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LEGISLATIVE PROPOSALS TO SUPPORT
PATIENT ACCESS TO MEDICARE SERVICES
THURSDAY, JANUARY 8, 2026,
House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:20 a.m., in Room 2123, Rayburn House Office Building, Hon. H. Morgan Griffith [Chairman of the Subcommittee] presiding.

Present: Representatives Griffith, Harshbarger, Bilirakis, Carter of Georgia, Crenshaw, Joyce, Balderson, Miller-Meeks, Cammack, Obernolte, Bentz, Houchin, Langworthy, Kean, Rulli, Guthrie (ex officio), DeGette, Ruiz, Dingell, Barragan, Schrier, Trahan, Veasey, Fletcher, Ocasio-Cortez, Auchincloss, Carter of Louisiana, Landsman, and Pallone (ex officio).

Also Present: Representatives Evans, Matsui, and McClellan.

Staff Present: Christian Calvert, Press Assistant, Press; Jessica Donlon, General Counsel; Sydney Greene, Director, Finance and Logistics; Jay Gulshen, Chief Counsel, Health; Annabelle Huffman, Clerk, Health; Megan Jackson, Staff Director; AT Johnson, Special Advisor; Sophie Khanahmadi, Deputy Staff Director; Sarah Meier, Counsel and Parliamentarian; Joel Miller, Chief

Counsel; Seth Ricketts, Special Assistant; Chris Sarley, Member Services/Stakeholder Director; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Nick Wooldridge, Professional Staff Member, Health; Lydia Abma, Minority Policy Analyst; Jacquelyn Bolen, Minority Counsel, Health; Keegan Cardman, Minority Staff Assistant; Tiffany Guarascio, Minority Staff Director; Jackson Hall, Minority Intern; Perry Hamilton, Minority Member Services and Outreach Manager; Brent Langellier, Health Fellow; Una Lee, Minority Chief Counsel, Health; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Hannah Treger, Minority Staff Assistant; and Laurel Uhomba, Minority Health Fellow;.

Mr. Griffith. The subcommittee will come to order.

The chair recognizes himself for 5 minutes for an opening statement.

In today's hearing, we will discuss 10 bills aimed at improving patient access in Medicare. As our population ages, it is critical that Medicare policies keep pace with patient needs. Ensuring beneficiaries can obtain timely, cost-effective services is essential to fulfilling Medicare's promise.

A handful of bills we are discussing today help increase access to durable medical equipment, or DME, which include wheelchairs, oxygen equipment, walkers, diabetic supplies, just to name a few. However, the way Medicare reimburses for these products can be improved.

Dr. Joyce from Pennsylvania is leading H.R. 1703, the Choices for Increased Mobility Act, which creates a new billing code to improve Medicare coverage for ultra-lightweight wheelchairs, particularly those made from titanium or carbon fiber. Currently, an individual must pay full price for the upgrade to a lighter, more functional wheelchair and then hope to get reimbursed by Medicare later. This bill would allow Medicare to cover a portion of the cost upfront to ease the financial burden on individuals.

Another bill, H.R. 2477, the Portable Ultrasound Reimbursement Equity Act led by Representative Van Duyne from Texas, provides Medicare reimbursement for portable ultrasound transportation and services which will help seniors get the care they need.

Representative Miller-Meeks from Iowa champions H.R. 2005. The DMEPOS, also known as DMEPOS Relief Act, would establish a fairer rate for DME supplies. The way DME products get priced is through a process known as competitive bidding. This is where DME suppliers bid to be the sole contractor in a certain area of the country, with the winning bid prices used to determine supplier reimbursement. These prices are not one-size-fits-all, and suppliers, especially in some areas, struggle to stay open due to these low rates. This bill aims to help mitigate that impact.

The last bill in the DME space is H.R. 2902, the Supplemental Oxygen Access Reform Act, led

by Representative Valadao from California. Among other things, this bill removes supplemental oxygen and its supplies from the competitive bidding program, and creates a new reimbursement rate for supplemental and liquid oxygen.

We will also be considering H.R. 2172, the Preserving Patient Access to Home Infusion Act, led by Representative Buchanan from Florida. This bill would make updates to the home infusion therapy benefit and support patient access to this benefit. The current reimbursement structure is not aligned with how these therapies are currently administered in the home. This bill will modernize the model, ensure adequate provider reimbursement, and support patient access to home infusions.

Another bill being considered today is H.R. 5269, the Reforming and Enhancing Sustainable Updates to Laboratory Testing Services Act, led by our own Richard Hudson from North Carolina. This bill would update how CMS establishes reimbursement rates for clinical laboratory services paid under Medicare Clinical Lab Fee Schedule. This important bill aims to create a less burdensome process for CMS to determine private payer-based rates for lab services.

A few other bills being considered today include H.R. 5243 led by Representative McClellan from Virginia that brings more transparency in the supplemental benefits provided by Medicare Advantage plans.

The Healthcare Efficiency Through Flexibility Act also led by Representative Buchanan -- this bill would extend certain methods for collecting Accountable Care Organizations' quality measurement data as well as establish a digital quality measure pilot program.

H.R. 6210, the Senior Savings Protection Act led by Representative Matsui from California, reauthorizes and funds certain programs under the Medicare Improvements for Patients and Providers Act. These programs help low-income beneficiaries understand and access their benefits.

Lastly, we will discuss H.R. 6361, the Ban AI Denials in Medicare Act, led by Representative Landsman from Ohio. This bill prohibits the Center for Medicare and Medicaid Innovation, or

CMMI, from implementing the Wasteful and Inappropriate Service Reduction model, or the WISeR model. While I understand the concerns around AI and prior authorization, the CMMI statutory mission is to lower healthcare costs and improve outcomes for patients. The WISeR model does not change Medicare coverage policy, but will focus on ensuring that, for a set of nonemergency services, seniors are getting safe, effective, and appropriate care.

I look forward to hearing from our witnesses today and working to advance these bills to a markup.

I now recognize the subcommittee ranking member, Representative DeGette, for 5 minutes for an opening statement. Representative DeGette.

Ms. DeGette. Thank you very much, Mr. Chairman. And I will say I am glad that this committee is finally having another hearing, and I am glad we are bringing up some bills that overall we can agree on in a bipartisan way, but I hate to tell you, Rome is still burning. Alarm bells have been ringing for healthcare affordability for months. And with the expiration of enhanced premium tax credits at the end of 2025, we knew that premiums would skyrocket in 2026.

Millions of Americans who get health insurance through the ACA were notified last year that their premiums were doubling or more. They are now trying to figure out how to pay for coverage this year or if they are going to take the terrifying step of going without insurance that has become too expensive, and they are also wondering if Congress will finally step in to save them from these skyrocketing premiums.

In my district, for example, a family of four making \$128,000 a year -- this is teachers, nurses, farmers, small business owners -- got hit with an average \$14,000 increase in their Silver plan premiums, but the majority has done nothing to help.

Now, enhanced premium tax credits aren't, on their own, the long-term fix for healthcare affordability that we need, but they have been a critical part of lowering premiums since we passed them during COVID, and they have expanded healthcare coverage even more than we expected.

So, while Republicans let the Federal tax credits expire, States like Colorado -- but not all States -- have stepped in with a short-term fix. But States like Florida and Texas, they might be forced to pay more than 20 percent of their income in healthcare premiums if they keep insurance at all.

This crisis did not appear overnight. For over a year, the Democrats on this subcommittee and everyday Americans have been warning Donald Trump and the majority about the healthcare affordability crisis and the impending expiration of the tax cuts. We asked for hearings to consider legislation and to do something -- anything -- to be able to help people afford their health insurance.

But rather than have a serious conversation about affordability, the majority wasted precious time on legislation that will only raise costs and kick people off their coverage. Instead of extending premium tax credits, meaningfully lowering healthcare costs, or expanding access to affordable coverage, Republicans' big, bad bill that they spent the first half of the year passing, sent 15 million people to cause their health insurance -- to lose their health insurance so that they could pay for tax breaks for the ultra-wealthy, and now the Republicans are doing everything they can to ignore the necessity of extending ACA premium subsidies and lowering costs.

Democrats literally had to force the majority to bring up the tax credit extension for a vote this week because -- at the same time Republicans are bringing up bills to police shower heads. Also, they are trying to change the subject to House savings accounts and, really, abortion restrictions. For once, I would encourage the majority to take Donald Trump's advice.

Just this week, Donald Trump implored congressional Republicans to, quote, "be flexible on abortion restrictions so we can actually focus on lowering costs."

Only time will tell if the majority will listen, but I am not too hopeful. They have completely avoided the topic of affordability, canceling town halls, holding as few Health Subcommittee hearings as possible, and simply allowing the crisis to unfold, which is why Democrats, with the help of four GOP members who are actually listening to the three-quarters of Americans who support extending

the tax credits, have stepped up to bypass the Speaker and put a 3-year enhanced ACA subsidy extension on the House floor which will be voted on later today. The extension will cut premium spikes by 80 percent on average. It will wipe out increases for lower-income families. It will save 5 million people from losing their insurance. While short term, it is a straightforward fix.

To those watching at home, I will say this: If your representative truly wants to lower your healthcare costs, they will vote in favor of this bill on the floor later today. If your Senators truly want to lower your insurance premiums, they will vote in favor of this bill when it goes to the Senate. And if President Trump truly wants to put money in your pockets, he will sign this bill into law. Republicans refused to act last year, and now we will see if they have the backbone to truly help lower costs.

I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the chairman of the full committee for 5 minutes for an opening statement, Mr. Guthrie.

The Chair. Thank you, Mr. Chairman. I appreciate the recognition, and I want to thank all of our witnesses for being here today to this hearing. Today's hearing is important. We will explore potential solutions to strengthen the Medicare program and enhance seniors' access to care.

For example, in 2014, Congress enacted Protecting Access to Medicare Act, which reformed Medicare payments for lapsed services, but it has become clear the law is not exactly operating as intended, and Congress has frequently modified or delayed aspects of this reform. Today, the subcommittee will examine potential solutions for payment stability and consistency for lapsed services, encourage innovation in diagnostic lab testing, and protect seniors' ability to receive these services, all while ensuring Federal taxpayers' dollars are used responsibly and sustainably.

The subcommittee will also hear testimony about several bills related to durable medical equipment, or DME, and home infusion therapy. These are critical items and services for seniors,

particularly for beneficiaries in rural and underserved areas. We will also examine the WISeR model, which is focused on promoting high-quality care for Medicare beneficiaries by ensuring that certain services are provided in alignment with existing CMS coverage policies.

While I know many patients and providers have frustrations with the traditional prior authorization processes, I also appreciate that our current Medicare spending trajectory is unsustainable. CMMI was created for the express reason of trying new payment models that might make our healthcare programs more efficient and effective. Therefore, we must think creatively to see how CMMI can harness cutting-edge technologies that aim to help beneficiaries avoid unnecessary care.

Despite all these reservations, I look forward to a robust discussion on all of the bills before us today, but our work cannot just end here. As we look forward to all the important work we have coming this year, we do need to take a broad examination of healthcare costs. As members of this committee know well, we do not shy away from tackling tough issues within our wide-ranging jurisdiction. And I am pleased to announce that, over the next few months, we will hold a series of hearings to examine healthcare affordability.

While some want to talk solely about a small subset of the population, I believe we have to take a broader look as to what is driving costs for all Americans. On January 22, we will hold a Health Subcommittee hearing with CEOs of some of the largest health insurance companies representing a cross section of the marketplace.

I am hopeful that we can have a productive discussion about what is truly driving increased healthcare costs and premiums for everyone.

From there, we need to look at the entire healthcare system, why prices and costs are going up, and what we can do -- hopefully, much of it in a bipartisan way -- to address these issues. We have the greatest healthcare system in the world. We just need to examine how we can make it more affordable for all Americans.

I thank the witnesses for their participation today, and I will yield back.

Mr. Griffith. The gentleman yields back. I agree with him and glad we are doing a lot of hearings on affordability.

And I will take a point of personal privilege and recognize the former chairman of this committee. Mr. Walden is in the room. We appreciate him being here. For those who don't know, it is not a mirror. That is his portrait. That is him.

I now recognize for an opening -- I now recognize for 5 minutes for an opening statement the ranking member of the full committee, Mr. Pallone, for an opening statement.

Mr. Pallone. The former chairman still looks good. He looks like the portrait. Anyway, thank you, Mr. Chairman.

Today, committee Republicans are holding a hearing on Medicare to supposedly strengthen the program and enhance access to care. Yet, congressional Republicans have spent the last year decimating our healthcare system, cutting more than \$1 trillion for the Medicaid program and the biggest cuts in this country's history, and all to fund giant tax cuts for big corporations and billionaires.

At the same time, Republicans refuse to extend the Affordable Care Act's enhanced premium tax credits that help low- and middle-income Americans afford their healthcare coverage. And last year, Democrats repeatedly pressed Republicans to take action, but they refused, and so the tax credits expired at the end of 2025. Now, here we are on January 8 with insurance premiums skyrocketing by two, three, and even four times for 24 million Americans.

This is a major failure of leadership to address the affordability crisis. In fact, it is such a failure that even members of our own party have joined -- of their own party, the Republican Party -- have joined Democrats in forcing a vote on the House floor to extend the tax credits through the discharge petition that we are going to be voting on or we are voting on this week.

Rather than addressing the healthcare affordability crisis that seniors and all Americans are

facing, Republicans are holding this hearing on Medicare bills that will mostly raise payment rates for certain classes of providers in Medicare. Now, some of these bills, like the RESULTS Act and the Preserving Patient Access to Home Infusion Act, address known payment issues in the Medicare program that we need to fix. And, while I support these efforts, I also believe that fixing minor payment issues in Medicare does nothing to fix the broader crisis Americans are facing in paying for healthcare and their rising cost of living across the board.

The failure to extend the enhanced premium tax credits are particularly harmful to older Americans preparing for retirement. Over half of all enrollees who are losing all support to purchase ACA coverage are between the ages of 50 and 64. Take, for example, a 60-year-old couple in Texas with a household income of \$85,000. They rang in the new year facing a more than \$26,000 premium increase just to keep their healthcare. Undoubtedly, older Americans like them will either go without coverage or they will purchase worse coverage that leaves them on the hook for thousands of dollars of medical costs when they get sick or need routine medical care. And, without these enhanced tax credits, they will become less healthy and face the possibility of financial ruin.

And the failure to extend these tax credits is compounded by the devastating cuts in the big, ugly bill that rips healthcare away from 15 million Americans, increases out-of-pocket costs for millions of Americans, and is already forcing hospitals, maternity care units, and clinics across the country to close their doors and cut services. The big, ugly bill even directly attacks seniors and people with disabilities who rely on Medicare. The Republican law makes it harder to enroll in coverage for programs like the Medicare Savings Program that make it possible for seniors struggling to afford healthcare costs to pay for their prescriptions and doctor's visits.

