stole from taxpayers and hospice patients. How did we get here?



By U.S. Rep. Earl L. "Buddy" Carter, R-Ga.

When scammers abuse federal programs, they are not stealing from some faceless government account. They are pickpocketing hardworking taxpayers and vulnerable patients who depend on these programs.

It happens every single day, and if you think it doesn't impact you, you're sorely mistaken.

In fiscal year 2025, federal agencies reported roughly $186 billion in improper payments across 64 programs. Since 2003, improper payment estimates have totaled about $3 trillion — an absolutely staggering amount that could have gone toward serving Americans in need, not lining the pockets of fraudsters.

President Donald Trump was right to wage an aggressive war on fraud, establishing the Task Force to Eliminate Fraud in March under the chairman, Vice President J.D. Vance, to coordinate a national strategy against fraud, waste and abuse in federal benefit programs.

As part of this broader crackdown, the Department of Justice recently announced charges against 455 defendants, including 90 doctors and other licensed medical professionals, in healthcare fraud schemes totaling more than $6.5 billion. That's equivalent to burning over $740,000 every hour for an entire year. As a pharmacist, I'm sickened to see medical professionals who, instead of fulfilling their role to improve the nation's health care system, use their insider knowledge to exploit the system.

One of the most disgusting examples is hospice fraud.

I owned and operated an institutional pharmacy that served hospices. I have seen firsthand the good work that honest hospice providers do. It's supposed to be about comfort and peace for patients at the end of life and for families walking through some of their hardest days.

It takes an especially sick person to exploit dying patients and grieving families for their own benefit. But these fraudsters do it without batting an eye.

At a House Energy and Commerce Committee oversight hearing earlier this year, I raised one example that should shock every American. Auditors found 112 hospice providers operating out of a single physical address. In Los Angeles County alone, hospice agencies likely overbilled Medicare by $105 million in just one year.

One address. 112 hospice providers. If that doesn't set off alarms, what will?

In response to the widespread fraud, the Centers for Medicare & Medicaid Services (CMS) announced a six-month nationwide moratorium on new Medicare enrollment for hospice and home health agencies, while also suspending payments to approximately 800 hospices and home health agencies suspected of fraud in Los Angeles. They were right to do so.

According to CMS, these providers were responsible for $1.4 billion in Medicare spending last year. That's a lot of your money being used improperly by bad actors.

As a pharmacist, I'm sickened to see medical professionals who, instead of fulfilling their role to improve the nation's health care system, use their insider knowledge to exploit the system

Punishment after the fact is important, but it's not enough. The Trump administration is doing its job and doing it well, but as members of Congress, we must also act to prevent the next wave of fraud before criminals get through the front door.

First, Congress should mandate faster data sharing and automatic reviews when red flags appear. When dozens of providers share the same address, billing patterns spike overnight, or ownership structures recur across suspicious entities, those red flags should prompt immediate scrutiny by the necessary federal, state and Medicaid fraud control units, as well as law enforcement.

Second, Congress should hold states or oversight systems more accountable if they fail to take appropriate measures to prevent the abuse. This is about punishing negligence that severely impairs care and burdens taxpayers. Poor coordination, slow investigations and the ignoring of warning signs enable fraudsters. States and oversight systems that receive or help administer federal dollars must be held accountable when these red flags go unanswered.

Third, every single stolen dollar must be returned by fraudsters, and they should be sent to prison. A slap on the wrist is not enough for criminals who prey on the sick and vulnerable.

Our ultimate goal should be to protect patients and taxpayers. When one scheme works, copycats follow. That is why Congress cannot wait for the next scandal to ask the obvious questions.

President Trump and Vice President Vance are right to put fraudsters on notice. Now it's Congress's turn to create proactive, creative solutions to ensure this never happens again.

Rep. Earl L. "Buddy" Carter (R-GA-01) represents coastal Georgia in the U.S. House of Representatives. A former small business owner and pharmacist by trade, he sits on the House Energy and Commerce and Budget Committees.

