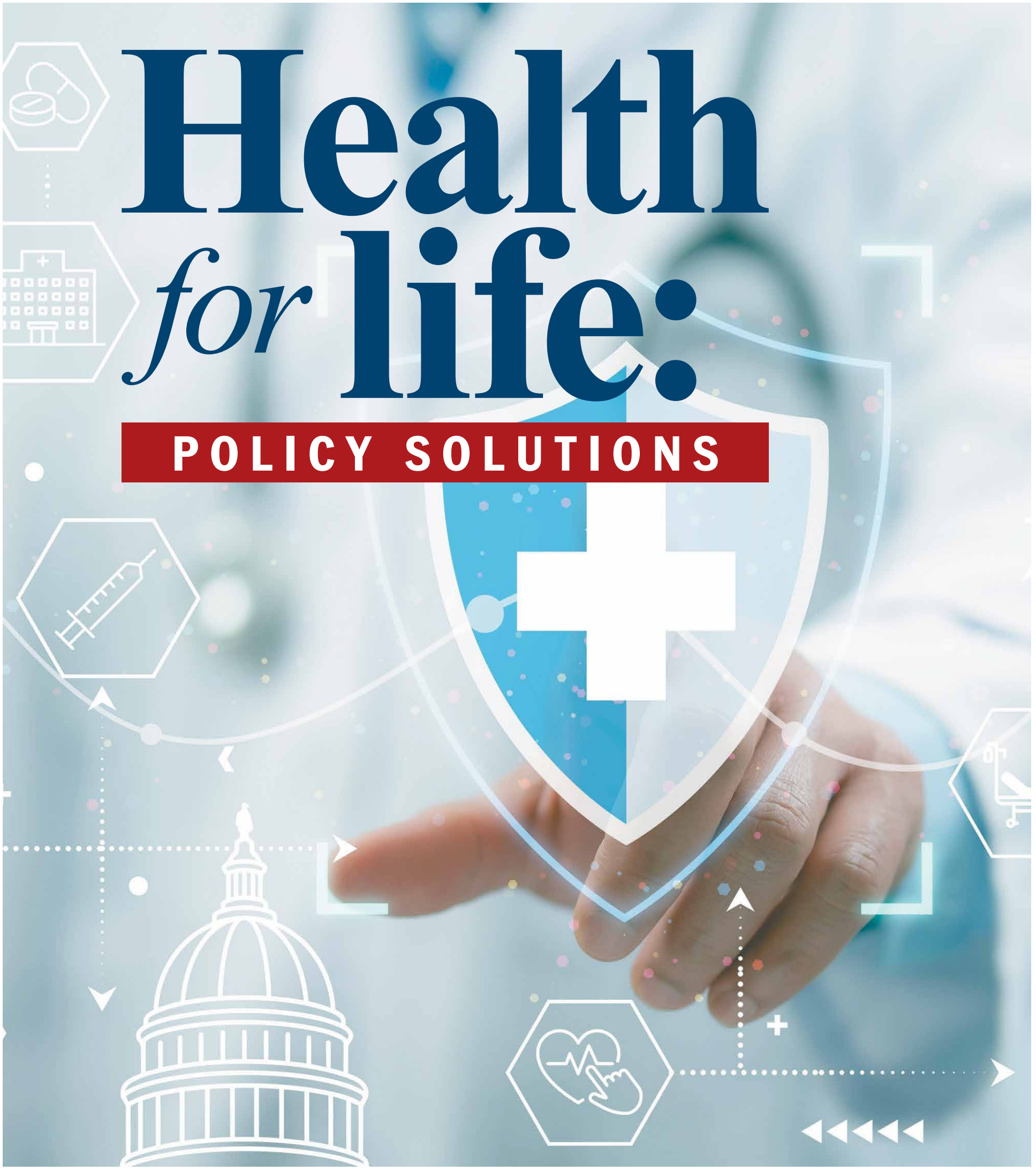
Health *for* life:

POLICY SOLUTIONS



A Special Advertising Supplement To The Washington Times

Health for life: Policy solutions

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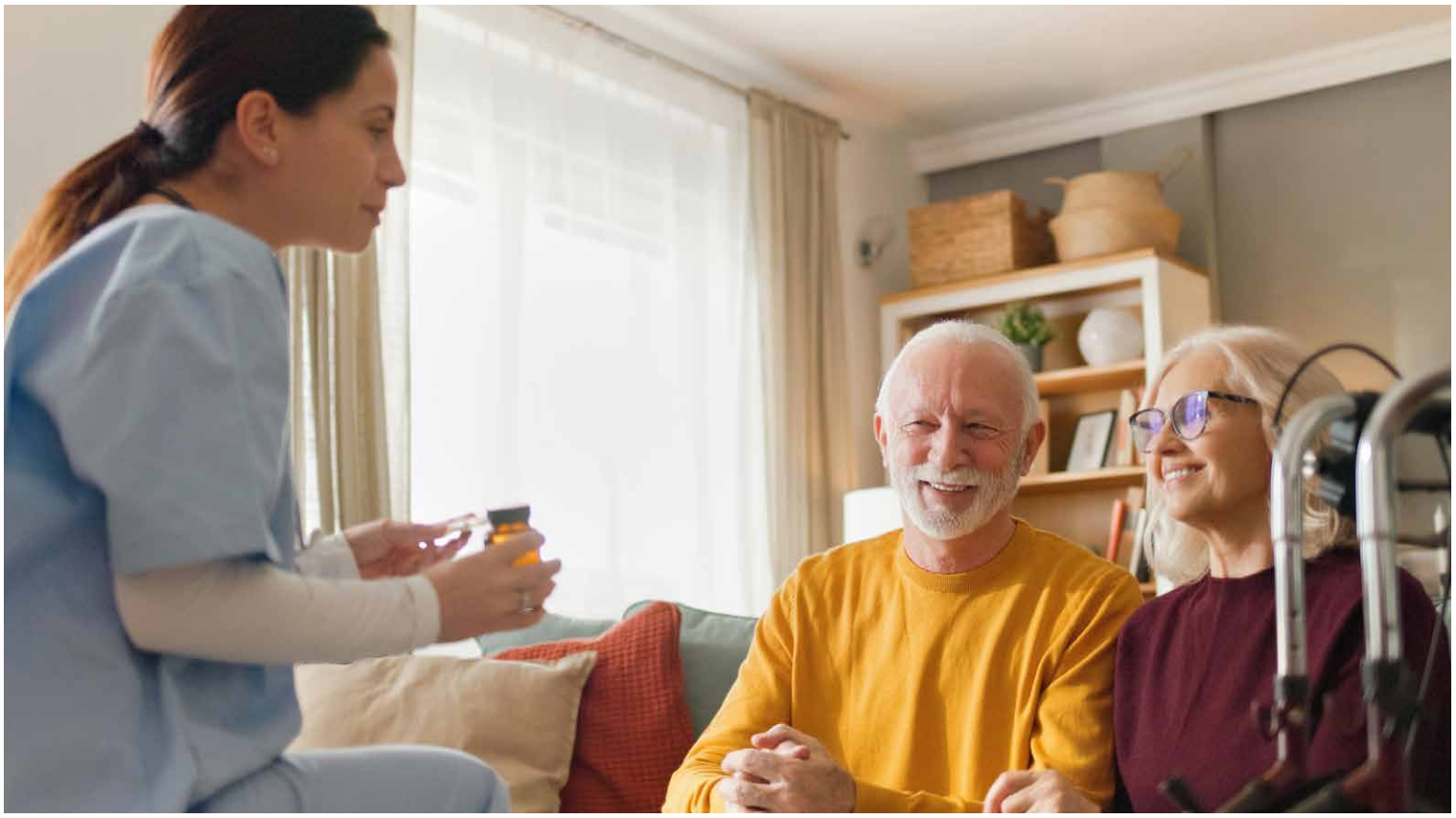
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Expanding choices for America's seniors



By U.S. Rep. Adrian Smith, R-Neb.

For more than 250 years, America has been built on the principle that individuals should have the freedom to make their own choices and shape their own futures. Yet, when it comes to solving some of our nation's biggest challenges, we too often default on one-size-fits-all solutions. Nowhere is this more apparent than in our nation's healthcare system.

Just as every American has different needs, priorities and circumstances, so does every patient. What works for someone in an urban community may not be practical for someone living in a rural area like many people across Nebraska's Third District. The right care setting for one patient may not be the best option for another, which is why our healthcare system must provide the flexibility to meet different needs and circumstances.

The right care setting for one patient may not be the best option for another, which is why our healthcare system must provide the flexibility to meet different needs and circumstances.

As a senior member of the House Ways and Means Subcommittee on Health, I am working to challenge this status quo and put patients back in the driver's seat of their own healthcare. That means expanding access for patients, empowering providers and ensuring Americans have meaningful choices when deciding how and where they receive care.

Last week, I introduced my bipartisan *Bringing Rehabilitation, Integrated Delivery, and Greater Extended (BRIDGE) Care at Home Act* to address this need for our seniors.

Consider a senior who just had a hospital stay and needs skilled nursing care as they continue their recovery. They may feel more comfortable continuing their recovery at home, surrounded by family and in a familiar environment. Yet, under current Medicare policy, qualifying skilled nursing care is only covered in a facility without a comparable payment model for delivering those same services at home. That means patients can be left without a choice, even when receiving care at home may better suit their needs and preferences.

When it comes to delivery of care for our seniors and rural patients, we must think outside the box. Too often, Medicare has failed to do so.

My *BRIDGE Care at Home Act* would establish a five-year Medicare Skilled Nursing Facility-at-Home (SNF-at-Home) pilot program. Similar to how Hospital-at-Home allows patients to receive inpatient-level care at their residence, SNF-at-Home would allow eligible Medicare beneficiaries to receive qualifying skilled nursing services in the comfort of their own homes rather than being limited to a traditional facility-based setting. This would give patients and their families a greater say in how and where they recover while allowing providers to develop care models that better reflect individual needs.

There is good reason to explore this approach. Research shows that 85% of people with experience receiving care in the home would recommend it to family and friends. Expanding access to care at home can also help alleviate capacity challenges at skilled nursing facilities and reduce unnecessary hospital stays, allowing patients to receive appropriate care in the setting that works best for them.