So we must do better for the American people, Mr. Chairman. Fortunately, today, we can support an extension of the premium tax credits by passing Leader Jeffries' discharge petition. If Republicans are serious about making healthcare more affordable and ensuring access to care, they

will support the discharge petition today.

And with that said, I support some of the bills we will discuss today, including H.R. 5243 led by Representative Jennifer McClellan -- I mean, by Representative McClellan -- H.R. 6210 led by Representative Matsui, and H.R. 6361 led by Representative Landsman of our committee as well.

Representative Landsman's bill would prohibit the Trump administration from implementing its so-called WISeR model, which would impose prior authorization in traditional Medicare by allowing for-profit companies to use AI to perform prior authorization reviews and then give them a cut of the savings if care is denied. And this model threatens beneficiaries' access to timely and necessary medical care, and that is why I support this legislation to halt it and any future model that imposes this type of coverage restrictions on seniors who rely on traditional Medicare to get the care they need. They don't need to face even more barriers. There are enough barriers out there without having to deal with this kind of a barrier as well.

And, with that, Mr. Chairman, I yield back the balance of my time.

Mr. Griffith. The gentleman yields back.

We now conclude with members' opening statements. The chair would like to remind members that, pursuant to the committee rules, all members' opening statements will be made a part of the record.

We want to thank our witnesses for taking their time to testify before the subcommittee. Although it is not the practice of this subcommittee to swear in witnesses, I would remind our witnesses that knowingly and willfully making materially false statements to the legislative branch is against the law under Section -- Title 18, Section 1001 of the United States Code.

You will have the opportunity to give an opening statement followed by questions from members.

And our witnesses today are Susan Van Meter, president of American Clinical Laboratory Association. Welcome.

Connie Sullivan, president and CEO of National Home Infusion Association. Welcome.

Mr. Thomas Ryan, president and CEO of American Association for Homecare.

And David Lipschutz, attorney and codirector of law and policy, Center for Medicare Advocacy.

Per committee custom, each witness will have the opportunity for a 5-minute opening statement followed by a round of questions from members. The light on the timer in front of you will turn from green to yellow when you have 1 minute left, and of course, from yellow to red when your time is up.

STATEMENTS OF SUSAN VAN METER, PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION; CONNIE SULLIVAN, PRESIDENT AND CEO, NATIONAL HOME INFUSION ASSOCIATION; THOMAS RYAN, PRESIDENT AND CEO, AMERICAN ASSOCIATION FOR HOMECARE; DAVID LIPSCHUTZ, JD, ATTORNEY AND CO-DIRECTOR OF LAW AND POLICY, CENTER FOR MEDICARE ADVOCACY

Mr. Griffith. I now recognize Ms. Susan Van Meter for her 5 minutes to give an opening statement. Ms. Van Meter.

STATEMENT OF SUSAN VAN METER

Ms. Van Meter. Chairman Griffith, Ranking Member DeGette, Vice Chair Harshbarger, Ranking Member Pallone, thank you for the opportunity to testify today. My name is Susan Van Meter. I am the president of the American Clinical Laboratory Association. ACLA is a trade association representing leading laboratories that develop and deliver essential diagnostic tests for patients and providers across the country.

Ensuring innovation in diagnostics and broad patient access to necessary testing requires a Medicare payment system that is fair, accurate, and predictable. Regrettably, the Clinical Laboratory Fee Schedule, the only Medicare payment system which statute requires be based on commercial market rates, suffers from significant foundational flaws. Current payment rates are inaccurate, artificially low, and still based on incomplete data from 2016.

We are now 23 days away from Medicare cuts to about 800 tests -- of as much as 15 percent -- hitting laboratories across the country, impacting most significantly routine tests used every day to care for Medicare patients. ACLA strongly endorses the RESULTS Act as a commonsense, smart-policy approach to reforming the Clinical Laboratory Fee Schedule and preventing deep Medicare cuts from taking effect January 31.

America's clinical laboratories are an indispensable part of the healthcare system, delivering tremendous value to patients and clinicians. Laboratory tests screen for disease, prevent diagnostic -- or provide diagnostic information that informs clinical care, support increasingly personalized medicine, contribute to the discovery of new therapies, and help identify emerging pathogens. From routine tests used to diagnose and monitor a wide range of diseases, to biomarker testing that enables clinicians to better target treatments, particularly in cancer care, laboratory testing helps patients avoid ineffective therapies while improving outcomes and reducing unnecessary costs.

Laboratory test results serve as the GPS for healthcare decision-making, informing roughly 70 percent of medical decisions, while payments to the Clinical Laboratory Fee Schedule account for less than 1 percent of total Medicare spending or approximately \$8 billion annually.

Despite this value, the Clinical Laboratory Fee Schedule lacks the stability and predictability laboratories need to maintain access to testing services that are relied upon by millions of patients and clinicians and continue investing in innovation.

The primary challenges lie in the foundational flaws of the Protecting Access to Medicare Act, or PAMA. When PAMA became law in 2014, Congress intended Medicare laboratory rates to reflect the commercial market by using a weighted median of private payer rates reported to CMS. However, the goal was not achieved.

PAMA's challenges fall into three core areas. First, CMS lacks access to timely and comprehensive commercial market data that reflect all segments of the laboratory market -- hospital outreach, independent, and physician office laboratories -- resulting in rates based on incomplete and outdated information. During the only data collection period since enactment of PAMA, CMS based rates on private payer data reported by fewer than 1 percent of laboratories. Hospital and physician office laboratories were significantly underrepresented, resulting in Medicare payment rates that did not accurately reflect the broader market, and absent further congressional action, laboratories soon will be required to report private payer data from 2019. Those data, collected before the COVID pandemic, will be used to set the Clinical Laboratory Fee Schedule for rates for 2027 through 2029.

Second, because of flawed data, Medicare payment reductions have been far greater than Congress intended, and current law allows those reductions to continue. Between 2018 and 2020, Medicare payments to laboratories were cut by nearly \$4 billion. That is about four times the \$1-billion reductions projected by the Congressional Budget Office for that period. Congress has appropriately delayed further reporting requirements and additional cuts several times, for which

the ACLA is grateful, but without further intervention, deep cuts begin again on January 31.

Third, reporting requirements impose a significant administrative burden on both laboratories and CMS, discouraging participation of reporting and contributing to low-quality data. PAMA requires clinical laboratories to report each and every payment rate from each private payer and the associated volumes for all 1,600 codes on the CLFS. The RESULTS Act fixes these problems. It would base CLFS rates on current, comprehensive, and representative commercial market data, establish guardrails to mitigate rate reductions, and prevent deep destabilizing payment cuts while dramatically reducing administrative burden on laboratories and CMS.

I thank you for the opportunity to testify. The ACLA looks forward to continuing to work with this committee to advance commonsense legislation that ensures Medicare beneficiaries continue to have access to the diagnostic services they rely on every day. I welcome your questions. Thank you.

[The prepared statement of Ms. Van Meter follows:]

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Mr. Griffith. I thank the gentlelady for yielding back.

I now recognize Ms. Sullivan for her 5 minutes of testimony. Thank you.

STATEMENT OF CONNIE SULLIVAN

Ms. Sullivan. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to testify today. My name is Connie Sullivan, and I serve as the president and CEO of the National Home Infusion Association, and I am also a licensed pharmacist.

NHIA represents pharmacies that coordinate and deliver home infusion care to patients across the country. Home infusion is the mainstream part of modern healthcare delivery. Every year, over a million patients rely on home infusion to treat serious infections, immune disorders, cancer, heart failure, and other complex conditions. Home infusion is strongly preferred by patients because it helps them get the IV medications they need with the least disruption to their daily lives, allows earlier discharge from the hospital, and lowers the risk for complications, such as drug-resistant infections.

Despite these well-established benefits, home infusion has largely been out of reach for patients with traditional Medicare. The Medicare home infusion benefit only covers a handful of available drugs, and is limited to a set of professional services that occur face to face in the home. As a result, Medicare beneficiaries remain significantly underserved compared to those insured under commercial or other government plans.

Despite clear evidence of safety, patient preference, and system-wide cost savings, Medicare's restrictive and incomplete benefit design impedes access to home infusion. This assessment was confirmed in a 2010 study conducted by the Government Accountability Office.

Their report accurately summarized the differences between Medicare and the commercial market, and is still relevant today.

Today, I am here to urge your support for H.R. 2172, the Preserving Patient Access to Home Infusion Act. This bill matters because Medicare still does not have a complete home infusion benefit, and this bill addresses a real access problem for America's seniors and people with disabilities.

Without home infusion access, seniors must travel back and forth to facilities or extend their hospital stay to receive these necessary and often lifesaving treatments. Here is a common example. A patient develops a serious infection due to an injury and is hospitalized. After a few days of IV antibiotics, the patient stabilizes and is ready to be discharged but must finish the 14-day course of daily IV antibiotics to ensure the infection doesn't reoccur.

If this patient has commercial insurance, they would most likely be discharged to home because it is a safe, effective way to finish therapy using the least intensive medical resources. For Medicare beneficiaries, discharge to home, especially for IV antibiotics, is more difficult because the Medicare structure does not support the home-based model. As a result, patients are directed to higher-cost institutional pathways, having to make daily trips back to a hospital for infusions, or be admitted to a long-term care facility for the duration of therapy, even when the patient has the appropriate caregiver support to complete that treatment at home.

This challenge is especially notable in rural communities, where the closest facility that can perform infusions may be hours away. For many patients, daily travel may be unrealistic, especially for someone who is medically fragile, has mobility issues, or is dependent on a family member for transportation. Without a workable home option, rural patients may be more likely to end up in a long-term care facility simply because there is no alternative supported by Medicare.

The Preserving Patient Access to Home Infusion Act fixes this coverage gap by modernizing the Medicare benefits so that more patients can access home infusion. The bill addresses gaps in

the current Medicare benefit by establishing appropriate coverage for the supplies and full scope of professional services needed to support home infusion care. The bill also expands coverage for home infusion of IV antiinfectives, which represent by far the most common situation where home infusion can prevent avoidable facility use. With these changes, more home infusion providers will be encouraged to participate in the benefit which would then expand access across the country for patients with a variety of needs.

In closing, the Preserving Patient Access to Home Infusion Act is a commonsense solution that strengthens access for Medicare beneficiaries, supports rural and underserved communities, and avoids unnecessary facility-based care.

Thank you for your attention to this issue. I appreciate your consideration of this important legislation, and I look forward to your questions.

[The prepared statement of Ms. Sullivan follows:]

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Mr. Griffith. I thank the gentlelady. She yields back.

I now recognize and welcome Mr. Thomas Ryan for his 5-minute opening statement.

STATEMENT OF THOMAS RYAN

Mr. Ryan. Thank you. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to testify today. My name is Tom Ryan, and I serve as the president and CEO of the American Association for Homecare. Before joining AAHomecare, I spent 25 years running a home medical equipment company in Long Island, New York, so I know firsthand how Medicare policy affects patients, families, and the small businesses that they serve.

AAHomecare represents the Nation's home medical equipment suppliers and manufacturers -- most of them are small businesses -- who support millions of Americans with oxygen therapy, mobility equipment, hospital beds, diabetes supplies, home infusion, and other essential medical products. Home medical equipment is a critical part of the care continuum. It keeps people healthier, more independent, and in the setting that they overwhelmingly prefer, their homes, while reducing costly hospitalizations and emergency room visits.

Today, I want to speak to three bipartisan bills that are essential to protecting Medicare beneficiaries' access to care: H.R. 1703; H.R. 2005; and H.R. 2902. But first, I must raise serious concerns about CMS' recently announced plans for the next round of competitive bidding. CMS is proposing to include ostomy and neurological supplies in competitive bidding, despite clear congressional intent that these items should not be included. CMS also plans to include new technology, like continuous glucose monitors and change their payment category in a way that will sharply reduce reimbursement. This threatens beneficiary access and undermines innovation in diabetes care.

Even more troubling, CMS intends to reduce the number of suppliers of these key product categories to fewer than 10 nationwide. This would devastate small businesses, it will destabilize the national home medical equipment infrastructure that patients rely on. And, finally, the proposed bidding methodology will artificially drive payment rates to unsustainable levels, leaving too few suppliers to meet the needs of our Medicare beneficiaries.

Now, I will discuss the bills. H.R. 1703 addresses a 2016 policy that effectively eliminated beneficiaries' ability to upgrade to titanium or carbon fiber wheelchairs unless they pay the full cost out of pocket. This is contrary to long-standing Medicare policy that has severely restricted access to these lighter, more durable chairs. The bill restores the ability for the beneficiary to pay the difference for the upgraded materials without adding any cost to Medicare. Individuals with disabilities deserve the ability to choose the equipment that best supports their mobility needs and their quality of life. I want to thank Representative Joyce, Buchanan, and Schrier for their leadership on the support and legislation.

Next is H.R. 2005, relief for non-bid, non-rural areas. Since 2016, CMS has applied competitive bidding rates that never participated in competitive bidding to these areas. These cuts often were more than 50 percent. They have been devastating, especially in rural and suburban communities. Congress has repeatedly stepped in with temporary relief, most recently through the 2022 omnibus bill, but that relief expired at the end of 2023. As a result, suppliers in these areas are, again, facing cuts of more than 30 percent.

H.R. 2005 restores a 75/25 blended rate for non-bid, non-rural areas through 2025. We are going to work with the committee on changing that, obviously. This is essential to maintaining access to home medical equipment and preventing further supplier choices. We appreciate the bipartisan leadership of Representatives Miller-Meeks, Tonko, Feenstra, and Panetta, and we look forward to working with the committee to update the timeliness as this bill advances.

And finally, H.R. 2902, the Supplemental Oxygen Access Reform Act. Finally, H.R. 2902

addresses long-standing access problems in the Medicare oxygen benefit, especially for patients who require liquid oxygen. Competitive bidding has produced savings, but it has also pushed reimbursement for liquid oxygen far below the cost of providing it. As a result, many patients cannot get the type of oxygen systems that their physicians prescribe. The bill creates a sustainable payment methodology for liquid oxygen, strengthens program integrity for a national electronic template, recognizes the essential role of respiratory therapists, and, of course, reimbursing the services for individuals with COPD, pulmonary fibrosis, heart disease, and other diseases. We strongly support this legislation and thank Representatives Valadao, Brownley, Smith, and Evans for championing it.

In conclusion, home medical equipment keeps people safe, independent, and in their home, and it saves Medicare money. These three bipartisan bills before you today -- H.R. 1703, H.R. 2005, and H.R. 2902 -- are practical, targeted solutions that will protect access to care for millions of Medicare beneficiaries. AAHomecare really looks forward to working with the committee to move these bills forward. Thank you very much.

[The prepared statement of Mr. Ryan follows:]

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Mr. Griffith. The gentleman yields back.

I now recognize Mr. David Lipschutz, welcome, for his 5 minutes for an opening statement.