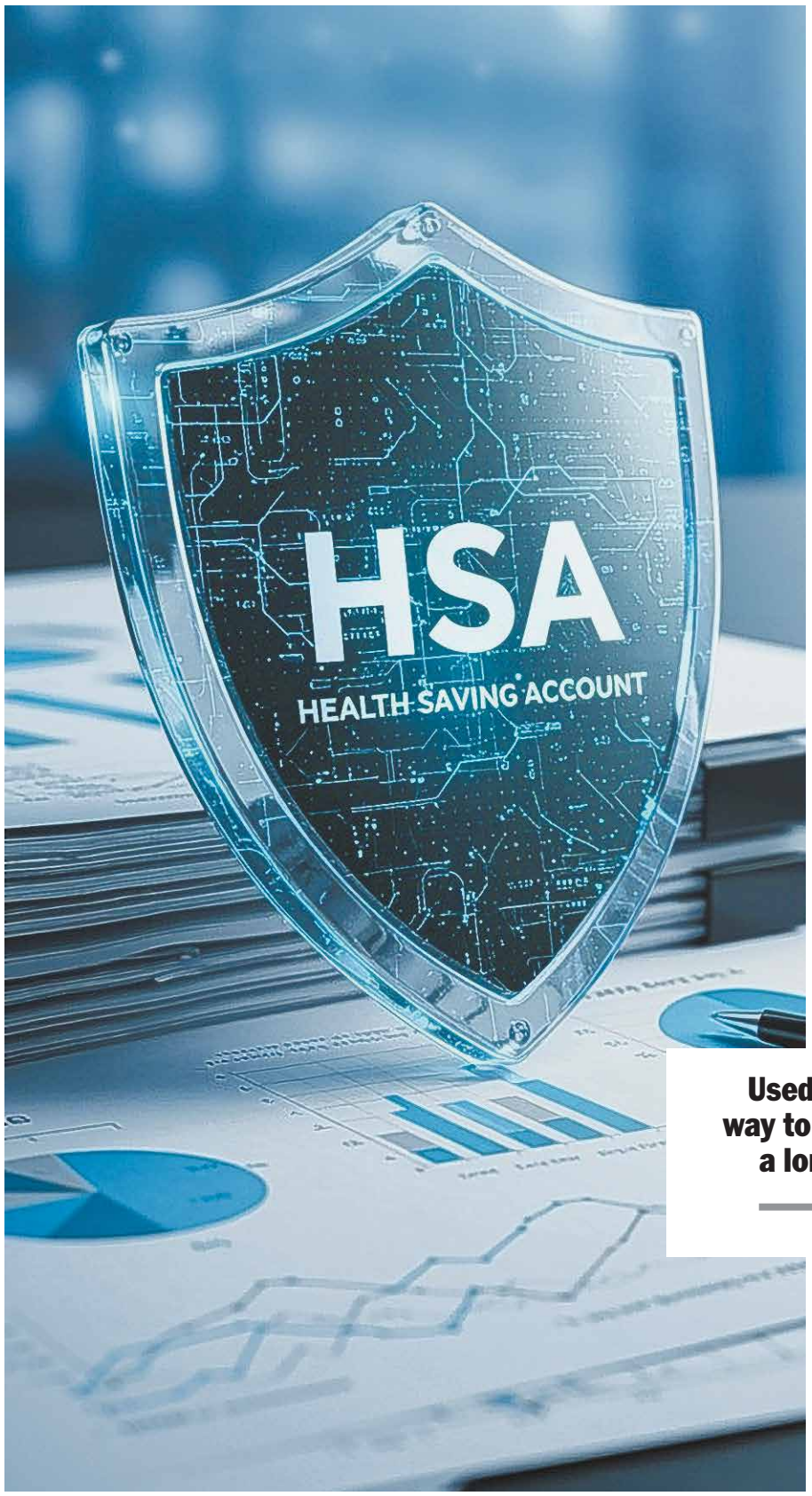
Expanding HSA eligibility can unlock savings opportunities

By U.S. Rep. Beth Van Duyne, R-Texas

After meeting with North Texas families and medical professionals, including through healthcare-focused roundtable discussions, I have heard repeatedly how healthcare and insurance costs continue to rise, and more Americans are having to go without needed care. Since my first term, I have introduced multiple bills to modernize and make Health Savings Accounts (HSAs) more accessible for Americans. I remain committed to ensuring that North Texans of all ages have access to more personalized and high-quality care options.

HSAs allow people to set aside pre-tax dollars for medical expenses, everything from prescriptions to deductibles to doctor visits. Used well, an HSA isn't just a way to pay this month's bills, but a long-term savings option. Contributions go in tax-free, the growth is tax-free and withdrawals for medical expenses are tax-free. For millions of Americans, it's the closest thing to a retirement account for healthcare costs.

They are great tools for hardworking American families, offering flexibility and allowing for tax-free money to grow. The issue is not everyone has access to these highly valuable tools. For years, federal rules tied HSA eligibility to a narrow definition of what counted as a High-Deductible Health Plan (HDHP). If you were on a Bronze or Catastrophic plan, the lower-premium, higher-deductible options are often the only realistic choice for younger workers, gig workers, contractors and the self-employed. The very people who could benefit most from HSAs were locked out, even though HSAs were designed to pair with their kind of plan.



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The Working Families Tax Cuts closed that gap. This past January, Bronze and Catastrophic plan eligible enrollees were able to open these accounts. This change unlocked HSAs for about 7.25 million previously ineligible individuals, allowing them to have greater control over their health spending and utilize the tax advantages they offer, leading to healthcare savings.