Just as importantly, my legislation prioritizes accountability. It directs the Secretary of Health and Human Services to evaluate the quality, outcomes, costs and patient characteristics of beneficiaries receiving skilled nursing care at home compared to those receiving care in a traditional facility. We should be making decisions based on what works for patients, and this pilot will help us better understand where these options can make a meaningful difference.

America has never been a nation that succeeds by demanding everyone conform to the same mold. Our strength comes from recognizing the value of individual choice and the freedom to pursue different paths. Our healthcare system must reflect those same principles, and I look forward to continuing my work in Congress to advance commonsense, bipartisan solutions that ensure patients receive the best care possible.

Rep. Adrian Smith represents Nebraska's 3rd Congressional District. He serves as chairman of the Trade Subcommittee on the House Ways & Means Committee, and is also a member of the subcommittee on Health.



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Everyone should have access to quality care as they age



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

Growing older should not mean losing control over where you live or how you receive care. Yet for too many families, a change in a loved one's health brings an agonizing question: Can we get the help they need to keep them safely at home?

Behind that anxiety is often an adult child trying to balance a job with caring for a parent or a spouse exhausted from providing care alone.

Families should not have to figure this out on their own. Access to quality care should not depend on how much money or resources you have. That conviction guides my work in Congress every day.

One program already helping families navigate these challenges is the Program of All-Inclusive Care for the Elderly, known as PACE. It brings medical care and social services together so eligible adults age 55 and older who need nursing home-level care can continue living safely in their communities.

There is room for Republicans and Democrats to work together here. Families caring for an aging parent need practical help, and they deserve a Congress willing to deliver it.

Rather than leaving families to coordinate care across a complicated healthcare system, PACE provides a team that works together around each participant's needs. For someone who wants to remain at home but needs substantial support, that coordination can make all the difference.

Just as meaningful is the connection participants find with other people.

Carol, a PACE Southeast Michigan participant from Trenton, which is in my district, put it plainly: "I don't know where I'd be without PACE." She describes the people there as family. Their support helps her continue doing the things that give her life meaning.

Michigan has the third-largest PACE program in the country, but there is considerable room to reach more people. According to PACE Southeast Michigan, about 6,500 people participate statewide. Meanwhile, too many families are on waiting lists for home and community-based services or struggling to find care close to home.

We should be building on what works. That is why Republican Rep. John Moolenaar (Mich.) and I introduced the bipartisan *PACE Improvement Act*. Our legislation would help existing programs expand and make it easier for new ones to open.

It would allow eligible participants to enroll and begin receiving care at any point during the month. When a family needs help, an administrative calendar should not stand between them and care.

The bill would also remove restrictions on when providers can apply to establish or expand programs, helping them respond to needs in their communities. And it would require states to offer PACE services under Medicaid, making this option available to more eligible Americans.

Expanding PACE is one part of the broader work we must do to strengthen long-term care. We must also protect Medicaid, which families depend on for services that make living at home possible. Supporting family caregivers-many of whom also rely on Medicaid for their own healthcare-means ensuring they have somewhere to turn before exhaustion becomes a crisis.

There is room for Republicans and Democrats to work together here. Families caring for an aging parent need practical help, and they deserve a Congress willing to deliver it.

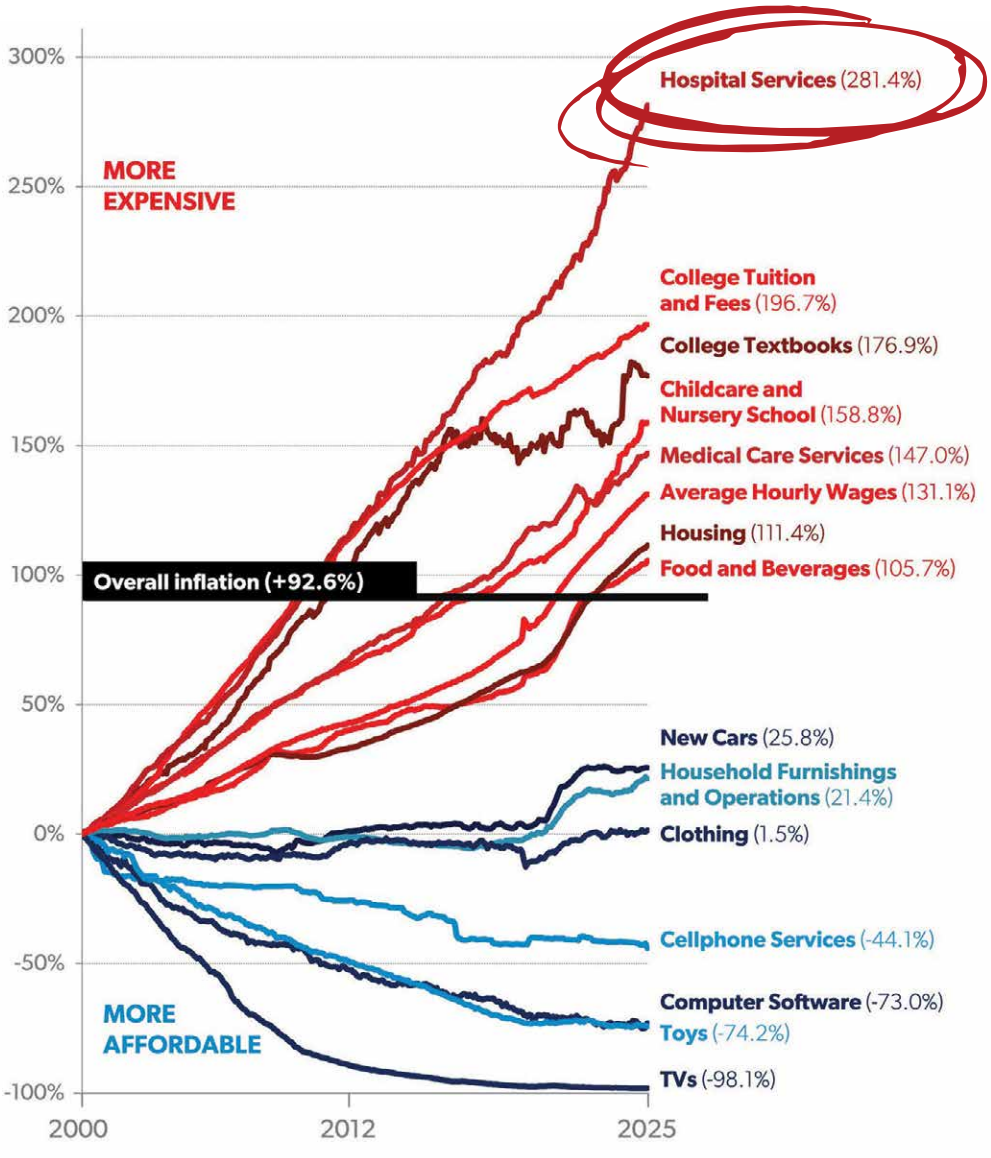
Healthcare ought to be the right of every American. And that includes recognizing our responsibility does not end when someone leaves a hospital or a doctor's office.

For Carol and families across Michigan, it means having the support to remain in the community they call home. We should give more Americans that opportunity.

Rep. Debbie Dingell represents Michigan's 6th Congressional District. She is a member of the Energy and Commerce Committee and the Natural Resources Committee, where she leads on critical issues including affordable and accessible health care, clean energy and water, domestic manufacturing and supply chain resilience, and protecting our wildlife and natural resources.

HOSPITALS SET THE PRICES

THAT RAISE HEALTHCARE COSTS FOR ALL AMERICANS



Source: Mark J. Perry, American Enterprise Institute, Bureau of Labor Statistics Jan 2000 – Dec 2025

PRICE CHANGES SINCE THE YEAR 2000

Selected U.S. Consumer Goods and Services, Wages

The prices that hospitals set are the first domino in a chain reaction of healthcare costs in our country. **America has a hospital accountability problem.** Too many for-profit hospitals maximize financial gain at the expense of patients. Too many non-profit hospitals fail to give back to their communities while paying their executives handsomely. If Congress is serious about lowering healthcare costs, lawmakers must scrutinize hospital pricing practices. Did you know that 40 of America's non-profit hospitals and health systems would qualify for the Fortune 500 if they were for-profit corporations?

HOSPITAL FACTS

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From the front lines of kidney health: Why your PCP matters

By Edward V. Hickey III and Paul T. Conway

The role of the primary care physicians (PCPs) will become even more important in the coming year as the new leadership of the U.S. Preventive Services Task Force (USPSTF), recently appointed by U.S. Health and Human Services Secretary Robert F. Kennedy Jr., considers adoption of the first kidney disease screening recommendation in American history.

Kidney disease is one of the quietest threats to American health, lives and livelihoods. Its reputation as the "silent killer" is well established. In its earliest stages, chronic kidney disease (CKD) rarely announces itself. There is often no pain and there are no obvious warning signs. Many people feel entirely well even as their kidney function steadily declines. When symptoms do appear, the window for the most proactive and effective interventions, including new FDA-approved drugs that slow disease progress and help prevent the need for dialysis, has closed considerably. This is why PCPs — medical professionals best equipped to detect subtle signs of early disease onset — have disproportionate influence in determining your future health, capacity to maintain work and mortality. In many instances, by the time a patient is referred to a nephrologist, or kidney specialist, the opportunity to change the trajectory of kidney disease has been lost. Tragically, over 50% of Americans living on dialysis today were first diagnosed with kidney failure in an emergency room – a preventable and avoidable burden to people and society.





Why upstream matters

PCPs see patients routinely, know their history and family medical history and are trained to detect risk factors and interpret lab tests that signal kidney function decline. Simple, inexpensive tests, such as a blood test for kidney function and a urine test to detect protein, can identify kidney disease before a crisis. When PCPs order these tests, interpret the results and act on the findings, patients can choose among treatments while they still have kidney function to preserve. New federal policies, including the Kidney Care National Plan, prioritize upstream interventions and aim to improve people's health, quality of life and survival, while preventing disability. Investment in screening, timely diagnosis and early management in primary care is not simply common-sense medicine; it is sound public policy to make America healthier.