STATEMENT OF DAVID LIPSCHUTZ

Mr. Lipschutz. Thank you. Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and distinguished members of the committee, thank you for the invitation to testify today. My name is David Lipschutz, and I am director -- codirector of the Center for Medicare Advocacy. We are a national, private, nonprofit, nonpartisan law organization that works to advance access to comprehensive Medicare coverage and quality healthcare. Our policy work is based on the real-life experiences of the beneficiaries and families we hear from every day. We appreciate the committee's focus on improving access to care for Medicare beneficiaries.

I would like to express support for three bills at issue in this hearing today which I will discuss in turn. First, H.R. 6210, the Senior Savings Protection Act, would provide a 5-year reauthorization of critical funding for State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center on Benefits Outreach and Enrollment.

First established under the Medicare Improvements for Patients and Providers Act, or MIPPA, since 2008, this funding has provided essential outreach and enrollment assistance for millions of low-income older adults and individuals with disabilities, including help with enrollment into programs which provide assistance with Medicare premiums and costs. Reauthorizing funding for 5 years will help ensure the community-based organizations can continue their important work helping older adults and individuals with disabilities access needed care and lower their healthcare costs.

This critical work includes helping people enroll in Medicare Saving Programs, or MSPs, in the Part D Low-Income Subsidy. MSPs are Medicaid programs that help with Medicare costs for those

who qualify. These programs, though, are significantly underutilized, with roughly half of individuals eligible actually enrolled. The need for education about and assistance with enrollment in MSPs is even more important following passage of H.R. 1, which delays implementation of a rule streamlining eligibility and enrollment in MSPs, which will result in fewer people accessing this financial help. Reauthorization of MIPPA funding will help these vital community organizations, SHIPs, AAAs, ADRCs, and others continue to provide needed assistance in their communities.

Second, we offer our support for H.R. 5243 to amend Title 18 of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage. Due to significantly higher payment to Medicare Advantage plans that Medicare spends on enrollees in traditional Medicare, virtually all Medicare Advantage plans provide supplemental benefits: items and services that are not covered in the traditional program. However, such benefits are not standardized and vary considerably by plan.

Research demonstrates that, while beneficiaries value supplemental benefits in theory, and these benefits are a major driver in planned marketing and beneficiary selection, many enrollees do not utilize the full range of supplemental benefits available to them. The data collection outlined in this bill -- particularly at a granular enrollee level -- along with the required public reporting requirements would make available essential information about how specific supplemental benefits vary across plans, how and whether they are used, and how much they cost enrollees. With more than half of Medicare beneficiaries enrolled in MA plans, this bill would provide needed transparency and oversight of the MA program.

Finally, we offer our strong support for H.R. 6361, the Ban AI Denials in Medicare Act. This bill would prohibit HHS from proceeding with the Wasteful and Inappropriate Services Reduction, or WISeR model, which began in six States just last week and would also prohibit the implementation of payment models testing prior authorization in traditional Medicare.

Currently, prior authorization requirements are applied to a very limited set of services in

traditional Medicare, while virtually all Medicare Advantage enrollees are subject to prior auth, particularly for more expensive services. Extensive research and studies and our own experience have found that prior authorization requirements can result in inappropriate denials and delays in obtaining medically necessary care. When appealed, over 80 percent of MA denials are partially or fully overturned, but too few people appeal, meaning millions of beneficiaries are forgoing their right to appeal and going without necessary care.

In recent years, problems with prior authorization in Medicare Advantage have been exacerbated by insurance companies or their vendors using AI or algorithmic software to aid their decision-making. The WISeR model borrows some of the worst elements of Medicare Advantage with respect to accessing care, and injects them into traditional Medicare.

The model employs private vendors using AI, or algorithmic tools, to review and approve or deny coverage. Such vendors are compensated in part based on a share of averted expenditures -- in other words, a reduction in improved services creating financial incentives to deny care.

Prior authorization is often dangerous for beneficiaries, far too burdensome from providers, and has no place in traditional Medicare. We strongly support this legislation that would halt the deeply flawed WISeR model, and prohibit future models that would incorporate harmful prior authorization requirements in traditional Medicare.

Thank you again for the opportunity to testify, and I look forward to your questions.

[The prepared statement of Mr. Lipschutz follows:]

***** COMMITTEE INSERT *****

Mr. Griffith. Thank you very much.

We will now begin our questioning period. I ask that members not begin a new question to our witnesses as their 5 minutes expire and would encourage members to submit written questions for the record if they have additional questions when their time is up.

I now recognize myself for 5 minutes.

Let me start with some good news. We always need some good news. I was able to attend a ribbon-cutting on Monday for the Stuart Community Hospital in Patrick County, Virginia. It was a reopening of one of my rural hospitals that had previously closed down back in 2017, and that is just really good news. I was very, very pleased to be there.

All right. Ms. Van Meter, I have concerns, particularly about routine tests that patients rely on every day. In your testimony, you mentioned one such test, a Complete Blood Count test, that regularly is furnished by these smaller labs. That is currently reimbursed under the Clinical Lab Fee Schedule at \$7.77. However, you say that it is scheduled to be cut by 11 percent on January 31, absent a change in the law. What does this mean for patient access to this test and others like it if we don't take action?

Ms. Van Meter. Thank you, Mr. Chairman, for the question. CBC is a very commonly ordered test. It can tell us quite a lot about monitoring a patient's condition, diagnosing it, the health of their immune system. It can also be the first sign that there may be a blood cancer like a leukemia.

You are exactly right. The Medicare program currently reimburses \$7.77 for this extraordinarily valuable test. That means the blood draw, the transportation to the laboratory, the medical laboratory professionals who assess that sample, run the test, and deliver the results to the patients and their clinicians, and that is done for \$7.77. It is a perfectly illustrative test of the value of clinical laboratories.

Now, that test is among the most common tests ordered, and common tests are subject to a disproportionate level of reductions under PAMA. Those cuts take place on January 31. For smaller laboratories in rural or frontier communities, for example, that have more narrower menus that focus really on those essential common tests, we have significant concerns about them being able to weather these deep Medicare cuts, again, that are disproportionately hitting those common tests that Medicare beneficiaries rely on every day.

Mr. Griffith. And let me see if I -- correct me if I have got my translation wrong, but if you are in a big city and you are doing a thousand of those tests a day, you might be able to justify the 7.77 -- maybe a little bit of a cut, but if you are in a rural area where you are doing five of those tests a day, there is no way you can possibly manage it for that amount of money. And so you have either got to decide whether you close up shop or whether you just stop doing that test. Is that what I am hearing?

Ms. Van Meter. Well, I think the impact could be profound for smaller laboratories in particular, but I must say, even larger laboratories, whether it be in urban areas or small communities -- there can be large laboratories in small communities -- it is extraordinarily difficult to have the professional laboratory and staff and the infrastructure -- these labs run 24/7 -- to be able to carry out that service in a timely fashion for \$7.77. They are committed to doing so. ACLA members are committed to doing so, but we worry profoundly about the impact of those reductions.

Mr. Griffith. All right. I appreciate that.

Mr. Ryan, I appreciate you being here today. You raised a couple questions in your testimony, but I want to go to my second question first, and then we will see if we have time to get to the others.

My district is considered very rural by many metrics. I represent southwest Virginia and Southside Virginia, the Appalachian region of the commonwealth. According to the competitive bidding process that CMS implements, CMS determined that a good portion of my district is

non-rural. Can you briefly explain how CMS decides this designation? Because I am looking at the map here of what is considered non-rural, and I can't figure it out.

Mr. Ryan. Thank you, Mr. Chairman. A lot of people can't figure that out. Medicare uses a set of ZIP Codes, and in the ZIP Codes, they chose what areas of the country were going to be competitively bid to see the areas of the country -- what areas of the country would be rural areas of the country and then what areas of the country would be non-bid, non-rural areas.

So your district probably has a lot of these non-bid, non-rural areas. Obviously, H.R. 2005 would help with that. The SOAR Act would help with that, because you get increased reimbursement for those product categories if that, in fact, comes into play. But that is a common question that is asked, and people are questioning CMS' methodology on that ZIP code application, and it is just one of the flaws of the program.

Mr. Griffith. Well, and I will have to check into that further. And I appreciate your answer because I have got a couple of counties -- some of them, I understand, but then I have got a couple of counties and a couple of communities that I just can't figure out how Duffield or New Castle in Craig County, a county that has about 4,000 people and is owned by the National Forest Service -- about half of it is owned by the National Forest Service -- how that is not rural. I don't understand that, but c'est la vie.

For the people back home, can you please explain what has already been done to help rural areas subject to competitive bidding?

Mr. Ryan. Yes. We have worked with Congress in the past, and we have enacted the 75/25 blended rate, which I said was in effect essentially until the end of 2023, and we have also worked with Congress and worked with the administration. And in that rural area of America, which originally was being reimbursed at 110 percent, we made it -- well, it is not permanent. Nothing with CMS is permanent. But we have a fix now that we get paid a 50/50 blended rate. Now, these percentages we talk about are essentially the adjusted amount or the bid amount and

the unadjusted amount, so --

Mr. Griffith. All right. I appreciate it.

Mr. Ryan. -- this needs some help.

Mr. Griffith. I will apologize to the committee. I violated my own rule and asked a question as time was running out but didn't realize it until after I asked the question. So I apologize for that, and I will have more questions for the record.

I now recognize the ranking member, Ms. DeGette, for her 5 minutes of questioning.

Ms. DeGette. Thank you so much, Mr. Chairman.

I want to thank all of the witnesses for coming today, and I particularly want to single out Ms. Sullivan because she is my neighbor to the north in Lyons, Colorado, and -- welcome -- and also because the home infusion benefit in the bill that she is talking about was originally in 21st Century Cures Act that was -- and anybody who was here then voted for that bill, and it allowed beneficiaries to be administered infused drugs in a home setting to begin with. So this is a commonsense expansion of that, and I want to thank you.

One of the themes that goes through all of these bills is an attempt to reduce costs for beneficiaries and for Americans, and so, I just want to talk about one thing the Democrats have done to bring down costs.

On January 1, thanks to our bill that we passed under the Inflation Reduction Act, negotiated drug prices went into effect under Medicare Part D, and now Medicare is going to negotiate the prices of certain high-cost drugs.

Mr. Lipschutz, what reduction in list price did this first round of negotiations achieve?

Mr. Lipschutz. Thank you, Ranking Member. When the prices were first announced, the discounts depended on the drug and ranged from roughly 40 percent to 80 percent discounts.

Ms. DeGette. Because of the negotiations?

Mr. Lipschutz. Exactly.

Ms. DeGette. And how much is this projected to save people on Medicare?

Mr. Lipschutz. It is projected to save Medicare beneficiaries about \$1.5 billion in out-of-pocket expenses this year.

Ms. DeGette. Wow. Now, that is tangible savings that American seniors will feel in their pocketbooks.

In the meantime, President Trump threatened extreme tariffs on drug companies if they didn't make deals with him. So let me ask you -- this is a little out there, but does that sound sort of like extortion to you?

Mr. Lipschutz. It kind of sounds like it, yeah.

Ms. DeGette. And why is that?

Mr. Lipschutz. Well, it is -- I believe the negotiation tactics were exchanging the lack of pursuing tariffs in order to extract promises from different companies.

Ms. DeGette. Now, are the deal details public that you know of?

Mr. Lipschutz. No.

Ms. DeGette. And companies that have made deals with the Trump administration, they haven't significantly revised their revenue projections so far. Does that seem like the behavior of companies that have agreed to take a revenue hit in this country?

Mr. Lipschutz. It doesn't sound like it.

Ms. DeGette. No. Okay. So I want to say that what we need to do -- as we are reforming healthcare in this country and looking at lowering costs, we need to do things that actually will lower costs, like this Medicare price negotiation. And if the majority really wanted to truly bring down costs for consumers, they would vote to extend enhanced premium tax credits and to strengthen the model of negotiating drug prices as well as other issues. I know Congressman Carter has worked on PBM reform and many, many other issues that we could work on to actually reduce the price of healthcare in this country.

I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the vice chairwoman of the Health Subcommittee, Mrs. Harshbarger of Tennessee.

Mrs. Harshbarger. Thank you, Mr. Chairman.

Thank you to the witnesses for being here today, and I want to turn to you first, Ms. Sullivan. Being a pharmacist myself, we know how important it is for patients to get care in the right setting, and for many patients, especially in rural areas like mine in east Tennessee and Chairman Griffith's in southwest Virginia, you know, home infusion can improve outcomes and the quality of life while avoiding unnecessary trips to the hospitals or extended facility stays. Because I have done this home health. I have done hospice respiratory companies. I have done it all as a pharmacist. So that is why I helped introduce the Preserving Patient Access to Home Infusion Act, and this bill updates Medicare's home infusion benefits so the patients can actually receive the care they need at home when appropriate.

Before I get to my questions, though, I wanted to ask unanimous consent to submit into the hearing record this letter from one of my constituents, Mr. Shane Bear, who stands to benefit from this legislation.

When you have people with chronic debilitating disease states, the best remedy for them most of the time is to be at home when they get immunoglobulin therapy or whatever. So, if we could do that, Mr. Chairman.

Mr. Griffith. And the date of the letter is?

Mrs. Harshbarger. January the 8th.

Mr. Griffith. January the 8th. Without objection, so ordered.

[The information follows:]

***** COMMITTEE INSERT *****

Mrs. Harshbarger. Thank you, sir.

When a Medicare patient needs IV antibiotics after discharge, what happens today if home infusion isn't an option, and how would this bill change that for rural patients and families?

Ms. Sullivan. Thank you, Vice Chair, for the question and for acknowledging our patient that has been very supportive of this bill and illustrates how important this service is for patients like him who -- he is bound in a wheelchair and relies on these services --

Mrs. Harshbarger. Absolutely.

Ms. Sullivan. -- and for lifesaving treatment.

Basically, what happens today, unfortunately, is that if a patient needs IV antibiotics, the first question that is asked by the physician or the discharge planner is not what does this patient prefer or is this patient safe to be at home; the first question is does this patient have Medicare?

Mrs. Harshbarger. Yeah.

Ms. Sullivan. Because it completely rules out home infusion, in most cases, for those particular patients. If the patient has commercial insurance, they work through the process of establishing the proper treatment in the home setting whenever possible. Unfortunately, because that is not available to Medicare patients, they start looking at the alternatives and what is going to be workable for that patient. Do they have someone that can drive them? In some cases, in Mr. Bear's case, it would be several hours through the mountains --

Mrs. Harshbarger. Yeah.

Ms. Sullivan. -- in inclement weather to reach an infusion center, which is a very difficult thing for a lot of patients to do, particularly our seniors and those with disabilities.

Mrs. Harshbarger. Totally. And, you know, he is in a wheelchair. I mean, not only do you fight the weather and everything else when you are in a mountainous region, but you have to deal with the prior approvals from the insurance or the out-of-pocket costs. It is ridiculous. And I have

had to deal with all that in the pharmacy, so thank you for that answer.

Mr. Ryan, I am a cosponsor of H.R. 2005, the DMEPOS Relief Act, and I know that when patients can't get timely access to oxygen, mobility equipment, or diabetes supplies, their conditions will worsen. And so how do these reimbursement cuts undermine Medicare's goal of keeping safely at home and avoiding costly emergency room visits and hospital stays, especially in rural communities with limited hospital access?