The Working Families Tax Cuts also made a permanent fix, so telehealth visits can occur before a deductible is met without disqualifying an individual from contributing to their HSA. People enrolled in Direct Primary Care (DPC) arrangements can also now contribute to their HSAs and use the funds tax-free to pay their DPC fees. This is a huge step, and personal to me, as my first job out of college was working for a small business start-up working to make DPC arrangements a possibility.

Through this landmark legislation, we expanded access for millions of Americans who will now be eligible for this tool, helping make healthcare more affordable and flexible. This was a great step, but we still have more to do.

Earlier this Congress, I introduced the HSA Modernization Act, legislation that was advanced by the Ways and Means Committee in the previous Congress. In addition to expanding HSA eligibility to users of Bronze and Catastrophic classified health plans, we were working to cut unnecessary regulations, modernize Health Savings Accounts, and expand eligibility for disabled veterans, working seniors and Native Americans.

The HSA Modernization Act would also ensure those on plans with a lower threshold for mental health services are not disqualified and would allow the coverage of health care services that occurred up to 60 days prior to establishment of the HSA. To ensure broader family availability, spouses can contribute "catch up" payments into the same HSA. And we would increase contribution limits to better align with what individuals might owe in out-of-pocket expenses to provide peace of mind and ensure Americans can cover their bills in an emergency.

Used well, an HSA isn't just a way to pay this month's bills, but a long-term savings option.

As hardworking families and small businesses continue to pay the price for limited healthcare options and higher premiums, we are helping to provide access for families to plan and save for their medical expenses. The Working Families Tax Cuts made millions of Americans newly eligible for HSAs; now it's time to cut the remaining red tape so even more can use this tool for greater flexibility and better access to high-quality care.

Rep. Beth Van Duyne represents Texas' 24th Congressional District. She's a member of the House Ways and Means Committee and chairs the Economic Growth, Tax, and Capital Access subcommittee of the House Committee on Small Business.

When disaster strikes, doctors shouldn't be stopped by state lines

By U.S. Rep. Rich McCormick, R-Ga.

Natural disasters, pandemics, and mass casualty events do not recognize state lines. They do not care about jurisdiction, bureaucracy or licensing requirements. When lives are on the line, we rely on a special kind of public servant to answer the call: our medical professionals.

Yet, during some of our nation's greatest emergencies, government red tape has stood in their way.

Hurricane Milton, which struck Florida's Gulf Coast in October 2024, exposed a problem that should concern every American. Under some interpretations of current federal law, doctors, nurses and emergency medical personnel responding from other states could not immediately provide care because they were not licensed where the disaster occurred. At the very moment we needed every available set of skilled hands, outdated rules created unnecessary barriers.

We learned the same lesson during the COVID-19 pandemic. While supporting operations in El Paso, Texas, the Department of Homeland Security authorized the use of out-of-state medical personnel. Without that flexibility, we would have been forced to pull healthcare workers from local hospitals that were already stretched to their limits.

Those experiences reinforced something I have long believed: our emergency response system must be built around saving lives, not navigating paperwork.

That is why I introduced H.R. 6211, the Medical Professional Access Act. The legislation expands license portability for healthcare practitioners across all disciplines who provide services during a federally declared emergency.

The bill is straightforward. It allows federally contracted healthcare professionals to respond wherever they are needed while protecting local healthcare systems from unnecessary staffing shortages. Too often, relief organizations are forced to recruit doctors and nurses from hospitals already struggling to care for their own communities. Robbing Peter to pay Paul has never been an effective strategy, especially during a crisis.

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Floodwaters inundate a residential neighborhood in Florida after Hurricane Milton, highlighting the widespread destruction and the urgent need for coordinated emergency response.

Disasters do not stop at state borders. Our emergency response system should not either.

Some will argue this legislation is a step toward a National Medical License. I believe that would be a welcome development.

There are times when limited government requires the federal government to establish clear national standards. Interstate commerce is governed by federal law because commerce does not stop at state lines. National defense operates the same way. Under Title 10 authority, the president can federalize National Guard units when national security demands it.

National emergencies deserve the same practical approach.

A national medical license would allow qualified physicians, nurses, and other healthcare professionals to practice wherever they are needed. It would give medical professionals greater flexibility to relocate to communities facing workforce shortages while reducing unnecessary administrative barriers. More importantly, it would strengthen our ability to respond to the next pandemic, hurricane, wildfire or other national emergency without repeating the mistakes we witnessed during COVID-19 and disasters like Hurricanes Milton and Helene.

Too often, relief organizations are forced to recruit doctors and nurses from hospitals already struggling to care for their own communities. Robbing Peter to pay Paul has never been an effective strategy, especially during a crisis.