Investment in screening, timely diagnosis and early management in primary care is not simply common-sense medicine; it is sound public policy to make America healthier.

The need is urgent. According to the Centers for Disease Control and Prevention (CDC), more than 1 in 10 U.S. adults (14%, or about 37 million people) are estimated to have CKD, yet nearly 9 in 10 adults with CKD are unaware they have it. Among adults with moderate or advanced CKD, only about 1 in 4 are aware of the disease. The CDC noted that this gap could be addressed by screening people with risk factors such as diabetes or high blood pressure. Clinical guidelines say CKD prevention and screening should take place in primary care. Yet, tragically, a 2025 systematic review found substantial underuse of primary care for CKD screening in America.

The gap is most visible in urine testing. A 2025 meta-analysis found that only about 1 in 5 adults with diabetes or

high blood pressure received the recommended urine albumin test (uACR) in routine practice. In a study of 24 U.S. healthcare organizations, blood-based eGFR testing of primary care patients with Type 2 diabetes (T2D) was uniformly high, but uACR testing was suboptimal and varied widely. The reasons are practical, not a lack of concern. A systematic review of PCPs found the most common barrier was lack of time. Another barrier was worry about causing patients anxiety by delivering a CKD diagnosis. Other PCPs cited frustration with confusing national care guidelines that change regularly. PCPs also pointed to inflexible electronic medical records and poor Medicare reimbursement for complex CKD care, particularly when managing care for patients with multiple conditions. The same PCPs offered solutions: electronic prompts and lab result support, concise guidelines and Medicare reimbursement reform. These tools can be created through more intelligent and patient-centered federal policies.

Keeping working-age Americans at work

Early disease diagnosis allows working-age Americans to remain in their jobs and the workforce and avoid disability and dependency typically associated with status quo dialysis. The financial benefits for patients and their families are profound. Detecting and managing kidney disease early helps patients maintain their income, savings and stability while reducing costs to taxpayers and society.

The stakes are significant: 53% of people with CKD are of working age. CKD is not only a disease of older age: CDC estimates that 13% of adults aged 45 to 64 and 6% of adults aged 18 to 44 have CKD. The National Kidney Foundation (NKF) reports that roughly 1 in 10 working-age adults has CKD, again, most without knowing it. For those individuals, keeping a job and work-related health benefits helps ensure timely access to the early, preventive care needed to avoid kidney failure. Employment equates to continued health coverage, regular medical appointments and consistent access to medications. By remaining in the workforce, patients remain active, productive, taxpaying citizens. By contrast, a late diagnosis can set off a tragic and unexpected chain of events, including job loss, financial crisis and family instability. Research proves this point. Studies of patients initiating dialysis have found that unemployment affects up to 75% of people beginning treatment for kidney failure and that about half of those who reach kidney failure are of working age. In 2023, about 131,564 Americans started treatment for kidney failure and about 831,000 were living with it, two-thirds of them on dialysis.

The societal return on early detection

When kidney disease is caught early and patients stay employed, benefits extend far beyond the exam room. Patients who earn a living contribute to federal and state tax revenue. Employers keep experienced workers on the job, strengthening the workforce productivity and reducing turnover. Early disease detection also reduces overall healthcare spending and taxpayer outlays for disability, Medicare and Medicaid. In short, earlier diagnosis is an investment that pays dividends for patients, employers, taxpayers and public programs alike.

The scale of those potential savings is striking. According to the U.S. Renal Data System (USRDS) 2025 Annual Data Report, Medicare fee-for-service spending for adult beneficiaries with CKD was $141.1 billion in 2023, or 36% of all fee-for-service spending. Younger adults (aged 18 to 65) with CKD made up 8.2% of their age group in that population but accounted for 17.8% of its total costs. Employers feel the cost too. The NKF reports that when an employee develops kidney failure, the employer bears the cost for the first 30 months before Medicare becomes primary, averaging $15,444 per month and totaling nearly $500,000.

Putting patients back in control

Arguably, the most important benefit of early detection by PCPs is both hardest to measure and the most meaningful to patients. Earlier diagnosis and intervention put kidney patients and the doctors they choose to care for them, back in control of their lives. Instead of reacting to a crisis, patients and their trusted physicians can plan together: managing blood pressure and blood sugar, adjusting medications, making lifestyle changes and coordinating with specialists before options run out.

A call to action

America has the opportunity to change its strategy for combatting kidney disease. A new, national kidney disease screening recommendation, empowered PCPs and implementation of the Kidney Care National Plan are the best line of defense against kidney failure. Supporting routine screening of at-risk patients, timely follow-up and early treatment will help millions of Americans protect their health, their livelihoods and their futures. Kidney disease may be silent, but our national response to it does not have to be. It should start upstream, in the primary care office, where the greatest good can be done.

Mr. Hickey and Mr. Conway are president and vice president of American Association of Kidney Patients (AAKP). Both are kidney disease patients with extensive professional histories across Capitol Hill and appointed service in multiple presidential administrations.

I AM MORE THAN MY KIDNEY DISEASE

AAKP

SCAN ME



Kidney health impacts families, jobs, and income.
Kidney disease develops without noticeable symptoms. Diabetes, high blood pressure, heart disease, and family history increase your risk. Ask your trusted health team if you need blood and urine tests to check your kidneys.

Know your risk. Ask questions. Protect your family. Be proactive in your health.

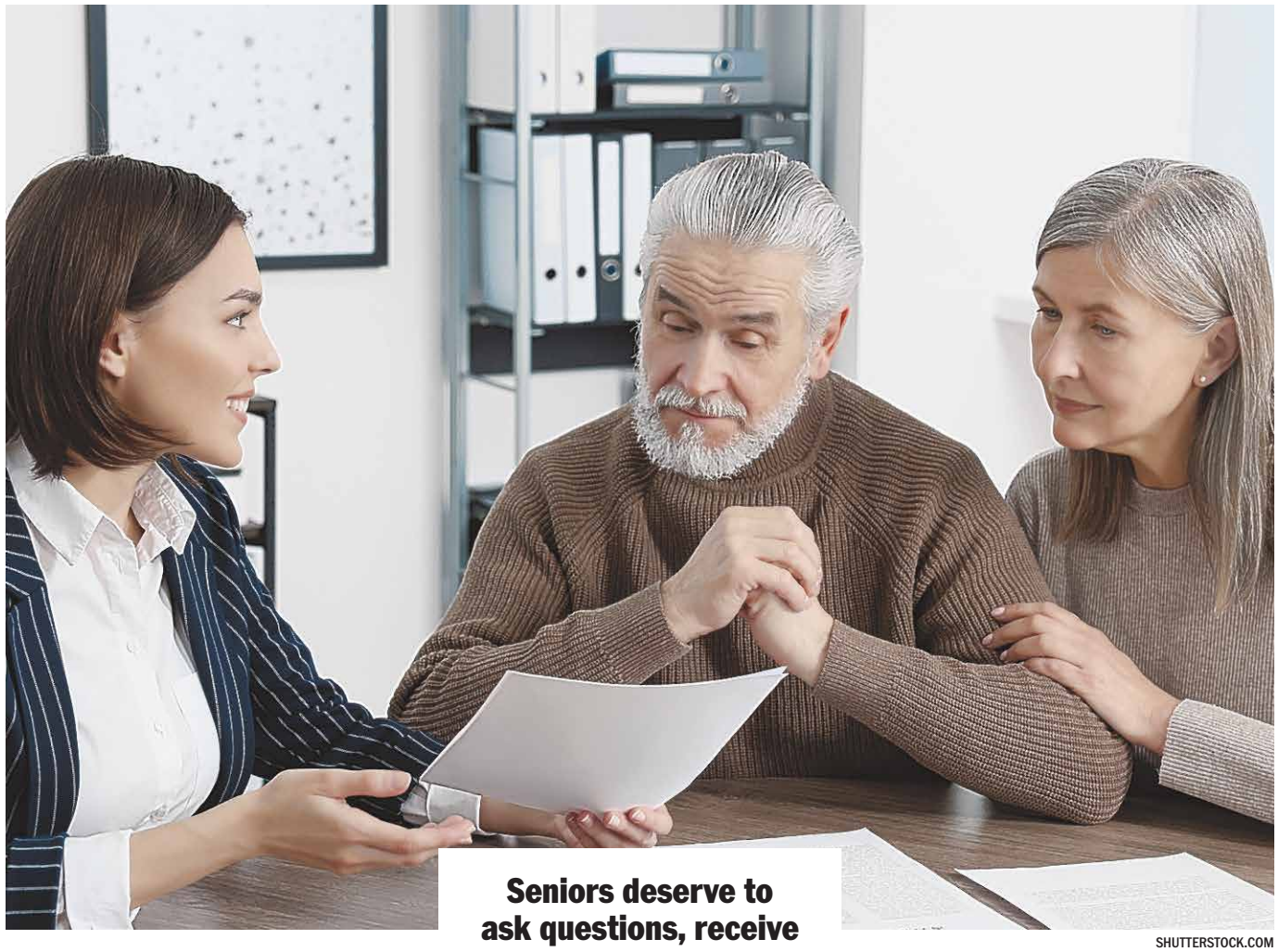
Since 1969, the American Association of Kidney Patients has led the interests of kidney patients through education, advocacy, national policy, and patient engagement. We fight for wider patient choice and access to innovative, lifesaving care, and new treatment options.

LEARN MORE AT AAKP.ORG/JOIN

Protecting seniors' savings starts with trusted Medicare guidance



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



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For seniors living on fixed incomes, every dollar matters. Rising household expenses can make it difficult to afford groceries, housing, utilities and prescription medications. Yet many older Americans unknowingly miss out on assistance that could lower their health care costs. Sometimes, the obstacle is simply not knowing that help exists or having someone trustworthy explain how to apply.

That is why I helped introduce the bipartisan *Senior Savings Protection Act*. This legislation protects community programs that give low-income Medicare beneficiaries free, unbiased, individual guidance. These services help seniors understand their benefits, identify potential savings and complete the paperwork necessary to receive assistance. No senior should lose access to affordable care because a confusing application stands in the way.