Mr. Ryan. Well, the service model has changed over the years because the reimbursement model has been devastating.

Mrs. Harshbarger. Yeah.

Mr. Ryan. It has been cut by over 60 percent since competitive bidding came into place. And we have thwarted technology. We have seen that technology has really gone down over the years. Patents decreased significantly, so innovation has been problematic. The service model has changed tremendously. When I was a respiratory therapist back in the 1980s and the 1970s, we would be in patients' homes following up on oxygen therapy and some of the things that the SOAR Act would offer.

Mrs. Harshbarger. Yeah. Absolutely.

Mr. Ryan. But the reimbursement has changed that dynamic, and patients are getting their equipment later. Repairs have gone up significantly because the quality of the equipment is not the same. And the reality is these -- the H.R. 2005 and the SOAR Act, you know, essentially put some of those savings back in place that makes some sense, particularly for access to liquid oxygen, which has been devastating.

Mrs. Harshbarger. Yeah.

Mr. Ryan. These patients who are on high-flow oxygen need to have this technology. It is actually old technology. One cubic foot of liquid oxygen converts to 860 cubic feet of gaseous oxygen. So, with a very small container, you could have a much greater amount of oxygen.

Mrs. Harshbarger. Yeah. True.

Mr. Ryan. When I was a therapist, we put liquid out all the time, but the Medicare reimbursement system taking oxygen and making it modality-neutral essentially -- getting one payment model for different types of oxygen therapy that are very different -- that whole infrastructure and that whole drug has gone away. It seems like an orphan drug now.

Mrs. Harshbarger. Well, they used to be able to do a nebulizer and the breathing medication that went in at the -- the respiratory therapy companies used to be able to do that. Then they said, no, we are not going to do it, so they had to get the medication at a pharmacy or a different place. It is just --

Mr. Ryan. Right. It is all about reimbursement. When I was at my company in New York for 25 years, we had a different model.

Mrs. Harshbarger. You can't keep up with the change. I gotcha. I feel your pain. I understand. I have had to deal with that, too.

Let me go to Ms. Van Meter. In your testimony, you warned that sustained Medicare cuts threaten not only testing capacity but also skilled laboratory workforce, and you also note that CMS has provided little education to laboratories about the mechanics and requirements for reporting their data. Absent statutory reform, do you expect the next data collection cycle to be materially better or more representative results than the last one, and why or why not?

Ms. Van Meter. Thank you, Vice Chair, for the question. It is a terrific question. I mean, a fundamental flaw within PAMA right now has to do with CMS' lack of access to robust and representative commercial market data. And if we were to move forward with that data reporting period come February 1, it is data from 2019 that labs would have to report for every payer with whom they do business, for every test on their menu, what those rates are, and the associated volumes.

Not only are systems old -- computer systems from which those data would have to be

gathered, and that is a fundamental challenge -- but you are exactly right. The training on what data and what mechanics need to be used to get those data in have not really been done in any sufficient way, so we are tremendously concerned that the reporting would be lackluster. The first time the data were reported -- 2016 data -- fewer than 1 percent of laboratories across the country reported data, and those data were used to set rates.

Mrs. Harshbarger. Yeah.

Ms. Van Meter. So, without that comprehensive, robust, you know, representative data, you have got artificially low data that we have been living with.

Mrs. Harshbarger. Well, I have got more questions, and I know my time is up, so I yield back. Thank you so much.

Mr. Griffith. The gentlelady yields back.

I now recognize Dr. Schrier of Washington for her 5 minutes of questioning.

Ms. Schrier. Thank you, Mr. Chairman. Thank you, Ranking Member DeGette. Thank you to all of the witnesses for this really -- for being here for this interesting hearing.

I just want to note before we get into today's topics that we are ignoring some gigantic elephants in the room right now. On Monday, Secretary Kennedy's CDC gutted the childhood immunization schedule recommendations without any substantive evidence or recommendations. He shocked CDC career staff and scientists. And, in fact, his changes were so radical that he even did a runaround his own handpicked vaccine advisory committee that is stacked with anti-vaccine activists. That is how extreme this was.

And I have to just say, again, as the only pediatrician in Congress, that this decision is going to harm children, it is going to cost lives, and it is going to make their families sicker as well. And I have asked again and again to hold an oversight hearing about Secretary Kennedy's recklessness and anti-vaccine and anti-science decisions.

And I just want to remind our chairman, you are not powerless here. You can call a hearing.

We can do oversight. And if you really care about children, I will urge you to do a hearing on this issue.

RPTR KRAMER

EDTR ROSEN

[11:21 a.m.]

Ms. Schrier. Turning to today's hearing, I consistently hear a couple things from my constituents. First, I just hear that healthcare is unaffordable, health insurance is unaffordable. And I also want to remind my colleagues that today we will have an opportunity to vote to extend the tax credits that help people afford health insurance, and I would urge my Republican colleagues to vote with us for that bill.

Now, the other thing I hear constantly from constituents is that the health insurance that they do have, that they pay a lot of money for, is not holding up their end of the bargain, and that their insurance companies are delaying or denying care due to, really, abuse of prior authorizations. And I hear the same thing, by the way, from physicians and from hospitals, and they are forced to hire more staff to deal with this bureaucracy and appeals than nurses. And the most egregious of these is Medicare Advantage, which is a type of Medicare plan, as you know, that contracts with private insurance companies to deliver care. About half of seniors are enrolled in Medicare Advantage because they are often a bit more affordable. And they seem great until a patient gets sick and then can't get the care that they need.

In 2023, traditional Medicare beneficiaries, the usual kind of Medicare, saw about 40,000 prior authorization requests. In that same year, Medicare Advantage beneficiaries saw nearly 50 million prior authorization demands. And I want you to keep in mind that this is about a 50/50. Half of seniors choose Advantage and half choose traditional.

So this seems so egregious. And then on top of that, the use of AI by insurance companies, you can dial that to deny more or to approve more. And it is causing more abuses and more denials. And healthcare decisions, as I said many times, should be guided by doctors and worked with patients and not be decided by insurance companies. And so, I am so supportive of

Representative McClellan's bill to increase data transparency in Medicare Advantage, and Representative Landsman's bill to stop the use of AI and prior authorization and the expansion of that true traditional Medicare. Our seniors deserve better.

Mr. Lipschutz, in your testimony, you point out that Medicare is projected to spend about 20 percent more for Medicare Advantage enrollees than it would spend if those enrollees had traditional Medicare, and yet, Medicare Advantage plans say that they have to use all of this prior authorization in order to keep costs down. Can you explain that contradiction, please?

Mr. Lipschutz. I don't know if I can.

Ms. Schrier. I don't know if I can either.

Mr. Lipschutz. Medicare Advantage plans have the ability to employ prior authorization, ostensibly to weed out medically unnecessary care. But in our experience, far too often, they weed out medically necessary care. And as cited in my written testimony, plenty of studies, including the HHS Office of Inspector General, have found widespread problems with inappropriate denials. And their own assessment of claims found, I think, an inappropriate denial rate, about 13 percent of claims that were denied that, in fact, were medically necessary in their estimation.

Ms. Schrier. That is right. I believe 95 percent of the appeals are ultimately approved. It is just that that care was delayed, and so, it is unnecessary. It is denying care. Our seniors deserve better. We need further oversight of this too. So thank you. I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the chairman of the full committee for 5 minutes for his questioning, Mr. Guthrie of Kentucky.

The Chair. Thank you, Mr. Chair. I appreciate that.

And questions -- Ms. Van Meter, how are you today? In 2014, Congress passed reforms to Medicare's clinical lab fee schedule to help lower costs, basing Medicare rates for those services on private market rates because at the time, Medicare rates were significantly exceeding the private

market. Under current law, CMS is required to collect data from laboratories about what they are paid by private payers. Can you describe the data collection and reporting process for lab? And how does this administrative burden ultimately affect the accuracy of private payer-base Medicare payments?

Ms. Van Meter. Thank you for the question, Mr. Chairman. And I would say that the original data upon which that assumption that Medicare rates were significantly higher than commercial market rates was -- there was a dearth of data to suggest such system analysis looking at three FEHBP plans and only 20 tests. Be that as it may, the collection of comprehensive commercial market data that is also representative of the three segments of the market -- that is, physician office labs, hospital outreach labs, independent labs -- is critical to ensuring that CMS actually understands commercial market rates and can appropriately set the Medicare rates based on those commercial market data. The RESULTS Act would be the step in the right direction to ensuring that CMS actually had access to that commercial market data. Without it, you cannot accurately set Medicare rates.

The Chair. Thank you. And so there is legislation considered in this hearing, the RESULTS Act, which would require CMS to contract with an independent claims database to obtain private payer data to calculate the Medicare payment rates. Can you speak to this idea of using independent claims database? And how would it improve accuracy?

Ms. Van Meter. Yeah. Certainly. Thank you.

The legislation would request that CMS contract with an independent not-for-profit database that has privacy and security policy in place, and that -- the data would be -- come directly from private health plans. It would be claims data with volumes associated. It would be representative of the entire laboratory field: physician office, hospital outreach, and independent laboratories.

That would give CMS tremendously robust data for the most widely available tests. Under the bill, widely available tests comprise 98 percent of the volume of tests paid for by the CLFS. One

database that could meet the criteria is the FAIR Health Database out of New York State. Currently, 20 States across the country use the FAIR Health database for any number of reimbursement-related policies, including no surprise billing, for example. And CMS considers the FAIR Health database, which has 54 billion claims in it, to be a qualified entity and have statistically significant data across the country.

The Chair. You know, the most important thing for us in solving this issue is how it affects the patient.

Ms. Van Meter. Yes.

The Chair. That is how the patients get the care that they deserve. And so, as more personalized and targeted treatments come to market, can you discuss the importance of innovation in the clinical space and how payment reform impact will affect the patient's access to care and innovation?

Ms. Van Meter. Absolutely. Innovation and diagnostics is really driving personalized medicine. It is changing healthcare as we know it. Diagnostics are truly the GPS of healthcare. We are able to determine in a cancer, for example, exactly the mutation that a patient may have in a solid tumor, to determine precisely the right therapy for that patient and to monitor that treatment. That is because there has been longstanding innovation, investment, and research and development. With an unstable payment system and a threat of reductions that constantly hangs over the head -- hangs over the head of clinical laboratories, you compromise the capacity to have long-range R&D. And while labs are investing today, if we were able to move towards the RESULTS Act, you would take away that threat of constant reduction and uncertainty, and thereby allow for greater investment and more advances to benefit patients.

The Chair. Okay. Thank you. And then I will close with this. I appreciate Dr. Schrier bringing it up -- pre-auth. We have to figure that out. I've sat with providers. I am not a doctor, and I know you are doctors, so you can read the information but I can't. But they presented to me

cases that got approved and cases that didn't get approved. And from what I could tell, there was little difference between what was approved and what wasn't approved. And so, some of the muses, well, why have preauthorization at all because -- if the doctor makes the decision, let them make it. What we do have to be concerned about people setting up entities and taking advantage of not having any preauthorization whatsoever.

So that is something we have to get right, though, because people are being denied care they will get eventually, or people -- providers are denied payment that they will get eventually because of this process. And so, I know Texas has done something called the gold standard. As long as you operate within parameters -- there is ways to fix it. And hopefully, Dr. Schrier, all of us can work together to figure that out, because we want patients to get the care that they need that the providers determine they need, and providers get paid for doing the care. So hopefully there will be opportunity -- we have insurance agent -- managers -- or CEOs in front of us recently -- to bring that up as well. So thank you for bringing that up, and it is something we need to deal with. I am sorry. My time is expired.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from California, Dr. Ruiz, for his 5 minutes of questioning.

Mr. Ruiz. Thank you, Mr. Chairman.

This is the first time this subcommittee has met in months. Months. And while I don't want to underplay the importance of the bills under consideration today, I think we need to first acknowledge how out of touch it is that while our constituents are suffering from the Republican-fabricated healthcare affordability crisis, they refuse to hold a hearing about it. Many of my constituents have been faced with overwhelming spikes in their ACA premiums because this Republican majority Congress refuses to extend the enhanced premium tax credits.

This politicking impacts real people. In fact, I am going to read you a letter from my constituent, Frank, who wrote to me that shows the kind of affordability crisis Americans are facing

across the country. Here is Frank's story from Indio, California.

Quote: "For my family, the change is immediate and severe. Our marketplace monthly premium would jump from \$704.20 to \$1,869 for the highest deductible, least desirable coverage available. That kind of increase forces families like mine to make impossible choices."

You know, Frank is not alone. His story is reflected in the stories of millions of people across our country. And we have to put people over politics. We have to put people -- we have to take care of them right now.

So getting back to the focus of this hearing, I would like to express my support for the bipartisan H.R. 2172, The Preserving Patient Access to Home Infusion Act, which is sponsored by Representatives Buchanan and also Dingell and Harshbarger here in this committee.

This bill removes the physical presence requirement for the Medicare Part B home infusion benefit, and acknowledges the full scope of professional services provided in home infusion into the reimbursement structure. I co-sponsored this bill because of its potential to improve access to care for seniors, and help keep them in their own homes and out of nursing facilities.

I represent a large rural area of southern California where many patients have to travel up to an hour or more to receive medical treatment. And like many underserved communities, transportation and geographic distance are considerable barriers, including the lack of nursing facilities in these communities. If a patient has to travel back and forth to a facility every day or every week for IV therapy, that barrier can be the deciding factor that pushes a patient into a nursing home, or leads them not to receive care at all. But receiving treatment in their own home is a game changer.

Ms. Sullivan, from your perspective, what does that look like for patients and families on the ground? And how would this bill, the Preserving Patient Access to Home Infusion Act, make home infusion a more dependable option for Medicare beneficiaries, reducing repeated travel, caregiver strain, and unnecessary time in facilities?

Ms. Sullivan. Thank you so much, Congressman, for the question.

You state the problem very clearly. And I wish I could say it was a rare problem, but it is not. Every home infusion company throughout the country gets a call every day from a physician or a hospital saying, "I have a Medicare patient. I really need them to get home infusion because I don't know how else they are going to get this treatment." And it just puts everyone in an impossible position. Families have to then make decisions about whether to be separated by hours from a loved one who needs to go to a skilled facility. And physician -- you know that when you need an IV therapy, you need an IV therapy. There is not simply an easier oral option that will take care of the problem. These issues are more urgent, more critical, and the IV is necessary.

And so, home infusion simply removes those barriers. It removes that stress. It removes the burden on the family to be able to bring that care to the home and provide all of the services that make it possible for that family to perform the infusions confidently, safely, and effectively and cost effectively.

Mr. Ruiz. Thank you very much. I yield back my time.

Mr. Griffith. I thank the gentleman. The gentleman yields back. I now recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. Bilirakis. Thank you, Mr. Chairman, and thanks for convening this very important hearing.