As both a physician and a member of Congress, I have seen what happens when healthcare systems are overwhelmed. In an emergency, minutes matter. Bureaucracy should never determine whether a patient receives care.

Our responsibility in Congress is to solve problems, not preserve outdated systems simply because they have always existed. The Medical Professional Access Act is a practical step toward modernizing disaster response, addressing healthcare workforce shortages during emergencies, and ensuring that qualified medical professionals can do what they were trained to do when Americans need them most: save lives.

Dr. Rich McCormick is a decorated veteran and Emergency Room physician who proudly serves Georgia's 7th Congressional District in the United States House of Representatives. He serves on the House Armed Services, House Oversight, and Science, Space, and Technology Committees.

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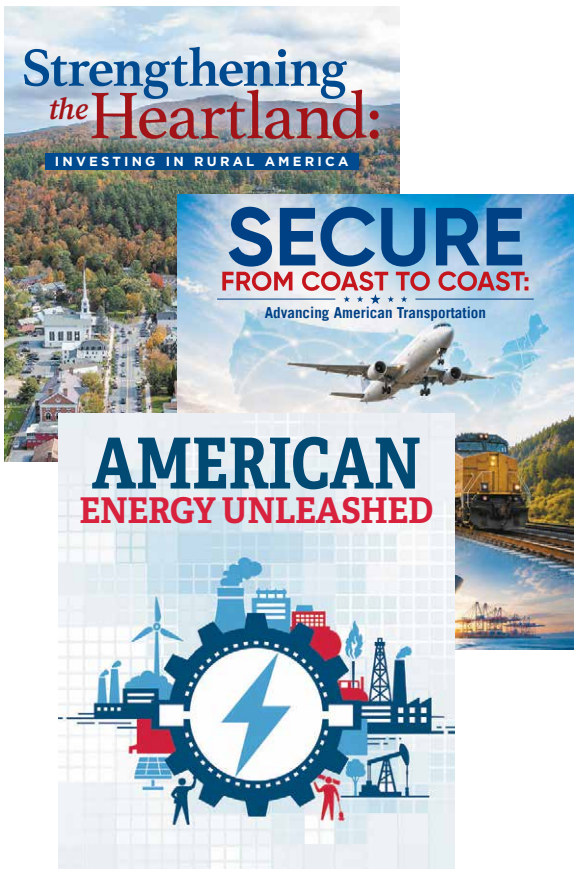

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How I'm expanding New York's healthcare workforce, one victory at a time

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

One of the biggest challenges facing our healthcare system is the shortage of qualified professionals. Across New York, hospitals, community health centers and medical practices are struggling to recruit and retain the nurses, physician assistants, physical therapists, occupational therapists, audiologists and other healthcare providers our communities rely on. In the Hudson Valley, where I represent, that means longer waiting times, higher costs and fewer options for patients trying to access care close to home.

If we want more people entering [healthcare] professions, we must make it possible for them to afford the education those careers require.

Solving this problem starts with making sure we have enough qualified healthcare professionals, which is why I've made expanding our healthcare workforce a top priority in Congress.

Last December, I introduced the Professional Student Degree Act to permanently expand the federal definition of "professional degree." My bill would ensure students pursuing graduate degrees in nursing, physical therapy, occupational therapy, physician assistant studies, audiology, social work, public health and other critical healthcare fields have access to the same federal student loan limits as students in other professional programs, like medical school. If we want more people entering these professions, we must make it possible for them to afford the education those careers require.

Just last month, we made important progress. On June 30, the Department of Education complied with a federal court order to expand its list of professional degree programs, restoring higher federal loan limits for thousands of future healthcare professionals. That decision followed months of sustained advocacy, including the legislation I introduced, bipartisan letters, formal comments and direct engagement with Education Secretary Linda McMahon.

My Professional Student Degree Act would permanently codify these protections into law, end the uncertainty for students once and for all and strengthen the pipeline of nurses, physician assistants, physical therapists and other critical healthcare professionals our communities need.

But a stronger workforce means nothing if providers don't have the funding to hire them and keep the doors open. That's why I fought for and secured a nine-month extension of New York's Managed Care Organization (MCO) tax, directing more than $1.2 billion in federal Medicaid funding to hospitals and safety-net providers in New York. I also delivered more than $2 billion in long-overdue FEMA reimbursements for COVID-related healthcare costs, ensuring providers weren't left footing the bill for services they delivered during the pandemic.

Together, these efforts have brought over $3.2 billion in targeted support to New York's healthcare system. Core Medicaid and Medicare benefits for eligible recipients remain fully protected, while we pursue responsible reforms that bring accountability and long-term sustainability to our programs.

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

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