In January, the House passed a spending package incorporating an extension of these critical programs. The final package was subsequently signed into law, continuing funding under the Medicare Improvements for Patients and Providers Act, known as MIPPA, through 2027. While our original legislation proposed a five-year extension through fiscal year 2030, this enacted extension represents meaningful progress in protecting services families depend upon.

For someone unfamiliar with these programs, their importance may be easy to overlook. But consider a senior who struggles each month to pay a Medicare premium while stretching a limited grocery budget. A trained counselor can help determine whether that individual qualifies for a Medicare Savings Program or prescription drug assistance, explain the requirements, and guide the application process.

That assistance can make a real difference in a household budget. It can help someone afford needed medication, keep a medical appointment or preserve money for other necessities. Just as importantly, it offers reassurance. Seniors deserve to ask questions, receive understandable answers and make decisions about their health without feeling overwhelmed, pressured, or alone.

Seniors deserve to ask questions, receive understandable answers and make decisions about their health without feeling overwhelmed, pressured, or alone.

MIPPA grants support State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers and national outreach efforts. These community partners provide counseling, eligibility screening, education, and enrollment assistance. They also reach people who might otherwise fall through the cracks, including rural residents, individuals with disabilities and caregivers managing complicated responsibilities for someone they love.

The need remains substantial. The National Council on Aging has estimated that nearly 5.8 million older adults qualify for Medicare Savings Programs but are not enrolled. Behind that figure are neighbors who may be paying more than necessary because they have never received clear information or practical help. Connecting eligible beneficiaries with existing assistance is a commonsense way to strengthen financial security.

This effort has brought Republicans and Democrats together because helping seniors navigate Medicare should be a shared responsibility. Our legislation earned support from AARP and the National Council on Aging. Preserving reliable guidance also helps beneficiaries distinguish accurate information from misleading claims, giving them greater confidence as they evaluate coverage and seek help with costs.

In my home state of Florida, seniors and their families can connect with SHINE for free, unbiased Medicare counseling by calling 1-800-963-5337 or visiting FloridaSHINE.org. As a senior member of the House Energy and Commerce Committee, I remain committed to strengthening Medicare and protecting the health and dignity of older Americans. That means supporting access to care while ensuring beneficiaries can actually use the benefits available to them. A program cannot fulfill its purpose if the people it serves cannot navigate it.

The funding extension is an important achievement, and I will continue advocating for lasting stability for these essential services. Seniors have spent their lives working, raising families and contributing to our communities. They deserve trusted support when seeking care. My commitment is simple: help our neighbors protect their savings, access their benefits, and age with the dignity and peace of mind they have earned.

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.

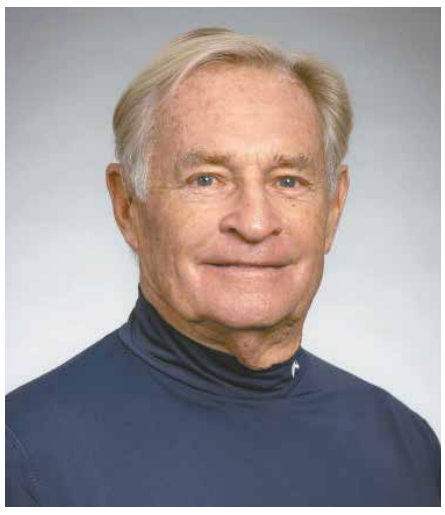


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Health professionals are sounding the alarm on reckless HHS peptide policy

By Ronald P. Jordan and Philip J. Schneider





With the withdrawal of Heidi Overton's nomination leaving the FDA without a permanent commissioner for the foreseeable future, America's physicians and pharmacists are urging the Department of Health and Human Services (HHS) to rescind a federal policy that is already exposing patients to unapproved, inadequately studied injectable drugs. HHS should listen before another preventable tragedy occurs.

On Oct. 28, HHS announced that it would refrain from enforcement against qualifying pharmacies and physicians compounding six experimental peptides, over the objections of the Food and Drug Administration's own scientific reviewers.

FDA's Center for Drug Evaluation and Research recommended against adding these six substances to the list of ingredients eligible for traditional pharmacy compounding. Yet an advisory committee nevertheless supported their inclusion, with eight newly appointed members with financial ties to the peptide industry providing decisive votes. HHS then advanced this policy while FDA was operating without a Senate-confirmed commissioner.

Now some of the nation's most prominent medical and pharmacy organizations are calling for the policy to be reversed.

On Nov. 9, the American Medical Association (AMA) formally urged HHS to immediately rescind its decision to ease restrictions on unapproved peptides and pursue enforcement against illegal distributors. The American Pharmacists Association (APhA) likewise called for withdrawal, warning that enforcement discretion cannot substitute for scientific review and established patient-safety protections. The American Society of Health-System Pharmacists (ASHP) also criticized HHS's reliance on enforcement discretion rather than established rulemaking, citing limited clinical and safety data.

As former presidents of APhA and ASHP, we share these concerns. Through the Alliance for Safe Biologic Medicines, we have repeatedly raised them with HHS Secretary Robert F. Kennedy, Jr., most recently in our Nov. 13 formal comments urging withdrawal of the policy.

The safeguards at issue exist for good reason. In 2012, contaminated steroid injections produced by the New England Compounding Center caused a nationwide fungal meningitis outbreak. More than 100 patients died and more than 800 were sickened. The tragedy prompted Congress to strengthen oversight through the *Drug Quality and Security Act*. We should not need another catastrophe to remember why.

Yet disturbing evidence continues to emerge about illegally compounded drugs. The FDA received two reports of deaths following use of products purportedly containing retatrutide, an experimental weight-loss peptide. FDA has also received more than 1,700 adverse-event reports associated with compounded semaglutide and tirzepatide. Following a December 2025 FDA warning letter citing serious deficiencies in its sterile drug production practices that put patients at risk, another compounding pharmacy recalled compounded tirzepatide injections nationwide in September 2026 over sterility concerns.

The risks extend beyond American pharmacies to the overseas manufacturers supplying their active pharmaceutical ingredients (APIs). FDA found evidence of noncompliance at 21% of the 48 GLP-1 foreign API manufacturing sites it evaluated. In May, the agency documented serious violations at China's Harbin Jixianglong Biotech, including relabeling ingredients from unapproved suppliers and inadequate testing for impurities and bacterial endotoxins. The company subsequently recalled two batches of semaglutide ingredients.

Similarly, in November Health Canada reported bacterial contamination in unauthorized injectable peptides supplied by a Chinese manufacturer. Authorities seized more than 11,400 vials, and two Canadian retail websites ceased operating following enforcement actions. Another investigation uncovered contaminated injectable peptides sold by an Ottawa wellness business.

In announcing it policy, HHS cited "significant interest" in compounded peptides, while Sec. Kennedy's policy asserted that expanding access would advance "patient choice and freedom." But public interest in a therapy cannot determine its safety and efficacy, its appropriate dosing, and its potential adverse effects.

HHS should heed its scientific experts and the medical and pharmacy professions and withdraw its policy until it can demonstrate adequate clinical evidence, independent scientific review, reliable ingredient traceability, effective adverse-event reporting and meaningful enforcement against illegal suppliers.

Ronald P. Jordan, RPh, FAPhA, is the founding and emeritus dean of Chapman University School of Pharmacy and a past president of the American Pharmacists Association.

Philip J. Schneider, MS, FASHP, FFIP, is a professor at The Ohio State University College of Pharmacy and a past president of the American Society of Health-System Pharmacists. Both serve on the Advisory Board of the Alliance for Safe Biologic Medicines.

Learn more at www.SafeRxCompounding.org

Medicare transparency: A policy priority



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



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Over the past 25 years, I have worked as a family medicine physician providing care to our seniors on Medicare. I have had a front-row seat to the bureaucracy that too often delays care, limits access through inadequate reimbursement rates and obscures the serious fiscal challenges facing the program.

Medicare serves a vital purpose: protecting Americans 65 and older from the potentially devastating costs of medical and hospital care. While that mission remains essential, the system responsible for administering the program has become increasingly burdened by red tape. Hospitals, clinics and physician practices, particularly in rural and underserved communities, are struggling with reimbursement rates that have failed to keep pace with inflation. At the same time, policymakers in Washington have too often postponed difficult decisions about Medicare's long-term financial stability, even as the program moves closer to insolvency.

Medicare spent more than $1.2 trillion last year. Its trustees project that the Hospital Insurance trust fund, which pays for Part A inpatient hospital care and related services, will be depleted in 2033. At that point, incoming revenue would cover only about 89 percent of scheduled Part A costs, leaving an 11 percent shortfall unless Congress acts.

The financial pressure is already being felt by our seniors. The standard Part B premium rose 9.7 percent this year, from $185 to $202.90, and the trustees estimate $209.50 next year.

With Medicare already facing significant challenges that affect patient access and quality of care, we should be cautious about expanding government control over healthcare. Patients deserve a system in which medical decisions are driven by physicians and patients, not by distant bureaucracies. When someone seeks care, they should have confidence that clinical judgment, not administrative hurdles, will guide treatment decisions.

Medicare is often discussed as though it provides free healthcare, but the reality is far more complicated. Beneficiaries face premiums, deductibles, copayments, coverage restrictions, prior authorization requirements and a maze of administrative rules. For too long, many elected officials have avoided honestly confronting the fact that Medicare's current trajectory is unsustainable. If Congress fails to act, future beneficiaries could face reduced access to the care they depend on.

I have had to sit across from far too many patients who tell me they will have to choose between buying groceries or their medications. I have also had to tell patients that while I think they need a certain procedure or medication, a government bureaucrat has decided they won't authorize it. At the same time, some providers have reduced their participation in Medicare because reimbursement rates often fail to cover the rising costs of delivering care. These challenges make it harder for seniors to access timely, high-quality medical services.

Congress must confront these realities. We need reforms that lower the cost of care, reduce unnecessary administrative burdens, strengthen the doctor-patient relationship and preserve access to Medicare for future generations.

Patients deserve a system in which medical decisions are driven by physicians and patients, not by distant bureaucracies. When someone seeks care, they should have confidence that clinical judgment, not administrative hurdles, will guide treatment decisions.