Improving Medicare is such a pressing issue for seniors in Florida and across the country, obviously. I am proud to support many of the bills on the agenda today, including the Senior Savings Protection Act, which reauthorizes critical programs for low-income Medicare beneficiaries. I have heard testimony from volunteers and program participants, and the impact of the Medicare improvement program is felt in my district.

I also co-lead the RESULTS Act with Mr. Hudson, of course Mr. Peters as well, and other co-sponsors. Strong clinical laboratories are vital to delivering high-quality care, especially for

seniors who depend on timely testing to maintain their health.

I am glad we are discussing this key legislative initiative to protect access to essential clinical laboratory testing, services, and help ensure that families in Florida and, of course, across the country have the benefit of the crucial information those test results offer.

You all know that one of my top priorities, of course, is improving access to cutting-edge medical innovation. So my first question is, Ms. Van Meter, your testimony speaks to the importance of clinical lab tests and delivering care. Can you elaborate more on this role, particularly for patients with rare diseases, please?

Ms. Van Meter. Thank you, Mr. Bilirakis.

Yes. Absolutely. It is incredibly important that a patient and their physicians have access to a comprehensive set of tests. That does, of course, include routine tests but also tests for rare diseases. Let me give an example of a disease -- rare disease. Autoimmune encephalitis. A patient that has autoimmune encephalitis may present with symptoms of confusion, memory loss, maybe psychiatric symptoms. Those types of symptoms really clearly mimic common conditions like a dementia, for example. But that patient with autoimmune encephalitis, that is, an autoimmune-triggered swelling of the brain, that is a disease that is treatable. And if that patient gets steroids and other therapies, they can overcome that disease. If they don't get that rare disease test, they aren't clearly diagnosed, that disease can be fatal.

Other examples of rare disease testing that apply to Medicare beneficiaries, but also our youngest patients include rapid whole genomic sequencing. These types of technologies are uniquely situated to discern, diagnose unique and rare conditions. Rapid whole genomic sequencing can diagnose hundreds, thousands of conditions, can help patients and their family end diagnostic odysseys. And this yields actionable results in 50, 60 percent of the time. That is the kind of information that patients and their families deserve.

So testing for rare disease is extraordinarily important, and we worry about innovation being

curtailed by deep and persistent reductions.

Mr. Bilirakis. Thank you. Well put.

Mr. Chairman, I ask unanimous consent to enter into the record a letter from over 30 leading organizations representing patients with cancer, diabetes, kidney disease, sepsis, autoimmune disorders, and a myriad of other conditions, urging Congress to act, stating that access to timely and accurate diagnostic information is foundational to patient healthcare and well-being, of course. So thank you, and I ask for this to be admitted into the record.

Mr. Griffith. Does the gentleman have a date on the letter?

Mr. Bilirakis. Yeah. It is November 19th, 2025.

Mr. Griffith. Without objection, so ordered.

[The information follows:]

***** COMMITTEE INSERT *****

Mr. Bilirakis. Thank you. And I yield back, Mr. Chairman.

Mr. Griffith. The gentleman yields back.

I now recognize Ms. Barragan for her 5 minutes of questioning -- of California.

Ms. Barragan. Thank you, Mr. Chairman.

Mr. Lipschutz, I want to start with you. First of all, thank you for the work that you do for the Center for Medicare Advocacy.

Last year, Republicans' priority was to give tax cuts to the rich, and take away healthcare through Medicaid. And even though the bill doesn't mention the word, "Medicare," according to the Congressional Budget Office, absent future congressional action, the bill will trigger \$490 billion in cuts to Medicare from 2027 to 2034 due to the Statutory Pay-As-You-Go Act of 2010.

Can you talk about what it will mean for recipients of Medicare if there are \$490 billion of cuts to the program?

Mr. Lipschutz. That would be a significant cut. That would require, perhaps, cuts to benefits, cuts to provider payments, reorganization of the way people access healthcare.

If you will permit me, I would like to address the impacts of H.R. 1 on Medicare. In addition to the cuts that providers will face as a result of significant cuts to Medicaid, the same providers that treat Medicare beneficiaries, and in addition to potential cuts that States will have to make to their Medicaid programs because of these cuts, services that people who are duly eligible for Medicare and Medicaid both use, H.R. 1, for the first time, strips away Medicare eligibility and coverage for entire groups of people.

Now, undocumented individuals have never been eligible for Medicare. But this bill strips away eligibility and coverage for groups of lawfully present individuals regardless of how long they have worked and paid into the system.

As previously mentioned, this bill also delays changes that were meant to streamline

enrollment and accessibility for the Medicare Savings Programs which helps people afford their Medicare programs to the tune of, according to CBO, \$66 billion in savings, which is money that otherwise -- going to come out of people's pockets.

In addition, if you will permit me one more point about H.R. 1, it also has an impact on Medicare prescription drug negotiation. The Inflation Reduction Act exempted certain orphan drugs from negotiation. H.R. 1 expands that exemption so that the Medicare program will be paying an estimated extra \$8 billion over the next 10 years as a result of that change.

Ms. Barragan. Thank you. The other topic, of course, that everybody has been talking about, except for Republicans, has been the Affordable Care Act tax credits expiring and people losing their coverage. So I want to echo the concerns that have been raised that we haven't had a hearing in this committee for months. And instead of having a hearing on what we can do to make sure more people have access to healthcare and keep their healthcare, we are talking about Medicare, which is also, again, very important. But what is before people right now is their inability to afford their healthcare.

Mr. Lipschutz, I want to follow up with you. Nearly one-fourth of the ACA enrollees are at least 55 years old. Many are early retirees who have to purchase insurance on the marketplace because they are not yet eligible for Medicare. If older Americans are forced to delay care because they can't afford it, doesn't that mean they are going to be more sick and in need of more expensive care by the time they need Medicare?

Mr. Lipschutz. Very likely. Right now, the expiration of the enhanced subsidies, 50 percent of the people who will lose it are between the age of 50 and 64, which means their premiums are skyrocketing, particularly compared with other groups of people. So yes, more people will go uninsured or underinsured, will delay care, will defer care, will go into debt, and will face bankruptcy because of healthcare costs.

Ms. Barragan. Thank you.

I would also like to -- important bill I think is missing from today's hearing called the Promoting Access to Diabetic Shoes Act. This bill would authorize nurse practitioners to certify a Medicare patient's need for diabetic shoes and refer them to a podiatrist. So patients with Medicare can more easily get the care necessary to prevent diabetic foot ulcers and other conditions. That is why I hope we can consider this legislation and have a hearing on it, including -- included on -- at a hearing I am proud to co-lead with Representative LaHood in a hearing soon. And with that, I yield back.

Mr. Griffith. The gentlelady yields back. I now recognize the gentleman from Georgia, Mr. Carter, for his 5 minutes of questioning.

Mr. Carter of Georgia. Thank you, Mr. Chairman. Thank all of you for being here. We appreciate it very much. And, Mr. Chairman, I want to thank you for holding this legislative hearing on proposals to support patient access to Medicare services, something that we are very dedicated to and working diligently on.

There are, however, two bills that are noticeably absent today that I want to mention because I believe they are essential to ensuring Medicare beneficiaries have access to critical services. One is called ECAPS, Ensuring Community Access to Pharmacist Services Act, which will allow seniors to access testing and treatment for common respiratory illnesses at the most convenient and accessible site of care for many Americans, and that is their local community pharmacy.

The bill does this by establishing permanent reimbursement for pharmacists under Medicare in States where scope of practice laws already allow pharmacists to deliver such services. And this is very important because in many States where such services are allowed under State scope of practice, when scope of practice is determined by the States, the only patients currently without coverage are seniors under Medicare. And the very patients most likely to have severe cases of common respiratory conditions are these patients.

Secondly, I want to mention the Preserving Patient Access to Long-Term Care Pharmacies Act,

which is a bipartisan piece of legislation that provides a critical fix so seniors can continue to access the safe, reliable, long-term care pharmacy services they deserve.

Again, let me remind you, these bills are especially vital for seniors in rural areas. Pharmacists are the most accessible healthcare professionals in America. 90 percent of all Americans live within 5 miles of a pharmacy. But many in the rural areas have to drive long distances to the closest physician office or emergency room, both which are much more expensive and less accessible points of care. Keep in mind, we all want the same thing whether you are Republican or Democrat. You want accessible, affordable, quality healthcare. That is what we are trying to achieve here.

Mr. Chairman, I know that you are a supporter of both of these bills. In fact, you are a co-sponsor of both of these bills, and I appreciate that very much. But I want to just ask, please, if we could have these two bills considered in the very near future, in the next relevant legislative hearing, and then in the next markup as well.

Mr. Griffith. Mr. Carter, I look forward to working with you on both of those bills, and hopefully we will be able to get a hearing set up soon.

Mr. Carter of Georgia. Thank you very much, Mr. Chairman. Again, I appreciate your support of this, and I know you are a co-sponsor on both of them.

Ladies and gentlemen, as a pharmacist, I always try to pull the conversation back to what patients deal with after they leave the hospital because treatment doesn't end in discharge. We all know that. Many still need infused treatments. And the question is, where do they finish them and how hard is it on the patient and the family? Home infusion is about safe care at home, not just drug delivery. But Medicare patients often struggle to access it, pushing them back into hospitals or facilities, and that is not what we want, options that are tougher on seniors and families and use more resources than needed.

Ms. Sullivan, I want to ask you, can you describe what home infusion pharmacies do to ensure

patients receive safe support at home over the course of treatment?

Ms. Sullivan. Thank you, Congressman Carter. I appreciate the question. I am always happy to talk about the important work that pharmacists across this country are doing on behalf of patients.

You know, the Medicare benefit today has an unusual restriction that does not exist in the commercial market, which has a robust home infusion benefit. Medicare restricts the services payments only to those that take place face to face in the home, which essentially is nursing. But without the essential pharmacy services that occur in the background in the pharmacy, home infusion is just simply not available.

I like to kind of describe it as the Medicare benefit for home infusion is kind of like a car without an engine. The pharmacy is what makes home infusion actually a functioning benefit. The pharmacy designs a plan of care that the patient can do and the family can support on their own with supportive nurses when it is needed. But they also provide that continuous support and 24/7 availability to answer questions, serve as a point of contact for physicians, and ultimately prevent patients from returning to the hospital or needing to visit the emergency room for support.

Mr. Carter of Georgia. Good. We are considering now today the Preserving Patient Access to Home Infusion Act. Would that make home options better? Would that improve the system?

Ms. Sullivan. It will change patients' lives dramatically today that have Medicare. They simply do not have the same benefit that everyone else in the country essentially enjoys and has access to when they might need a home IV therapy unexpectedly.

Mr. Carter of Georgia. Mr. Chairman, I just want to point out, make sure committee members understand that what she is saying here is that most of the private insurance are covering this, but Medicare is not. And that is a big gap and something we need to fill in. So thank you for pointing that out, Ms. Sullivan. I appreciate it.

Again, we all want the same thing: accessible, affordable, quality healthcare. Accessibility

is extremely important. So thank you, Mr. Chairman. And I yield back.

Mr. Griffith. I thank the gentleman for yielding back.

I now recognize Mrs. Fletcher of Texas for her 5 minutes of questioning.

Mrs. Fletcher. Thank you, Mr. Chairman, and thank you to all of the witnesses for your testimony here this morning. I do appreciate this hearing today and the hearings that have been announced this morning, but I do want to echo the concerns of many of my colleagues that have already been raised about this committee and this Congress's failure to address the healthcare affordability crisis.

And it is important that we also understand how we got here because we have to connect the dots in this committee that a driver of this affordability crisis that we are now talking about comes from decisions that this Congress has made. Cutting Medicaid funding and eliminating the Affordable Care Act enhanced premium tax credits are a huge part of it. They are not the only drivers, but they are important ones. And they are things that we can actually change in here.

And so I really think it is important, as Mr. Pallone has mentioned, as several other people mentioned in here today, we could vote to restore those premium tax credits today, this afternoon, and I intend to do that. And I think this is an important hearing. And I think that, you know, as we talk about improving patient access to Medicare services, we have to understand what Mr. Lipschutz was talking about a little while ago, that the cuts that are being made by this committee, by this Congress right now are also impacting Medicare recipients, and they are -- they are affecting their access to Medicare services as well.

Cutting access to healthcare for millions of Americans, which is indisputably what is happening right now, is increasing costs for everyone across the country, and it is hurting Medicare recipients.

So I have the privilege of representing many people who work in the Texas Medical Center, the world's largest medical complex, and many of the more than 120,000 people who work there live

in my district and have warned me about how disastrous the actions of this Congress are for patients across the healthcare system, and in this case, letting the premium tax credits expire.

Now, Texas already has the highest uninsured rate in the country. It is estimated that Texas will experience the highest coverage loss of any State with the expiration of the tax credits. And last fall, when we were still working on this, the Texas Medical Center institutions and our local Chamber of Commerce, the Greater Houston Partnership, sent letters to me and to everyone in our delegation outlining the impact that that loss is going to have on our constituents. It is a bipartisan concern in the medical community and the business community and across our community that people are losing access to healthcare that they desperately need.

And so, I know most people in this room know how all that works, but the idea that hospitals are going to be forced to reduce services and staff, that patients are going to have to wait longer -- this applies to Medicare recipients, too. And so I appreciate the importance of what we are talking about here, expanding access to Medicare services. That is what we should be doing. But we can't have this conversation without acknowledging the harm that is currently being done by decisions that are being made by this current Congress and limiting access to healthcare for all Americans.

So Mr. Lipschutz, I appreciate the work that the Center for Medicare Advocacy does to promote access to quality healthcare for Medicare beneficiaries. I appreciated your answers earlier. And I just want to know if you can talk about, with the time we have -- I will have another question to submit, I think, to you for the record at the rate I am going. But could you discuss how this increase and the overall number of people across the country who are not insured impacts access to care for Medicare beneficiaries?

Mr. Lipschutz. Well, if you have a significant group of people that don't have insurance at all, it is going to be unaffordable for them. And many people will defer care until they absolutely need it. It will -- it will increase pressure on emergency rooms. It will increase pressure on, you

know, frontline providers. It affects the entire healthcare system when you have people who are uninsured and underinsured. It adds pressure across the board, including the providers who provide care to everybody, not just Medicare beneficiaries or Medicaid beneficiaries.

Mrs. Fletcher. Okay. So it looks like you are going to give me time to ask you my other question, but I may have to take the answer off the record -- or for the record. But I do want to acknowledge one of the issues that you raised in your testimony about the WISeR model because that is one of the things I have heard about ever since I have been here from the physicians in my district, are about the problems with prior authorizations and prior authorization in Medicare Advantage in particular and how it really slows down access to appropriate care, forcing physicians to spend a ton of time on the phone with insurance companies instead of caring for their patients. And they are really concerned about the implementation of the WISeR model, which is being implemented in Texas. So I am going to submit a question for you on that for the record. But I appreciate your insights. I appreciate all of your time here today and all of the work that you do. Thank you, Mr. Chairman. I yield back.

Mr. Griffith. The gentlelady yields back. I now recognize the gentleman from Pennsylvania, Dr. Joyce, for his 5 minutes of questioning.

Mr. Joyce. Thank you, Mr. Chairman. And thank you for including my legislation, H.R. 1703, the Choices for Increased Mobility Act, in this hearing. This is commonsense legislation. It would give greater access to Medicare beneficiaries to titanium and to carbon fiber wheelchairs.

There is one keyword in this legislation, and that is "choice." This bill allows Medicare patients the opportunity to decide whether a titanium or a carbon fiber wheelchair is the right choice for them. And if it is, then patients with Medicare B have the ability to pay out of pocket for wheelchair upgrades if they so choose.

Mr. Ryan, with your background, can you speak to some of the benefits that these lighter weight wheelchairs will offer for those with disabilities?

Mr. Ryan. Certainly. Thank you.

Yeah. These patients who are using these type of wheelchairs are not just, you know, broken leg. These are patients with serious diseases, spinal cord disease, and they ambulate on their own the best they can if they have the ability. And just the wear and tear on them, on their shoulders, on their arms, trying to get around and be about and lead a mobile life is just, you know, unfair. Other insurances cover this. We haven't gotten Medicare to cover it yet. But the ability to the patient if they have the means to at least pay the upgrade amount makes perfect sense.

And that is the way it had been in Medicare previously, but through subregulation, they made a change and is no longer in effect.

Mr. Joyce. You bring out a great point. That is previously what Medicare patients had the capabilities of having, to have a lightweight wheelchair. And this legislation once again will provide that for the patients. Thank you for those statements.

I urge all of my colleagues to support this commonsense, zero cost measure which passed unanimously out of this committee last Congress, so that it may be signed into law.

I would now like to turn to H.R. 5269, the RESULTS Act. As a doctor, I know firsthand that accurate diagnostic testing is critical for the precise patient care. And that is why I strongly support the RESULTS Act, to improve patient access to these necessary services. This is bipartisan legislation, and it provides for stability and it provides for predictability, and ensures that CMS has a comprehensive cost data for the market-based Medicare payment structure that was originally intended under PAMA for clinical laboratory services.

Since the passage of PAMA, we have seen drastic cuts in reimbursement for lab tests with cuts as high as 30 percent from previous rates. These cuts across the board impact testing for everything from a skin biopsy to a complete blood count. This under-reimbursement is a dire threat to access for seniors across our country. And there are more cuts slated to occur if we in Congress fail to act. The payments reforms in the RESULTS Act has strong support from a diverse coalition

that includes doctors, laboratories, hospitals, and diagnostic manufacturer organizations. I urge all of my colleagues to support this legislation.

Ms. Van Meter, thank you for your testimony and your leadership on this bill and building such broad consensus. I would also like to thank Representative Hudson for his leadership on this legislation. I urge the committee to advance the reforms of the RESULTS Act and provide the relief for compounding payment cuts.

Ms. Van Meter, can you speak briefly to the impact that these sustained cuts will have on access?

Ms. Van Meter. Thank you, Dr. Joyce, for your question.

Yes. We are tremendously concerned that these sustained cuts in an unstable payment system can lead to longer turnaround time for patients to get the results they deserve, to have test menus curtailed for those laboratories that focused on the most common routine tests that are essential to everyday care. Those tests disproportionately get cut. We worry about the viability of those laboratories. And then there is innovation. Innovation is tremendously important in diagnostics to help reduce costs overall and to --

Mr. Joyce. And you and I recognize it, that innovation is the cornerstone of American medicine. Thank you.

I would also be remiss if I didn't mention the compounding cuts and underpayments under the Medicare physician fee schedule that have continued to negatively impact seniors' access to their doctors and have forced more consolidation and even higher costs in our healthcare system. I have also become very concerned over the utilization of tools like AI going beyond the already onerous prior authorization process in both Medicare Advantage and Part D delaying and restricting necessary care. I look forward to working with my colleagues to address these pressing issues in a bipartisan process. And with that, my time has expired, and I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from New York, Ms. Ocasio-Cortez.

Ms. Ocasio-Cortez. Thank you, Mr. Chairman. And thank you to our witnesses for being here today.

I want to expand a bit on Representative Schrier's point earlier. It is so important that we acknowledge what is happening right now, particularly in the area of health. Just 3 days ago, Secretary Kennedy stopped recommending life-saving childhood vaccines across the United States. And this includes hepatitis A, hepatitis B, and other vaccinations including rotavirus, the leading cause of hospitalization in U.S. infants.

Millions of babies across the United States are going to be at greater risk now than they were 3 days ago. And, in fact, we are already seeing the results of this. In 2025, just wrapping up the end of this last year, the United States has recorded more cases of measles than any year since 1993, in over 30 years.

And later this month, the United States in general may lose its official measles elimination status. It is back. And yet, we are only cutting more vaccinations to allow increases and risk in increases in hepatitis A and B and babies across the country.

These cuts are deeply concerning. But then on top of that, Secretary Kennedy is instituting some of the most devastating cuts to scientific research that we have ever seen. Independent scientific research is what provides us with new medical technologies and treatments and is critical to getting harmful products off the market, products that corporations will sometimes sell to consumers despite the fact that there are serious safety and health concerns.

Mr. Lipschutz, you are a patient advocate, correct?

Mr. Lipschutz. Correct.

Ms. Ocasio-Cortez. And I imagine that patients you have worked with have shared instances where corporations and healthcare conglomerates have not always acted in their best interests in mind, correct?

Mr. Lipschutz. Correct.

Ms. Ocasio-Cortez. And we have seen large circumstances of this. And I want to break down why corporations stand to profit from RFK's cutting scientific research. Let's look at Johnson & Johnson, for example. They are known to manufacture talcum powder, more commonly known as baby powder. As early as 1971, top J&J executives knew that their talcum powder contained asbestos, a carcinogen that can cause ovarian cancer. But because they wanted to continue to profit off this product, the company hid the evidence. Or we can look at DuPont, which was dumping cancer-causing chemicals into our drinking water. These chemicals contained -- these chemicals caused cancer and birth defects. And both of these companies worked successfully to keep the public in the dark from scientific research proving their harms, all to protect their bottom line.

Mr. Lipschutz, are you aware that J& J released falsified studies and suppressed and discredited research finding their product could be dangerous?

Mr. Lipschutz. I am.

Ms. Ocasio-Cortez. And in 1976, Johnson & Johnson lied to Federal regulators stating their talcum powder was not toxic.

And I use these examples because we even have instances of this that may be going on today. In fact, RFK himself had a personal history -- allegedly had a personal history going after Monsanto around Roundup and pesticides. However, just after giving a closed door -- after giving closed door listening tours where his only guests were biotech and pharma CEOs with products awaiting FDA approval, giving them private access instead of patients with doctors. On top of that, his AI-generated MAHA report has turned around on his own personal history on Roundup and instead parroted pesticide industry talking points rather than include any proposals to hold chemical companies accountable.

He surrounded himself with top advisors who come from the for-profit wellness industry that

set up the same exact conflict of interests that he says that he is rooting out.

So in other words, he has done nothing except completely dismantle the system that provides independent public research. RFK is not cutting these cancer research and purging these scientists because they are corrupt. He is purging these scientists because he is. And I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Ohio, Mr. Balderson, for his 5 minutes of questioning.

Mr. Balderson. Thank you, Mr. Chairman. And thank you all for being here this morning.

My first question is for Mr. Ryan. I have heard from constituents and stakeholders alike that there is often difficulty in finding an oxygen supplier that carries the equipment and supplies for liquid oxygen, particularly portable liquid oxygen. While patients may still be able to obtain different equipment, they are often unable to leave their home except for a very limited period. Some do not have the appropriate equipment that would allow them to travel, even for something like a doctor's visit. Can you discuss how the SOAR Act would help address this problem?

Mr. Ryan. Yes, certainly. And you are correct. Usage of liquid oxygen has gone down significantly over the years. Portable liquid oxygen is down 77 percent. Stationary liquid oxygen is down 80 percent.

And the reason for this is the reimbursement. Reimbursement under the competitive bidding program would not allow suppliers to provide liquid oxygen. And there are a certain subset of patients that have high liter flow needs that cannot be met with traditional portable oxygen concentrators, and certainly they have a high liter flow need, it couldn't be met with the gaseous tanks. Those tanks wouldn't last quite as long.

The SOAR Act would take all oxygen out of competitive bidding, which would be very helpful to get more technology in the sector, and it would treat liquid oxygen differently, and it would give it a much higher rate that would hopefully add to some expansion of the product category if necessary, set up a group that would kind of look together to see how this should be reimbursed in the future.

It is a small group of patients, but these patients are the most, you know, fragile, and they can't get out and about, and they are -- sometimes they are very young -- even a younger population -- pulmonary fibrosis requires such a high liter flow that it can't be met. So they are tethered to their home.

The SOAR Act would make an effort to take that away, give liquid a separate reimbursement, figure out what is the best as it goes in the future. And who knows? If we took oxygen out of competitive bidding like the SOAR Act is saying, we might put more technology back in that sector and have the technology in years to come with a portable oxygen concentrator provide higher liter flow. So it is an excellent bill.

Mr. Balderson. I agree. Thank you.

My next question is for Ms. Van Meter. Thank you for being here this morning today.

According to the Department of Health and Human Services Office and Inspector General, Medicare paid between 18 and 30 percent more than other insurers for 20 -- for 20 high-volume and/or high expenditure lab tests in 2011. I apologize. The Protecting Access to Medicare Act and its reform to the clinical laboratory fee schedule adjusted the rates to stop this excessive Medicaid spending. The RESULTS Act would address concerns with the underlying data collection and rate adjustment. If we continue to postpone data collection and reimbursement adjustments, do we risk returning to a situation like 2011 where Medicare is paying significantly higher rates for clinical tests than other insurers?

Ms. Van Meter. Thank you for your question.

That OIG report focused on, as you mentioned, 20 high-volume tests, but looked at only three plans within the FEHBP. I would suggest that is a dearth of data from which we could draw broad generalizations about the differentiation between rates between Medicare and private payers.

What the RESULTS Act would effectively do is establish reforms to the current CLFS and allow CMS to pull in comprehensive commercial market data, representative of all three segments of

laboratory industry to give a much greater picture about if there is any difference between the Medicare rates and the commercial market rates and allow for Medicare rates to be more appropriately and accurately set.

Mr. Balderson. Thank you. I will follow up with you. Rural hospitals act as a backbone for thousands of seniors living in the district that I -- the 12th congressional district that I am fortunate enough to represent, providing them with timely, accessible, and affordable care. The RESULTS Act would prevent a 15 percent Medicare reimbursement cut for nearly 800 common clinical laboratory tests. How could this 15 percent cut in reimbursement impact rural hospitals and patients around the country? I have 30 seconds left.

Ms. Van Meter. It would dramatically curtail access, reduce the -- or increase turnaround time, and suppress innovation. But particularly for communities like the ones that you were mentioning, we worry significantly about any reduction in access to those patients within those communities that are served by rural hospitals. That infrastructure will be harmed by persistent reductions of that magnitude.

Mr. Balderson. Thank you. Mr. Chairman, I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman of Texas, Mr. Veasey, for his 5 minutes of questioning.

Mr. Veasey. Thank you, Mr. Chairman.

And I am going to pivot away from these bills for a moment because I want to ask a question that Donald Trump posed to my colleagues yesterday: What have you done for America's health lately? The President asked my colleagues look in the mirror and ask themselves what have you done lately on healthcare. Well, I am going to answer it for them. Just this week they stood by while RFK Junior unilaterally revoked recommendations for vaccines against deadly diseases like flu, hepatitis, and meningitis. Even the very conservative Review and Outlook in the Wall Street Journal talked about some of these crazy moves that RFK is making.

These are deadly diseases, and yet my colleagues have let the lunacy of pseudoscience overtake long-standing, objective medical truth, and that is the truth that children will die without these vaccines.

And they are doing this as Texas and other States battle the worst measles outbreak that we have seen in decades with more than 2,000 cases in 2025 alone. And this outbreak has killed children.

Also this past week, Donald Trump -- they allowed Donald Trump to freeze more than \$10 billion in childcare funding. Not because of waste, not because of fraud, but because daycare workers refuse to let a YouTuber harass babies and toddlers. A YouTuber. Damn. Let that sink in. Working families across the country won't be able to take their kids to daycare because of a YouTuber trying to be an influencer, so they can put some money in their pocket. That was just this past week.

Last year they terminated dozens of billions of dollars in cancer research. Then they led the charge and gleefully gouging more than \$800 billion in Medicare dollars from children, mothers, and working families. And as if this weren't enough, my colleagues refuse to negotiate to lower insurance premiums for more than 22 million Americans. Add to that the reckless Medicaid cuts, and Republicans have robbed Americans blind of almost \$1 trillion in healthcare dollars. And these are not coincidences. This is not incompetence. This is a Republican manufactured health crisis. And let me be clear. This crisis was manufactured by my Republican colleagues, decision by decision, vote by vote.

Now, despite my colleagues' obstruction this afternoon, Democrats will vote to protect the Affordable Care Act's premium tax credits because healthcare is not a game. Repeat: This is not a game. We have children's lives that are at stake.

So I have to ask, how can we sit here today and talk about how Congress should support Medicare while Republicans do everything in their power to make sure America's children don't live

long enough to even become Medicare beneficiaries? I appreciate that we are here to talk about serious policies that will improve Medicare for our seniors, but I can't separate that work from the reality that Republicans are actively undermining our healthcare system. Republicans are dismantling the system dollar by dollar, program by program, piece by piece, and it seems they won't be satisfied until nothing, nothing, is left.

These assaults on America's healthcare are anti-child. They are anti-family. They are anti-American. And so when the President told you to ask yourselves what have you done lately, I hope you will look hard in the mirror and that you are honest with yourselves about the reality of why we are here. You created this crisis, and American children are paying the price. American families are paying the price. Thank you, Mr. Chairman. Thank you, witnesses, for bearing with me. I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Iowa, Dr. Miller-Meeks, for her 5 minutes of questioning.

Mrs. Miller-Meeks. Thank you, Mr. Chairman, and thank you to the witnesses for testifying before this subcommittee today. I appreciate the Health Subcommittee's focus on ensuring Medicare beneficiaries have reliable access to durable medical equipment, prosthetics, orthotics, and supplies, commonly known as DMEPOS, because for millions of patients, these items are essential to daily living and ongoing care.

As a physician and nurse, I have seen firsthand how critical timely access to oxygen equipment, mobility devices, and home medical supplies is to keep patients healthy and out of hospitals. When access to these services is disrupted, patient outcomes suffer and costs to the healthcare system increase. That is why I introduced H.R. 2005, the DMEPOS Relief Act. DMEPOS supplies, particularly small independent providers and those serving rural communities, are under growing financial pressure due to inflation, workforce shortages, supply chain disruption, and Medicare reimbursement rates that have not kept pace with real-world costs. In many cases,

suppliers are being forced to limit services or exit the Medicare program altogether, leaving beneficiaries with fewer options and longer wait times. The DMEPOS Relief Act provides targeted temporary payment relief to stabilize the supplier market and preserve beneficiary access without undermining program integrity or patient protection.