Watching my own patients fight through these hurdles is precisely why I decided to attend law school after completing medical school and practicing as a family doctor. I knew that to truly fight for them, I needed to learn more about the very system that was working against them.

As both a physician and a member of Congress, I have worked across the aisle to improve Medicare for seniors and strengthen our healthcare system. I have supported legislation such as the *Seniors Timely Access to Care Act*, which would streamline and standardize prior authorization procedures to reduce unnecessary delays in treatment. I have also cosponsored the *Reducing Medically Unnecessary Delays in Care Act*, which would require Medicare coverage decisions and prior authorization requirements to be based on transparent clinical criteria developed with physician input.

We must also address inadequate physician reimbursement, which is contributing to reduced patient access and increased consolidation throughout the healthcare marketplace. That is why I have cosponsored the *Patients First Act*, legislation designed to stabilize independent and rural physician practices, address chronic reimbursement challenges and reduce unnecessary paperwork that takes physicians away from patient care.

The challenges facing Medicare are not new. We know the program faces serious financial pressures. We know patients encounter barriers to accessing care. And we know many solutions already exist. What has been lacking is the political will to act.

I will continue fighting for practical, patient-centered reforms that improve access to high-quality care. That means cutting unnecessary red tape, modernizing approval processes, improving payment models, addressing workforce shortages and strengthening local healthcare systems. Most importantly, it means ensuring that Medicare remains sustainable, accessible and responsive to the needs of the seniors who depend on it.

Rep. Mike Kennedy, a family physician, represents Utah's 3rd Congressional District. He sits on the House Committees on Natural Resources; Science, Space, and Technology; and Transportation and Infrastructure.

Americans Want Medicare to Cover Dental, Vision, and Hearing

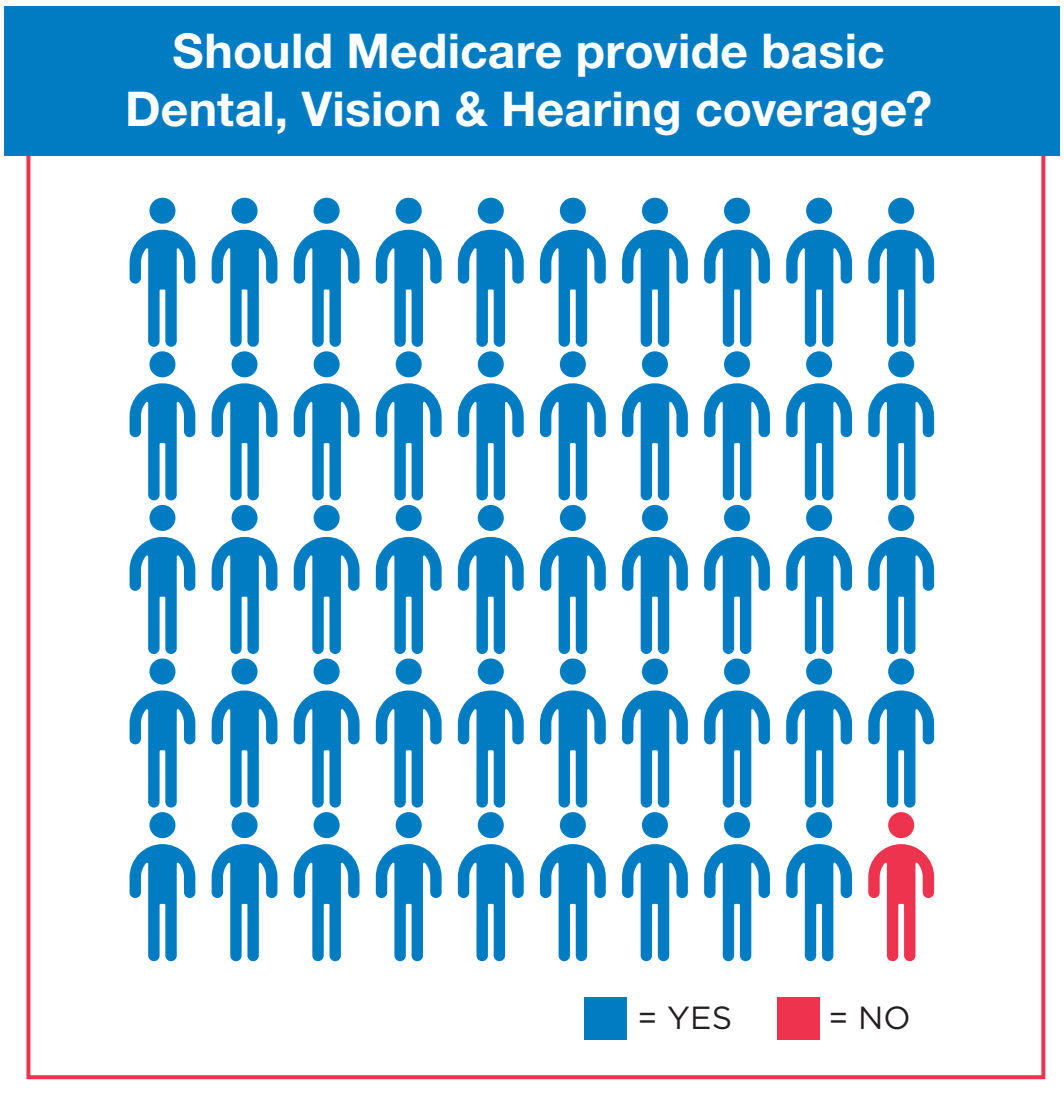
56% of Seniors Skip Medical Procedures, With Dental, Vision and Hearing Care Most Affected

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 Medicare reform, we urge lawmakers to ensure that dental, vision, and hearing coverage are included. These are not luxuries.

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.



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A lifeline for families facing early-onset Alzheimer's

By U.S. Rep. Sharice Davids, D-Kansas

When people think about the day-to-day work of a member of Congress, they often imagine big speeches on the House floor or heated debates during late-night hearings. But the most important work I do doesn't happen in Washington — it happens at home in Kansas, sitting around the table listening to the priorities of my constituents.

During a town hall last year, I heard from Nina Westvold, a resident of Overland Park, Kansas. Her story broke my heart, but it also exposed a glaring defect in our nation's healthcare system.

So, I got to work.

Nina's husband of 35 years, Kent — whom she calls the "love of my life" — was diagnosed with early-onset Alzheimer's at just 61 years old. A diagnosis like that turns a family's world upside down. Alzheimer's is a fatal disease, and managing it requires extensive medical care and constant support.

Hoping to navigate this devastating news, Nina looked into healthcare coverage options. Medicare, our national healthcare program for seniors, typically starts at age 65. However, federal law allows some younger Americans diagnosed with terminal illnesses to access Medicare early if they have been on Social Security Disability Insurance.

That is where Nina and Kent ran into a brick wall.

To qualify for Social Security disability, a person must have worked and paid into Social Security for a certain number of years. But years ago, Kent stepped back from the workforce to stay home full-time, keep their son focused on school, and manage their household while Nina worked. It was a choice that paid off for their family — their son grew up, graduated college, bought a home, and started a successful career.



U.S. Rep. Sharice Davids meets with Kansas constituent Nina Westvold, whose experience caring for her husband, Kent, helped inspire the Early-Onset Alzheimer's Coverage Act.

Yet, because Kent was a stay-at-home dad for over a decade, he lacked the qualifications needed for Social Security disability, and therefore, could not get access to early Medicare coverage.

Nina had to retire early to become Kent's full-time caregiver. With both of them under 65 and unable to access Medicare, they were forced to pay astronomical costs out of their own pockets for private medical insurance while facing a terminally ill diagnosis.

As Nina put it to me, finding out her husband couldn't get Medicare simply because he chose to raise their child felt like "a punch in the gut." Parents sacrifice so much for their families; they should never be punished by the healthcare system when tragedy strikes.

When a constituent brings a broken system to my attention, I don't just sympathize with them. I take action to fix it.

That is why I introduced the *Early-Onset Alzheimer's Coverage Act*, which Nina described as "a true lifeline."

The fix is straightforward and practical. My bill creates a direct pathway for people like Kent to buy into Medicare coverage.

It removes the arbitrary requirement that forces terminal patients to go through the disability system first just to get health coverage. Families like Nina and Kent would also have a designated Medicare enrollment window, as well as access to supplemental plans to keep medical bills manageable.

This policy isn't about partisan debates; it's about basic fairness and common sense. No spouse should have to choose between financial ruin and caring for a dying partner. No parent who stayed home to raise the next generation should be denied healthcare access when a fatal disease strikes.

Nina said, "I am so grateful to Representative Davids for standing up for families like mine, listening to our pain, and taking real action to fix this broken system."

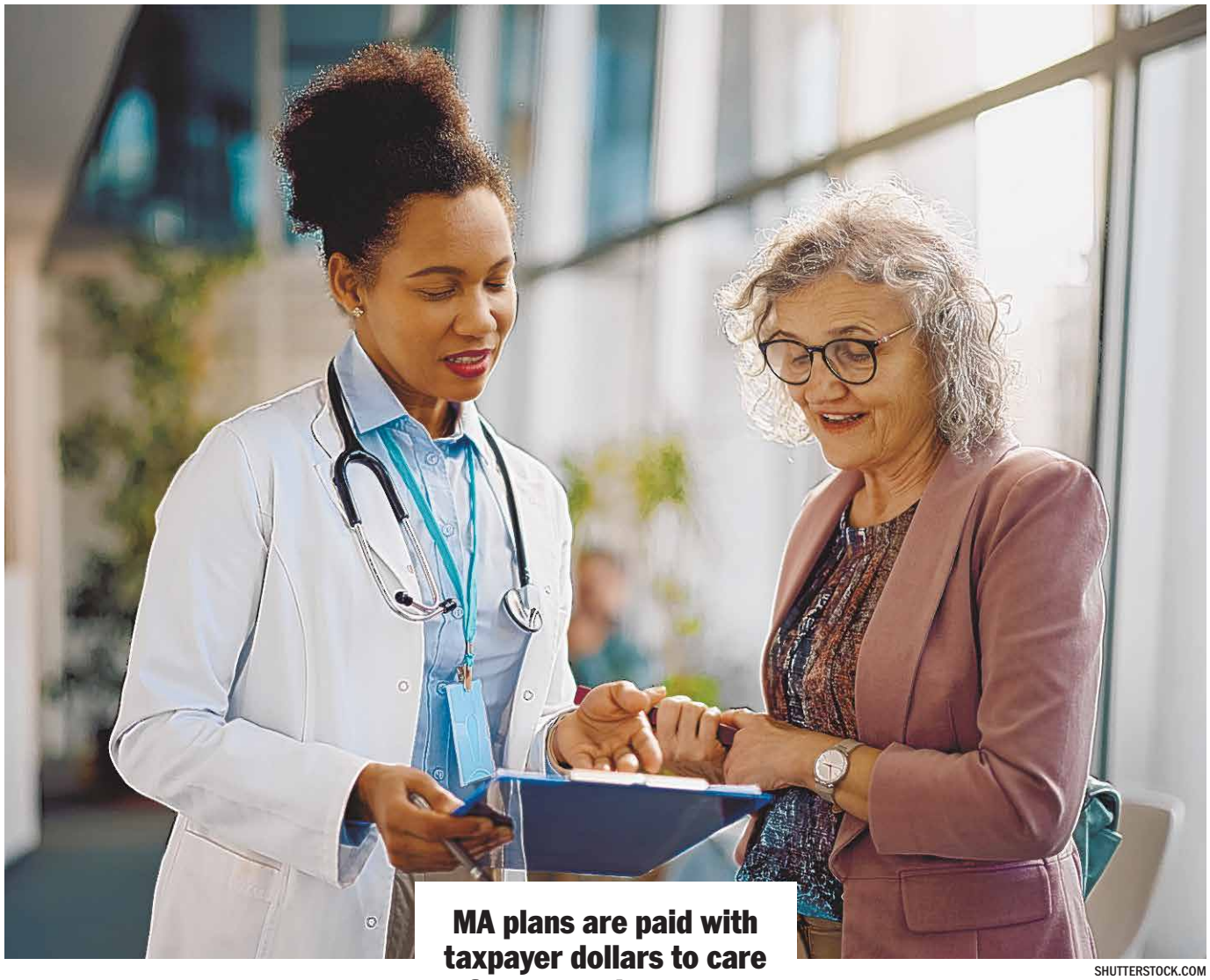
But the work is not over. We must reach across the aisle to pass the *Early-Onset Alzheimer's Coverage Act* to fix this gap, support our caregivers, and offer a real lifeline to families facing one of the hardest challenges life can bring.

Rep. Sharice Davids has represented Kansas' Third Congressional District since 2019. She serves on the House Committee on Transportation and Infrastructure and the House Committee on Agriculture.

Seniors deserve Medicare transparency



By U.S. Rep. Bob Onder, R-Mo., M.D., J.D.



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For millions of American seniors, navigating the health care system means fighting insurance companies and bureaucratic obstacles at the very moment their focus should be on getting well.

Consider the experience of Margaret, a 70-year-old Missouri woman, reported this summer by KFF Health News. Margaret has a primary immune deficiency, a condition I have treated as a board-certified immunologist. She relies on Hizentra, a weekly immunoglobulin maintenance therapy, to restore her immune system and prevent infections. It worked, and it kept her healthy, but it is expensive. Without insurance, it costs thousands of dollars a month.

When she switched Medicare Advantage (MA) plans, her new insurer denied prior authorization for that medication. After missing several doses, she developed a serious infection that required emergency care and an overnight hospital stay.

Then, despite her physician's recommendation, her insurer denied coverage for the hospital stay, deciding she was not sick enough to need it.

Yes, you read that right. Margaret got sick because her insurance plan denied her medication, and, when the resulting infection required hospitalization, her insurer denied coverage for her hospital stay.

She appealed and won, on both claims. But she should never have had to spend her time and energy, while sick with a life-threatening infection, fighting for care her doctors had already said she needed. And remember, MA is paid for by your and Margaret's tax dollars, which she worked for decades to earn.

Margaret is not alone. According to KFF, 81% of appealed denials in MA were at least partially overturned in 2024, yet few seniors appeal because it is a burdensome bureaucratic process. Think of your local Department of Motor Vehicles: stuck on hold, talking to an unhelpful AI chatbot, or, if you finally reach an agent, talking to someone on another continent with marginal English proficiency.

More than half of Missouri's 1.3 million Medicare beneficiaries are enrolled in MA or other private plans. These MA plans are paid by the government every month to provide healthcare to beneficiaries, but too many of them seek to maximize profits by denying necessary care, even care they have preapproved.

It is beyond ridiculous that seniors and healthcare providers must fight to prove, all over again, that previously approved care is medically necessary. Insurers pledged last year to honor existing approvals for 90 days when patients switch plans, but at least one major insurer has said that promise does not cover prescription drugs.

Seniors deserve to know that when their plan says yes, it means yes. That is why Rep. Greg Landsman, D-Ohio, and I introduced the bipartisan *Protecting Approved Care Act*, which would prevent MA insurers from retroactively denying or reducing payment for care they have already approved. But protecting approved care is only part of the solution.

MA plans are paid with taxpayer dollars to care for our seniors. They owe those seniors, and taxpayers, clear rules, honest coverage decisions, and accountability when they get it wrong.

Seniors also deserve to know what their plan will actually cover. In June, I led a letter with fellow physicians in the GOP Doctors Caucus urging the Centers for Medicare & Medicaid Services to set minimum national standards for drug coverage in MA. Too often, plans use step therapy to force patients to try an insurer's preferred drug first, even when that drug is not available where they live. Rheumatologists call these "ghost formularies": drugs that exist on paper, but patients can't actually get. Meanwhile, seniors with painful conditions like rheumatoid arthritis are left waiting far too long for treatment.

MA plans are paid with taxpayer dollars to care for our seniors. They owe those seniors, and taxpayers, clear rules, honest coverage decisions, and accountability when they get it wrong.

Insurance reviewers are not in the emergency room with patients, and they bear no liability when their denials of care result in the worsening of patients' conditions or even death. Yet those reviewers have the authority to decide whether a patient can be admitted to the hospital. As a physician and member of Congress, I believe those decisions should be between patients and their doctors, not insurance executives or Washington bureaucrats.

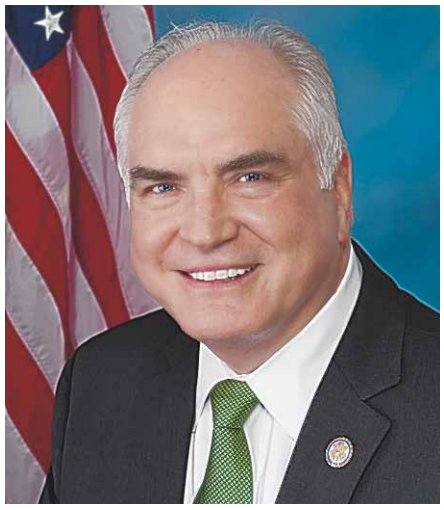
Our seniors have spent their entire lives working, raising families, serving our country, and strengthening our communities. They deserve a health care system that works for them, not against them. I will continue working with my colleagues, Republican and Democrat, to fight for them in Washington.

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.



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Patients over paperwork: Prior authorization reform can help American seniors



By U.S. Rep. Mike Kelly, R-Penn.

It's easy to believe Washington is divided. In some cases, it's true.

But I'm proud to lead one of the most bipartisan pieces of legislation in Congress, and it's a game changer for the millions of American seniors enrolled in Medicare Advantage (MA).

For the last seven years, I've led the *Improving Seniors' Timely Access to Care Act* with Rep. Suzan DelBene (D-Wash.). This legislation modernizes and improves the prior authorization process for Medicare Advantage plans by establishing a standardized electronic system. Prior authorization is a tool to ensure that patients receive efficient and necessary treatment while spending insurance dollars appropriately.

While valuable, this tool has, in practice, been often abused by health insurers. Perhaps most notably, the final decision about your care often isn't made by your provider — it's by your insurance company. At times, "prior auth" leads to burdensome paperwork for physicians and hospital teams while slowing timely care for vulnerable patients.

Healthcare should be centered on patients, not bureaucracy. Seniors who have earned their Medicare benefits deserve access to the care they need when they need it.

More than 35 million Americans, including 1.5 million in the commonwealth of Pennsylvania, are enrolled in Medicare Advantage plans. Every day, they are faced with bureaucratic hurdles – often with unnecessary delays – only to later receive approval for the treatment or care their doctor originally recommended. Our seniors deserve better, and our bill provides that.

The current prior authorization process is antiquated. The system relies on outdated fax machines, phone calls, and inconsistent procedures. The goals of our legislation are simple: to increase transparency for both the patients and providers, to set clear timelines for decisions, and to strengthen protections for beneficiaries. By replacing these with a more efficient electronic process, we can reduce unnecessary delays and ensure patients receive the timely, necessary care they need.

Improving healthcare is not a red issue or a blue issue – it's a red, white, and blue issue. Our bill has more than 300 U.S. House of Representatives co-sponsors and more than 70 U.S. Senate co-sponsors. This bipartisan supermajority reflects the widespread agreement that the current prior authorization process needs significant changes and the status quo is unacceptable. This summer, the legislation unanimously passed the Ways and Means Committee, on which I chair the Tax subcommittee and serve on the Health subcommittee, and now advances to full U.S. House consideration.

Healthcare should be centered on patients, not bureaucracy. Seniors who have earned their Medicare benefits deserve access to the care they need when they need it. Enrolling in a Part C "Advantage" plan should be just that: an advantage. At the same time, physicians and hospitals deserve systems that support personable patient care.

What's most telling when I'm back home meeting with constituents in my Western Pennsylvania district is just how widely supported this legislation is not only by patients, but by providers, as well. This summer, I met with an ophthalmologist in Erie, Penn., who explained to me he has multiple employees dedicated solely to managing prior authorization requests with insurance companies. The slow-moving process takes valuable time away from patient care. It's another barrier for all parties to clear as they seek urgent medical care. These lengthy delays are unacceptable, and our legislation would fix this.