The goal is simple: to ensure seniors and individuals with disabilities can continue receiving the equipment and supplies they need, where and when they need them.

Today's hearing is an important opportunity to hear directly from providers and experts about how current payment policies are affecting patients and care delivery. I look forward to hearing more from our witnesses and how Congress can act responsibly to address these challenges and prevent further erosion of access, especially in rural and underserved areas.

I hope this discussion will help inform bipartisan solutions that protect patients, strengthen home-based care, and ensure Medicare policies that reflect the realities facing providers and beneficiaries alike.

Mr. Ryan, from the perspective of home medical equipment suppliers across the country, particularly small, independent providers and those serving rural communities, how are current Medicare DMEPOS reimbursement rates affecting beneficiary access to care? And how would targeted relief in H.R. 2005, the DMEPOS Relief Act, help stabilize access for patients who depend on these services?

Mr. Ryan. Yeah. Thank you, Congresswoman.

Let me just say, you know, when those rates cuts came into effect, again, we did a survey around the country of our membership, and some of the key findings were finding out that 65 percent of the companies reduce the amount or type of products they offered, 46 percent reduced their service areas, 53 percent laid off staff, 35 percent used personal savings to maintain that business. I know that route, did that myself. And over one in 10 surveyed said they will be out of business probably within a year.

So those areas of the country, the non-bid, nonrural areas of the country, they woke up overnight and got a significant decrease, a 30 percent decrease without getting an increase in market share.

When I had my company in New York, I bid responsibly, and I lost 32 contracts and essentially went out of business. But at least when I bid, I had the option of potentially getting more market share. These areas of the country, those suppliers of the country didn't get any increase market share. In fact, competitive bidding for those legacy items is not, at this point, in effect. But they see these tremendous rates.

So what has to happen is they have to look for less expensive equipment. Technology is going to be thwarted. At the end of the day, we are taking the patient-preferred, cost-preferred setting in the home and bringing it down to a commodity. We used to spend 2.2 percent of Part B on DMEPOS. Now we are 1.3 percent.

Mrs. Miller-Meeks. Thank you, sir.

Mr. Ryan. That number should be higher.

Mrs. Miller-Meeks. Thank you. I have a question for Ms. Sullivan on H.R. 2172, Preserving Patient Access to Home Infusion Act, that I will submit for the record for you to answer. And also one on Medicare reimbursement rates affecting timely access to diagnostic testing for beneficiaries.

Mr. Lipschutz, you were asked some questions about the ACA premium. So let me ask you, are the premiums for those who are not on the ACA exchanges, are those premiums increasing for those 130 to 160 million Americans?

Mr. Lipschutz. Well, Congresswoman, I am more of an expert on Medicare than I am on the ACA --

Mrs. Miller-Meeks. The ACA is Medicaid and not Medicare, but the answer to that question would be yes. And so can you tell me the COVID-enhanced era tax credits with no income limits with subsidies that are going directly to profitable insurance companies -- do extending those COVID

era tax credits lower premiums for those 130 to 160 million Americans?

Mr. Lipschutz. I think it should be Congress's goal to lower premiums for people across the board and --

Mrs. Miller-Meeks. I wholeheartedly agree with you. Our goal should be to lower premiums. It is why we passed Lowering Health Care Premiums for All Americans Act, which my colleagues on the other side of the aisle voted against, and while in control of government for 4 years, did nothing to pass legislation to lower premiums for Americans. So the answer to the question is no, it does not lower premiums for 130 to 160 Americans not on the ACA.

With that, Mr. Chair, I yield. Thank you.

Mr. Griffith. The gentlelady yields back. I now recognize the gentleman from Massachusetts, Mr. Auchincloss, for his 5 minutes of questioning.

Mr. Auchincloss. Thank you, Chairman. I want to begin by lifting up the poignant remarks from the gentleman from Texas, Mr. Veasey, about this committee's failure to do one of its fundamental jobs, which is to exercise oversight and accountability over Secretary Kennedy and Health and Human Services. We are whistling past the graveyard right now. He is, as he said he was going to do -- there is no surprise here -- gutting the childhood vaccination schedule. This will lead to an increase in morbidity and mortality from infectious disease for children. This is preventable. This is predictable. And it is going to be a tragedy. Shame on this committee for not acting. We have requested repeatedly oversight hearings over the Secretary, over FDA, over his actions with ASIP. There has been nothing. That needs to change in 2026.

There is action that we can take, though, that is immediate and bipartisan, including with Secretary Kennedy, and that is on community health center funding. The community health centers are bipartisan priorities. And they are struggling through a period of acute financial uncertainty, with their Federal funding scheduled to expire in just 22 days on January 30th, repeated short-term funding extensions that limit community health centers' ability to plan for their patients' needs and

exacerbate the difficulty of working on already very tight margins.

I know that this is true for members on both sides of the aisle, that we value the work of our community health centers in our districts and we should take action to ensure they have the funding they need to be successful. And indeed we should be working on legislation to expand that funding and help them triple their reach across the United States. I hope we can work in a bipartisan way to provide long-term health center funding that protects patients' access to comprehensive primary care before the January 30th deadline.

Moving to the issues at hand with this hearing. Mr. Lipschutz, I want to address my questions to you. You have talked in depth in both your written and oral testimony about the use of AI, how it can be instrumental and lifesaving, also dangerous if used inappropriately or excessively, and that is the case with the use of AI to evaluate prior authorization requirements. There is ongoing class action lawsuits from Cigna, UnitedHealthcare, and Humana, about improperly denying claims, which is why I am working on legislation that would place guardrails around the use of AI for prior auth determinations in Medicaid-managed care plans and Medicare Part D plans. My legislation would require these plans to establish an electronic prior auth program, enabling them to meet the new timelines -- timeliness -- excuse me -- requirements for plans' prior auth determinations. It would require full transparency about a plan's prior auth requirements and the clinical criteria used for decision-making with public reporting to ensure audit capabilities and annual review of plans' utilization management trends.

It will eliminate unnecessary prior auth reviews for certain providers, items or services for patients with conditions that require ongoing care. And it would implement guardrails by requiring only qualified physicians to make prior auth determinations, prohibiting retroactive denials, requiring a standardized appeals process, and mandating a 60-day advance notice for any changes in prior auth requirements.

Mr. Lipschutz, recognizing your expertise in Medicare, and understanding that you haven't

been able to review the text of what I am proposing, but just hearing those broad outlines, do you think that could be an effective addition to prior auth legislation for Medicaid MCOs and Medicare Part D?

RPTR DETLOFF

EDTR HUMKE

[12:21 p.m.]

Mr. Lipschutz. Yes. It would be an important start in trying to rein in inappropriate use of AI.

Mr. Auchincloss. Anything I am missing that I should be considering?

Mr. Lipschutz. I think we should ask the question of whether or not these tools actually do learn from their own mistakes. I can elaborate unless you have further questions.

Mr. Auchincloss. If I could, let me try to -- what I think I hear you saying is whether the models are purely tokenized LLMs where they are making just predictions or whether they actually have a worldview, whether they are world models that actually feel like they have inherent logic and are learning.

Mr. Lipschutz. Let me give an example. So, in the Medicare Advantage context, we often see plans deny care -- ongoing care in a skilled nursing facility. Say, initially, care is authorized. The plan will come back and prematurely terminate coverage. A person, if they appeal -- they often win, but then the next day or a few days later, they get another denial --

Mr. Auchincloss. So it is just a --

Mr. Lipschutz. -- and no change in condition. So we are unconvinced that the machine learning tools are learning from their own mistakes and accounting for them.

Mr. Auchincloss. Helpful. Thank you, sir.

I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Louisiana, Mr. Carter, for his 5 minutes of questioning.

Mr. Carter of Louisiana. Thank you, Mr. Chairman, and thank you to the witnesses for participating today.

We are in this committee today discussing various proposals that would improve access to healthcare services covered by Medicare while seniors, families, and small business owners across the country saw their premiums skyrocket last month after Republicans failed to extend the ACA tax credit -- premium tax credits before January 1. These tax credits are a lifeline and help make healthcare coverage affordable at times when the cost of living continues to climb.

I stand with Leader Jeffries and my Democratic colleagues on this committee as we continue to fix and fight for an extension of the tax credits to make healthcare affordable for all Americans. And I underscore all Americans. Not Democrats, not Republicans, not independents, but all Americans. The fallacy that this only impacts some and doesn't impact others is something that we must at all costs dismiss.

Mr. Lipschutz, thank you for joining us. Louisiana has one of the highest percentage of MA enrollees in the country, many of whom live in my district. Given how many of my constituents get their healthcare through MA plans, it is important to me that they have the information they need to make the best decision about their healthcare, which also includes choosing the supplemental benefits that best meets their needs.

Can you talk more about how collecting supplemental benefit data from MA plans help seniors and why it is important for these plans to notify beneficiaries of their benefits?

Mr. Lipschutz. Thank you for the question. So Medicare Advantage plans use their considerable payments in part to offer supplemental benefits to their enrollees. They often use these supplemental benefits heavily in marketing to try to entice people to enroll. Oftentimes, for example, we will hear about people drawn to so-called flex cards that are essentially debit cards that, among other things, could be used to purchase over-the-counter items.

And we hear stories of people contacting the SHIP programs, State Health Insurance Assistance Programs, asking what plan will give them the highest-value card while disregarding all the more important considerations like do my doctors contract with the plan? What services are

covered? What kind of prior authorization will I be subject to.

We also hear from folks who are drawn to supplemental benefits -- say, a dental benefit, for example -- but when they are enrolled in the plan, they find out that they have trouble getting -- finding a provider that will take their plan or their services are capped at a far lower level than they believed.

So what this bill would do would help gather information to give the public and give the Medicare program a better idea of what services are being offered, who is using them and to what extent, how much it is costing folks, and if people are actually getting value out of these services for which we pay plans considerably.

Mr. Carter of Louisiana. So how do we better educate? Because we know that many people are either hoodwinked into going into, as you suggested, a plan that has greater variables that may not very well be the best fit for their true medical coverage. How do we -- listening from this committee and working with our other agencies back home, how do we do a better job at making sure that we educate people on these MA options?

Mr. Lipschutz. So we just discussed one of the bills being evaluated today that would increase requirements for collection of data on supplemental benefits. I will pivot to the other bill that would extend MIPPA funding for key community health organizations like State Health Insurance Assistance Programs, AAAs, ADRCs, and others. Part of that funding goes exactly towards trying to provide people with information about their Medicare coverage options primarily through the SHIP programs.

The best way, in my view, to help educate people is to invest even more into the SHIP program, which is really the only source of pure unbiased information where counselors -- they have no stake in someone's decision. They have no financial stake.

Contrast that with the billions of dollars spent annually on marketing and commissions all aimed to try to convince people to enroll in certain plans to the benefit of the people who are paying

those commissions and ads but not necessarily to the benefit of enrollees.

So we need more unbiased, neutral information that can help people understand their options, and that is where I would suggest Congress focus its attention.

Mr. Carter of Louisiana. Hence the transparency measure that my dear colleague Jennifer McClellan will be offering, and I fully support the representative's effort because it makes all the sense in the world to create -- we talk about transparency all the time, but it seems to be more selective than it should be.

Transparency should be universal. This measure will, in fact, do that. It will save lots of money and opportunities for people to be better educated and have the healthcare more accessible.

Thank you very much. My time is up. I yield.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Ohio, Mr. Landsman, for his 5 minutes of questioning.

Mr. Landsman. Thank you, Mr. Chairman, Ranking Member, for this hearing. I thank all of you for being here and offering your expertise. A lot of good bills.

I want to give a little bit of context for our bill. As you know, Medicare provides healthcare for tens of millions of seniors. It is one of the most significant things we do as a community of Americans, is provide healthcare in general but in particular to our seniors. And it is an earned benefit. Folks pay into the system.

The WISeR pilot picked six States -- Ohio included -- to test whether or not the following is a idea: To use AI to deny healthcare to seniors. Now, this is the first time to my knowledge that Medicare is using AI for anything. And I have been sitting here listening to all of you thinking of all kinds of great uses of AI, the paperwork and billing and all kinds of other things that would help you all provide better healthcare. The first time they are going to use AI is to deny healthcare to seniors.

And they will say, well, this is the low-hanging fruit, it is really basic stuff, to which I would

say, then why do you need AI? Why not just say this is low-hanging fruit and we are going to make these changes? There is something very suspicious going on, which is to say they are going to use AI in this context, hoping that no one would notice because it is low-hanging fruit, and then expand it to the kind of healthcare decisions that will lead to life-and-death decisions or situations.

And that is why this is being called by many, many people these AI death panels because AI is going to make decisions on whether or not somebody gets the healthcare they need, and that decision may lead to that person losing their life.

So, on top of that, there is an incentive to deny care that for-profit companies get. They are going to get a percentage of the money saved when they deny it. So very perverse. Very problematic.

My bill prohibits HHS from doing WISeR, from testing WISeR, using AI to deny care in Medicare. There is immediate confusion and concern, just so you know, not surprisingly. There is no transparency or little transparency. So the big pieces here are the financial incentive model. No one knows what is in it. They do know that the burden will be on the provider.

So, here, I am a doctor and I am providing healthcare to a senior using Medicare. It gets denied. I am now on the hook. So you are going to have all these doctors who just stop providing certain care.

And then the lines of code that will be deciding whether or not somebody gets healthcare -- which is insane -- there is no transparency for that either. We don't know whether or not it is a learning model or if it is just, you know, pretty basic stuff that is just denying what it is going to -- what it has been told to deny.

In any event, the -- you know, one of the things that came up is just how often people get denied claims wrongfully. Why not use AI to stop that, to stop the wrongful, you know, denials of claims? Instead, they are using AI to deny healthcare.

I would encourage all of my colleagues to think about how important this is to bring this bill to

the floor or to this committee up for a vote and to make it unanimous, bipartisan. There are lots of ways to deal with the denial situation. Adding AI and for-profit companies and these financial incentives is a disaster, and we should stop it.

I would ask any of you if you know of the coding or the financial modeling behind this. I mean, is there -- does anyone know? Because my providers have no idea what is going on.

Mr. Lipschutz. Congressman, I think the only thing that we do know is that these vendors that have been hired to participate in the WISeR model, as you noted, have a financial stake in denying care. They benefit when care is withheld, which is exactly the wrong model to be using in healthcare, particularly with the Medicare population.

Mr. Landsman. I couldn't agree more, and I yield back. Thank you.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from New Jersey, Mr. Kean, for his 5 minutes of questioning.

Mr. Kean. Thank you, Mr. Chairman. I appreciate this committee's efforts to educate all of us on legislation that could help our seniors who rely on Medicare. I support H.R. 5269, the RESULTS Act.