Health plans, healthcare providers and patients agree that the prior authorization process must be improved to better serve patients and reduce red tape for clinicians. The prior authorization process remains the number one burden identified by healthcare providers.

As we near the end of the 119th Congress, and as the partisan pendulum swings in Washington, there is no time to waste – we must pass the bipartisan *Improving Seniors' Timely Access to Care Act* today. It's good policy that puts people over paperwork. By improving the Medicare Advantage prior authorization process, patients across the board – not just MA enrollees -- will benefit from a stronger, more stable healthcare system.

Rep. Mike Kelly is the sponsor of the Improving Seniors' Timely Access to Care Act. He serves as chairman of the Ways & Means Subcommittee on Tax and is a member of the Ways & Means Subcommittee on Health.



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Ending the patient runaround



By U.S. Rep. Michael Cloud, R-Texas

Washington bureaucrats attempt to make the piece of cheese at the end of the maze bigger. Very few get rid of the maze. The Ending Patient Runaround Act is written to take it apart by strengthening transparency, competition, and patient rights.

How many soccer games, bedtime stories and dinners have you missed because you were on hold with your health insurance company? Families pay thousands of dollars in premiums to avoid the hassle, then feel like they are working part-time for the insurance company.

The United States spent $5.7 trillion on both health care and insurance in 2025, averaging about $16,500 per person. For thousands of dollars, patients should be receiving accessible health insurance and fair bills. Often, patients are receiving neither.

American Hospital Association (AHA) found that 62% of patients have had medical care delayed because of their insurance provider, and half of those patients say their health has gotten worse as a result. A 2024 report from the Commonwealth Fund found that 45% of insured, working-age adults reported receiving a medical bill or being charged a copayment in the past year for a service they thought should have been free or covered by their insurance. Additionally, 17% of respondents said that their insurer denied care that was recommended by their doctor; more than half said that neither they nor their doctor challenged the denial. Fewer than half of the people who ran into those problems challenged them, mostly because they didn't know they could.

Doctors are experiencing the same issues from their side of the desk. The American Medical Association (AMA) found that 93% of physicians report that prior authorization delays necessary patient care. Furthermore, 82% of surveyed doctors indicate that these administrative hurdles can lead patients to abandon their recommended treatments. A patient who gives up on recommended treatment because of paperwork has been failed by the system.

Washington bureaucrats attempt to make the piece of cheese at the end of the maze bigger. Very few get rid of the maze. The *Ending Patient Runaround Act* is written to take it apart by strengthening transparency, competition, and patient rights. Here is what it does for patients:

1. **Ending Prior Authorization Abuse:** A patient waiting on approval for a procedure gets a timely decision in writing within 30 days, with peer-to-peer accountability for denied coverage.

2. **Ending Rug-Pulled Coverage:** Once coverage starts, an insurer cannot reduce drug coverage or cut services from the plan midway through the year.

3. **Ending Secret Prices:** Plans must give enrollees the procedure code and the price for each service covered, plus the full list of what is covered, with the insurance contract. People can compare plans before they sign.

4. **Ending In-and-Out of Network:** Plans must cover an out-of-network provider what they would pay an in-network provider for the same service. In rural areas, where the nearest in-network specialist can be a long drive away, patients won't be punished for choosing the doctor they trust.

5. **Ending the Obamacare Ban on Actual Insurance:** Catastrophic plans, renamed Basic Plans, would be open to everyone, including on the ACA marketplace. They work like home or car insurance, built around a major event. Obamacare banned almost everyone from being able to purchase these plans.

6. **Ending Overseas Customer Service:** Insurance providers must assign you a single customer service point of contact based in the United States and proficient in English.

7. **Ending Overbilling:** If a plan or provider bills a patient too much, the patient gets the money back plus a penalty, compounded for delayed payback.

Additionally, individuals are given a Universal Savings Account, allowing adults to put up to $10,000 a year into an account after tax, grow it tax-free, and take it out tax-free for any purpose. That could be a medical bill, tuition for a child, repairs after a hurricane or flood, a down payment, or a cushion for the unexpected. Your HSA (Health Savings Account), FSA (Flexible Spending Account), and HRA (Health Reimbursement Arrangement) become one simple account. The money belongs to the account holder. No insurer or agency decides how it is used.

This bill makes insurers and providers do what they should already be doing: answer on time, show their prices, keep their word, and fix their own mistakes. It's time to put patients back in the driver's seat.

Rep. Michael Cloud represents Texas's 27th District, from the Coastal Bend to part of Bastrop County, one of the fastest-growing areas in the state. The district is home to the nation's top domestic energy export port and a major LNG hub, Naval Air Station Corpus Christi, the Corpus Christi Army Depot, and some of the state's best ranch and farm country. On the House Appropriations Committee, he serves as Vice Chairman of the Energy and Water Development Subcommittee and sits on the Interior and the Financial Services and General Government subcommittees. He also serves on the House Oversight and Government Reform Committee.

America's biological defense cannot wait



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



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Since President Donald Trump returned to office, his Administration has made strengthening our national security a priority. Congress must do its part to ensure America is prepared for biological threats. As a physician and an Army veteran, I know that readiness requires sustained investment and planning before a crisis strikes. That is why I am calling for a multi-year reauthorization of the *Pandemic and All-Hazards Preparedness Act* (PAHPA) before the current extension expires on Dec. 31. We must give our hospitals, researchers, and health officials the tools they need to protect the American people.

PAHPA is the backbone of America's health emergency preparedness, underpinning everything from the Strategic National Stockpile (SNS) to the development of critical medical countermeasures. Congress first passed it two decades ago and built in expiration dates so lawmakers would regularly revisit and strengthen it. Since most of the law lapsed in 2023, Congress has relied on short-term extensions that make serious, long-term crisis preparation nearly impossible.

PAHPA has delivered real results. The law created the Biomedical Advanced Research and Development Authority (BARDA), the federal hub for developing and buying medical countermeasures needed to address biological, radiological, and nuclear threats, pandemic influenza, and emerging infectious diseases. Products BARDA has backed have earned 116 Food and Drug Administration (FDA) approvals, licensures and clearances to date.

PAHPA's investments have paid off. Working with industry through Project BioShield, which PAHPA reauthorizations have funded, BARDA has helped add 23 products to the Strategic National Stockpile to counter threats ranging from anthrax and smallpox to nerve agents and radiation exposure. When Ebola and Zika outbreaks hit, BARDA supported critical medical countermeasures and diagnostic technologies. And when COVID-19 emerged, a decade of investment in medical countermeasure research and development enabled BARDA to respond quickly, issuing its first pandemic awards in early 2020.

PAHPA also authorizes the Hospital Preparedness Program, which helps hospitals keep their doors open and restore services during disasters. Through the regional health care coalitions it supports, nearly every acute care hospital in the country now plans for emergencies alongside public health and emergency management agencies.

But those gains are at risk if Congress keeps running PAHPA on short-term extensions.

America's adversaries are investing in exactly the capabilities PAHPA exists to counter. The State Department's most recent compliance report concluded that Iran has not abandoned its intention to research and develop biological agents and toxins for offensive purposes, and that it retains the flexibility to turn legitimate research into lethal biological weapons agents whenever its leadership gives the order. The Office of the Director of National Intelligence (ODNI) has reached a similar conclusion.

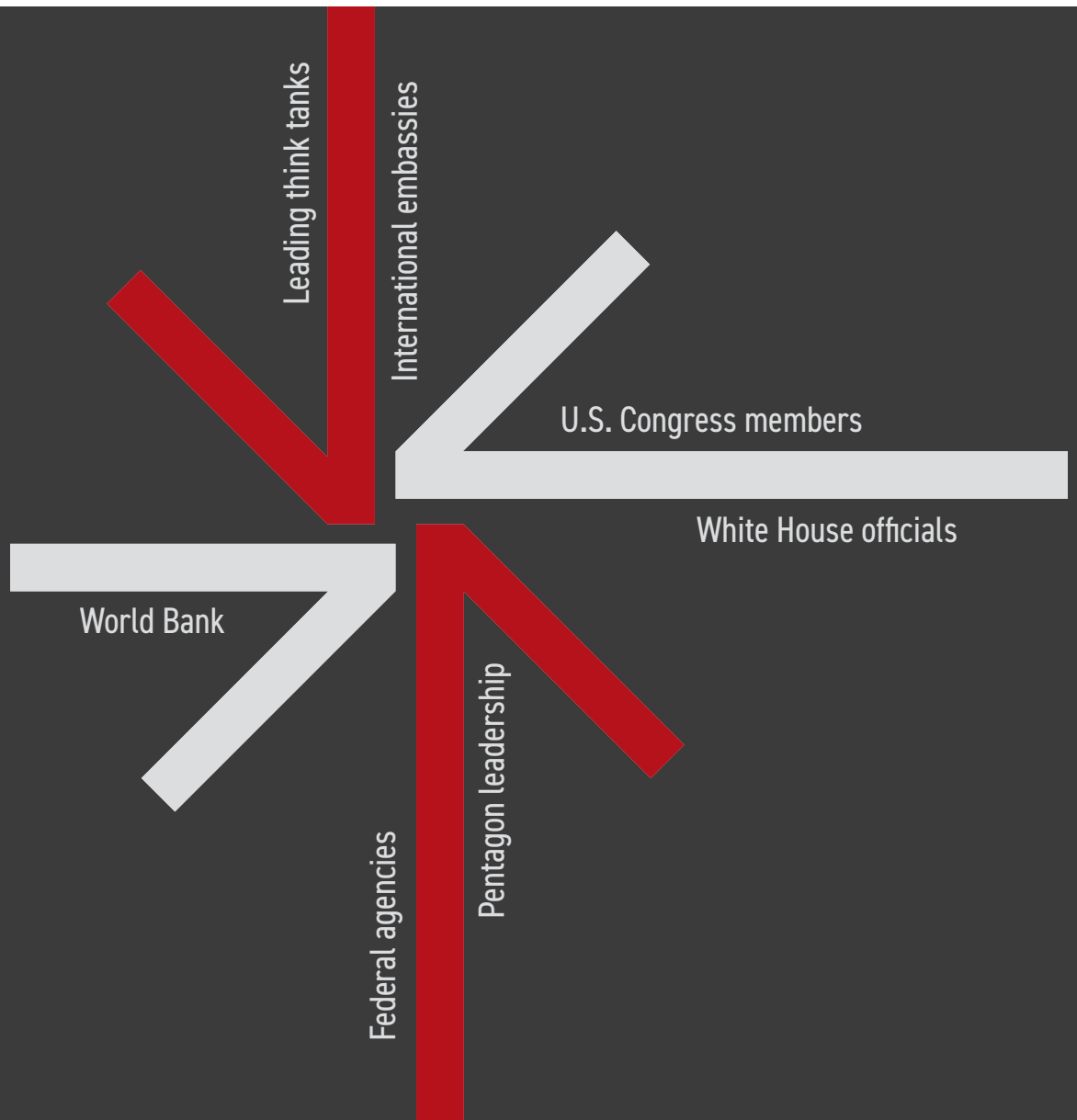
A weakened health security system is a national security vulnerability. Developing and maintaining the medical countermeasures, diagnostic tools and response capabilities needed to address biological threats requires time and investment.

A weakened health security system is a national security vulnerability. Developing and maintaining the medical countermeasures, diagnostic tools and response capabilities needed to address biological threats requires time and investment. Companies will not make that investment against authorities that expire every few months. Short-term extensions keep the lights on; they do not build capability. The solution is a multi-year PAHPA reauthorization.

As a physician, a veteran and a member of Congress, I know that protecting Americans requires us to prepare before a crisis strikes. That means listening to the hospitals, researchers and state and local officials who put these programs to work — and making sure we are investing in what delivers results. PAHPA is an opportunity to strengthen that readiness, modernize our defenses, and ensure taxpayer dollars support the capabilities we need to keep Americans safe.

We cannot wait until an emergency to build a stockpile, develop a vaccine or prepare our hospitals to care for a surge of patients. These capabilities take years to develop, and our adversaries will not wait for Congress to get its work done. With the current extension expiring Dec. 31, Congress must pass a multi-year reauthorization. Protecting the American people is our first responsibility. We need to act now.

An Army veteran and physician from Panama City, Congressman Neal Dunn proudly represents the Second Congressional District of Florida. He serves as vice chair on the House Committee on Energy & Commerce and is a member on the Select Committee on China.



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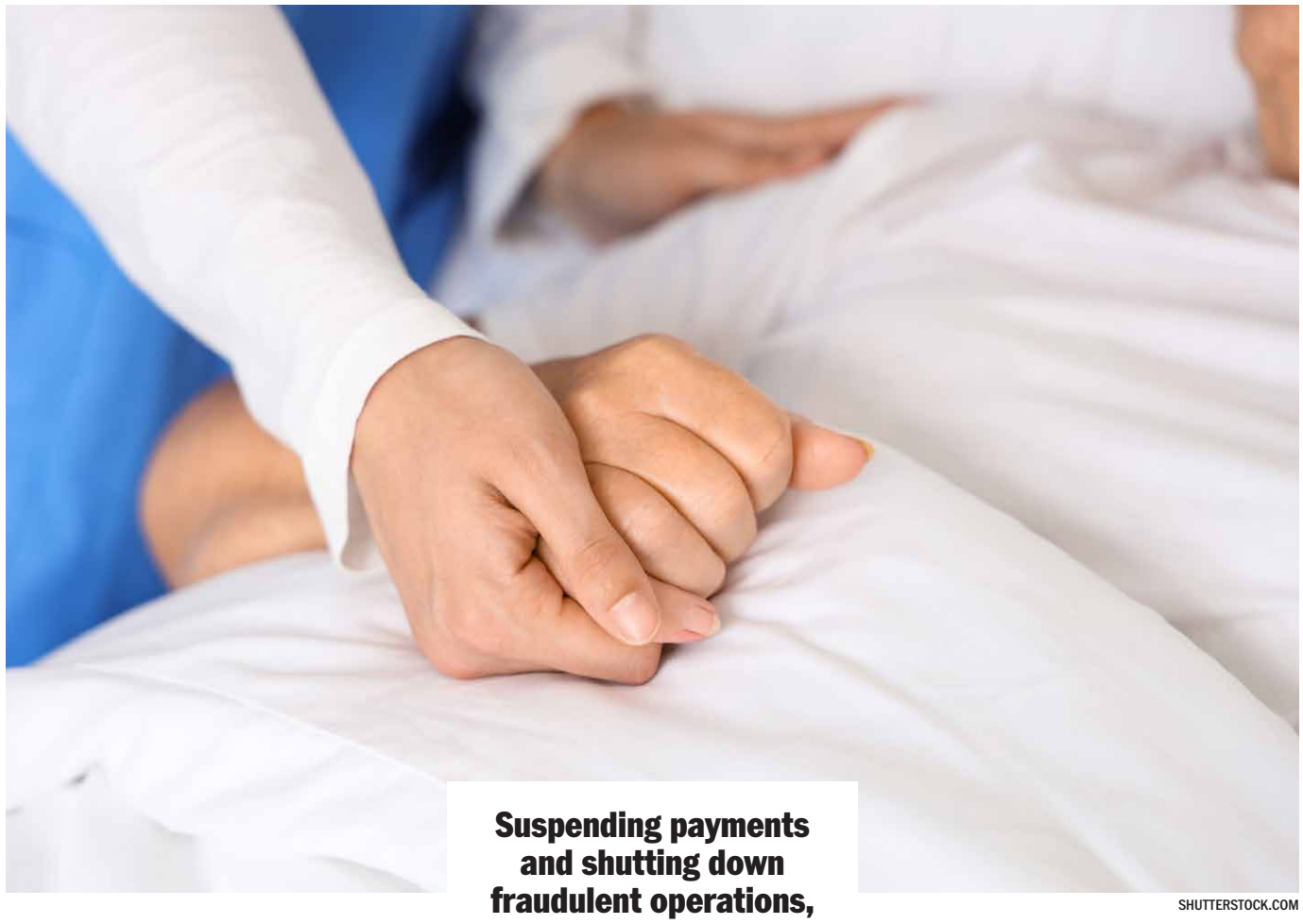
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Medicare accountability: Protecting seniors and stopping fraudsters



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



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In Los Angeles alone, approximately 800 hospice and home health agencies suspected of fraud accounted for a staggering $1.4 billion in Medicare spending last year before the Centers for Medicare & Medicaid Services (CMS) suspended their payments. Many of these operations were not providing care at all. They were exploiting a program designed to serve our most vulnerable Americans, siphoning taxpayer dollars into fraudulent schemes while putting seniors and their benefits at risk.

More than three years ago, I sounded the alarm about rampant hospice fraud and the lax oversight by the Biden administration and state governments that allowed it to flourish. I warned that these schemes were not simply wasting hundreds of millions of taxpayer dollars. They were undermining the integrity of Medicare, jeopardizing legitimate hospice providers and exposing vulnerable seniors to identity theft, fraudulent enrollment and stolen benefits.

In March 2023, and again in March 2024, I confronted then-U.S. Department of Health and Human Services Secretary and incoming California Governor Xavier Becerra about his department's failure to address these abuses. I also led a bipartisan letter to the HHS Inspector General demanding action on alarming reports of fraud that threatened patient safety and fiscal accountability.

The warning signs were unmistakable. The evidence was mounting, yet the Biden administration failed to take meaningful action. This was not a problem of insufficient warnings. It was a failure of leadership and accountability.

CMS Administrator Dr. Mehmet Oz and Vice President JD Vance's White House Task Force to Eliminate Fraud moved aggressively to confront these schemes, suspending payments to approximately 800 suspected fraudulent hospice and home health agencies in Los Angeles alone.

As HHS Secretary Robert F. Kennedy Jr. testified before the House Ways and Means Committee in April, "clearly, these were fraudulent."

These operations were not serving patients. They were exploiting Medicare as a vehicle for theft. Rather than allowing the abuse to continue unchecked, the Trump administration took action to stop taxpayer dollars from flowing to suspected fraudsters.

As the daughter of a physician, I grew up understanding the extraordinary dedication and sacrifice of our health care professionals. I know how deeply hospice and home health providers care about their patients and the families who depend on them during some of life's most difficult moments.

That is precisely why this fraud is so infuriating. Every dollar stolen through a fraudulent claim is a dollar diverted from the patients and legitimate providers Medicare was created to serve. Every fraudulent enrollment threatens a senior's access to care. Every sham operation undermines public confidence in a system millions of Americans rely upon.

We cannot allow criminals to exploit vulnerable seniors while honest providers are forced to navigate the consequences.

Suspending payments and shutting down fraudulent operations, while essential, are only part of the solution. We must stop fraud before it starts.

Suspending payments and shutting down fraudulent operations, while essential, are only part of the solution. We must stop fraud before it starts.

CMS needs stronger tools to identify suspicious activity, prevent fraudulent enrollments, hold bad actors accountable and protect beneficiaries without creating unnecessary barriers to legitimate care.

That is why I introduced the bipartisan Protecting Seniors and Stopping Fraudsters Act. My legislation strengthens Medicare oversight, targets fraudulent hospice and home health operations, protects seniors from improper enrollments and improves accountability throughout the system.

The objective is straightforward: Make it harder to steal from Medicare, not harder to care for patients.

We must never lose sight of what is at stake. Hospice care provides comfort, dignity and support to patients and families at one of the most vulnerable moments of their lives. Families have only one opportunity to get end-of-life care right. They deserve access to trusted providers, meaningful choices and the peace of mind that their loved ones will receive the care they need. Protecting that access must remain our priority.

The American people should not have to choose between safeguarding taxpayer dollars and preserving compassionate care. We can and must do both.

The Trump administration has demonstrated that decisive action against fraud is possible. Now Congress must build on that progress by closing loopholes, strengthening safeguards and ensuring the government protects patients rather than enabling criminals.

Medicare was created to care for American seniors, not enrich fraudsters. It is time to pass the Protecting Seniors and Stopping Fraudsters Act and make certain that every dollar intended for patient care goes toward patient 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.



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