The bill has been introduced by my colleague from North Carolina, Representative Hudson. This bill would make vital reforms to Medicare's Clinical Lab Fee Schedule which pays for lab tests New Jersey seniors rely on for routine care and for diagnosis of more complex conditions like cancer. In New Jersey, there are over 2,300 laboratories. In my district, there are over 200.

Ms. Van Meter, can you articulate the urgency of reform needed for Medicare's Clinical Lab Fee Schedule?

Ms. Van Meter. Yes. Thank you, Congressman. On January 31, about 800 tests will get cut by up to 15 percent. The cuts are going to hit tests that are among the most routine that Medicare beneficiaries rely on every day. Those kinds of reductions will have an impact on beneficiary access to services and will also stifle innovation in the next generation of diagnostics

those same patients need and deserve.

Mr. Kean. Thank you. In New Jersey, as a follow-up on this, we have several companies with great employees who are developing new diagnostics to ease the process of diagnosing suffering patients. These include companies like WuXi Diagnostics or Thermo Fisher.

In your testimony, you mentioned innovations in biomarker testing or rapid whole genome sequencing. First, can you explain to us the exciting hope that these new tests can promise patients, including those with rare diseases?

Ms. Van Meter. Absolutely. Biomarker tests can be used in a variety of conditions and diseases -- cardiac, neurological, cancers, many others -- and it is the foundation for precision medicine; in other words, being able to plot a personalized course for patients on the best medicines and best treatments for their particular condition. We are seeing tremendous growth in this field bringing treatments and improvements and saving lives for patients.

With rapid whole genome sequencing, that technology is uniquely situated to diagnose rare diseases. Thousands of rare diseases can be diagnosed using this technology that is essential for patients who are living with such diseases and conditions.

Mr. Kean. And can you explain how the current Medicare Clinical Lab Fee Schedule under PAMA is affecting the development of these tests and the ability of these patients to access them?

Ms. Van Meter. The key to ensuring that we have long-range research and development is a stable and predictable Medicare payment system, and we do not have that right now under PAMA. There are years of cuts that have taken effect and there is a constant threat of deep reductions over the field.

While innovation has been happening, with that threat of constant cuts, looking out for long-term research and development certainly is compromised, and that includes the work that we can do in biomarker testing and beyond.

Mr. Kean. So, currently, CMS would rely upon data from 7 years ago, 2019, to determine

the reimbursement rates for lab tests. In your testimony, you write that around one-third of lab testing codes are new since 2019. Without some type of changes to the current system, could you give us your thoughts on how realistic it would be to expect CMS to gather stakeholder input individually to determine the price of each one of these codes, and what impact would further delays on these repricings have?

Ms. Van Meter. It is an excellent question. So, yes, because there is constant innovation, there has been hundreds of new codes that have been established since the last data collection period, but that would not be captured within the 2019 data that labs are due to report come February 1, and CMS will not have any commercial market data upon which to make any changes to those rates for those tests that have been established since 2019.

We have consulted with CMS. We have encouraged them to use the rates that have been set to date. We think it is beyond the scope of what is reasonable for the agency to do to really update those rates. They should be maintained. But, most importantly, if we move forward with the RESULTS Act, that becomes a moot issue.

Mr. Kean. Thank you to all of our witnesses for being here today and your valuable insights.

I yield back, Mr. Chairman.

Mr. Griffith. I thank the gentleman for yielding back.

I now recognize the gentlelady from Massachusetts, Mrs. Trahan, for her 5 minutes of questioning.

Mrs. Trahan. Thank you, Mr. Chairman, and thank you to the witnesses for being here today.

You know, it is refreshing that this subcommittee is finally doing the work that the American people expect us to do. The last time that we met was September 18, 112 days ago. Even as families were staring down the barrel of a healthcare price hike that was entirely created by Republicans' failure to meaningfully extend the ACA premium tax credits, nothing -- not a single

official action from this subcommittee with direct jurisdiction over Americans' healthcare, even as RFK Jr. puts our children at risk of death, hospitalization, and illness as he dismantles vaccine policy in our country.

Instead, House Republicans passed a bill to make this crisis that they created even worse, increasing premiums for millions of Americans, raising the number of uninsured by an average of 100,000 people each year according to CBO, and ignoring the ACA tax credits altogether.

You know, Mr. Chairman, in 2025, 24 million individuals obtained health insurance through the ACA marketplace, and it is estimated that 22 million of them receive tax credits that helped reduce costs. Without these subsidies, premiums are skyrocketing, increasing by an average of 114 percent. That is hundreds or even thousands of dollars every month. And, like all of my colleagues, my office is being inundated with messages from constituents facing that massive sticker shock.

A 54-year-old woman on disability says that her cheapest plan is jumping from \$250 to \$570 a month, forcing her to considering dropping her coverage. A 61-year-old forced into early retirement says his family's premiums are already \$1,600 a month and rising another 11 percent next year with a \$3,000 deductible on top of that, making healthcare his largest household expense before he reaches Medicare age. And one constituent who relies on premium tax credits says their premiums are set to triple from \$300 to \$900 per month.

This is all on top of the more than \$1 trillion in Medicaid cuts Republicans already passed last summer to pay for tax cuts for the wealthy, cuts that will push millions off coverage and make it harder for seniors, people with disability, and low-income families to get the care they need.

So, Mr. Chairman, we all know that these policies will not only push people off coverage but it also exacerbates our physician shortage and accelerates hospital closures. That is why the authors of the big, ugly bill included a \$50-billion rural health fund to try to offset the expected 137-billion reduction in Federal Medicaid spending in rural communities. That is the very definition of a

Band-Aid on a bullet wound.

And, if it hasn't been made clear already, it should be now. House Republicans have shown that protecting Americans' healthcare is just simply not a priority. Policies are pushing people off coverage, driving up their costs, and destabilizing the very providers that our communities rely on.

With that reality in mind, I want to turn to a couple of specific Medicare payment policies where decisions we make in this room in this committee can help stabilize care. The PURE Act aims to improve access to portable diagnostic imaging for seniors and medically fragile patients who can't easily travel for care. These services allow clinicians to evaluate serious conditions directly at the bedside. But, unlike portable X-ray, Medicare does not reimburse transportation costs for portable ultrasounds, making it harder to bring timely diagnoses to patients or provide diagnostics to patients.

Mr. Ryan, how important is timely access to diagnostic services for seniors and medically fragile patients, particularly when it comes to catching problems early, avoiding unnecessary hospitalizations, and reducing long stays?

Mr. Ryan. Yeah. It is obviously very, very important. As I continue to talk about today, care in the home is extremely important. It is where the dollars should be going these days. It is where the infrastructure should be building up. And, certainly, knowing travel time and what it costs to do travel time and using it as an example for, you know, repairing wheelchairs where you get wrench time. You only get paid for the time you are in the home and actually fixing the chair. I can certainly empathize with that industry for wanting to get some sort of a reimbursement for that travel time.

Mrs. Trahan. Thank you. Seniors and other Medicare patients must continue to have that access to vital testing used to diagnose, monitor, and manage diseases such as diabetes, heart disease, and cancer.

Ms. Van Meter, I am not sure if you will have time to answer, but I will get my question on the record. Under current law, Medicare reimbursements for lab testing continues to face significant

downward pressure. How have those cuts already affected laboratories' ability to serve seniors, and how would the RESULTS Act help protect access to diagnostic tests patients rely on to detect and manage disease?

Mr. Griffith. If you can do it quickly.

Ms. Van Meter. It is compromising access and stifling innovation. Having a stable payment system that the RESULTS Act would bring to bear would do a tremendous amount to ensure that patient access.

Mrs. Trahan. Thank you.

I yield back, Chair.

Mr. Griffith. I thank the gentlelady. She has yielded back.

I now recognize the gentleman from New York, Mr. Langworthy, for his 5 minutes of questioning.

Mr. Langworthy. Thank you, Mr. Chairman.

For millions of our seniors, access to Medicare services is only as good as the payment policies behind them, and when those policies fail to keep pace with modern care delivery, the patients feel it first through delayed services, fewer provider options, and reduced access to care in their communities. Across the country, providers are telling us the same thing: Outdated reimbursement rules and rigid payment schedules are making it harder to deliver care where patients need it the most, which is at home, close to family, and outside of institutional settings.

And, with that, Ms. Sullivan, my district covers a large stretch of rural communities where a simple infusion appointment could easily turn into an all-day ordeal for patients and caregivers, family that have to be responsible for transportation, and in the winter especially. You know, I represent western New York and the southern tier of New York where it is a harsh winter.

Weather and road conditions can make repeated trips to a hospital outpatient department unrealistic. And missing doses isn't just inconvenient. It can derail the treatment plan of a

patient. When Medicare doesn't make the home option dependable, the system too often defaults patients into a more inconvenient setting simply because it is the only workable way to complete their treatment.

Ms. Sullivan, can you explain how the Preserving Patient Access to Home Infusion Act would help keep Medicare patients on track with treatment for patients that are a long ways away from their next hospital campus or infusion center so that their care isn't determined by weather or logistics but by what their doctor believes is safest for them?

Ms. Sullivan. Thank you, Congressman, for the question. Home infusion operates on a model that is incredibly efficient in that we rely on the pharmacy to provide that support and the continuity of care for patients so that they can independently infuse their medications at home. They don't rely on a nurse regularly.

The nurse visits periodically to make sure things are on track, to lay eyes on the patient. Maybe they have a wound or something that needs to be assessed to make sure it is healing properly. But the support really comes from the pharmacy on a daily basis and largely happens behind the scenes.

The Medicare program's benefit is so fragmented, which was confirmed by the GAO report that I mentioned in my opening remarks that they pay for only the services that happen in the home, which are the most infrequent of the services that occur with a home infusion patient. So the pharmacy is working behind the scenes, communicating with the physician, monitoring the labs, making sure everything is working properly for that patient and can communicate with them without the patient needing to travel, without needing to send resources to the home. So it is an efficient model that has been widely adopted in the commercial market.

And you would think with almost a million beneficiaries under the Medicare program being sent to hospital outpatient departments for these infusions, the hospitals would not want to lose that. In fact, most health systems have signed letters of support of this particular legislation

because they recognize these are not patients that need to be there, that they have other patients that are -- that would better benefit from their resources. And so it is one of those common-sense solutions that helps patients, helps our health systems, and uses appropriate resources.

Mr. Langworthy. The keyword is common sense.

Ms. Van Meter, as you know, Medicare lab payments are still based on outdated data that fails to reflect real costs, and in just 25 days, labs could be hit with payment cuts of up to 15 percent across hundreds of tests, making it harder to deliver timely and accurate care. What are some of the unique challenges that these payment cuts create for labs serving rural communities or other vulnerable populations like those in nursing homes?

Ms. Van Meter. Thank you for the question. The infrastructure that exists in rural or frontier communities may not be as robust as is ideal. Right now, we have patient service centers, there are hospital laboratories, physician office labs, and obviously large commercial labs that have capacity to move samples around the country, but if the cuts go into effect, we worry that that infrastructure will be compromised, fewer patient service centers, smaller menus, longer turnaround time.

We need those tests to be timely in order to make clinical judgments about the right pathway for care. So we are concerned about patient access to those services across the country but certainly in rural and frontier communities.

Mr. Langworthy. Thank you. I am a proud cosponsor of the RESULTS Act, which is a common-sense fix to prevent these payment cuts while reducing the administrative burden on laboratories and CMS.

And, finally, Mr. Ryan, last year, AAHomecare conducted a survey on the impact of the 2024 payment cuts on durable medical equipment. Could you briefly summarize your findings in the remaining time?

Mr. Ryan. Well, we discussed this earlier today, Mr. Congressman. But, certainly, when

those 75/25 rate cuts went into effect -- again, this is in the non-rural, non-bid area of the country that -- when they woke up overnight and just saw a 50 percent cut -- a 75 percent cut, and we had Congress intervene twice to make sure those cuts were not in place and the 75/25 rate remained in place.

Well, since they have stopped, the key findings are that 65 percent of the products have been reduced. The companies are offering fewer products. Forty six percent reduced their service area, 53 percent laid off staff, 35 percent used personal savings to maintain the business, and one in 10 surveyed said they would be entirely out of business within a year.

Mr. Langworthy. Well, thank you. Thank you for bringing that up, and I yield back.

Mr. Griffith. The gentleman yields back.

We now enter into the next phase where we go to Ms. Matsui for her 5 minutes of questioning.

Ms. Matsui. Thank you very much, Mr. Chairman. I want to thank the witnesses for being here today.

I am glad to be here discussing this bipartisan slate of bills. I am especially excited to discuss my bill, the Senior Savings Protection Act, but I would like to echo my colleagues. This hearing misses the point. We are in a full-blown healthcare crisis.

On January 1, over 20 million Americans saw their premiums skyrocket. They are facing a dire choice: Pay crushing premiums or risk going without coverage to afford other basic necessities. They have been begging Congress to act. Instead, House Republicans have refused to extend premium tax credits and pushed a sham of a bill that would cut even more people off care. That managed for what we are discussing today.

My bill focuses on helping Medicare beneficiaries afford their care, but we can't ignore the millions of older Americans who aren't yet eligible for Medicare. Nearly 5 million older Americans, age 50 to 64, rely on the ACA marketplace for their healthcare. In my jurisdiction, a 60-year-old

couple making \$150,000 annually just saw their premiums jump from about \$800 a month to over \$2,500 a month. Where are they supposed to find another \$20,000 a year to afford healthcare?

When premiums skyrocket, despite -- when premiums skyrocket, people just delay care. That means a sicker Medicare population, more preventable ER visits, and higher costs down the line. It is all connected, and we all need to govern like it is, but Republicans are intent on ripping benefits from hardworking Americans. It is even more important that we ensure people maximize the benefits available to them.

That brings me to my bill, the Senior Savings Protection Act. Congress has created programs to help low-income Medicare beneficiaries afford their care. The IRA expanded and added new programs to support seniors, but millions of Medicare beneficiaries eligible for these programs aren't enrolled in California, especially -- I will bring that up -- because there are over 2.3 million Medicare beneficiaries eligible for Extra Help but less than 300,000 are enrolled.

Mr. Lipschutz, how do programs like the Low-Income Subsidy or Extra Help and the IRA smoothing provision help seniors afford their healthcare?

Mr. Lipschutz. Thank you for the question, Congresswoman. As you noted, Congress created these programs to help Medicare beneficiaries afford some of their healthcare expenses. Part D Low-Income Subsidy for those who meet the income and asset test is able to pay for Medicare premiums and much of the cost sharing under the Part D benefit. The smoothing provision that you mentioned from the Inflation Reduction Act allows beneficiaries to spread their prescription costs over the course of the calendar year. It is most helpful for people who have high out-of-pocket expenses earlier in the year.

Ms. Matsui. Right.

Mr. Lipschutz. I would add to that list the Medicare Savings Programs as well --

Ms. Matsui. Yes. Right.

Mr. Lipschutz. -- for folks who qualify for them.

Ms. Matsui. Well, that is why I introduced the Senior Savings Protection Act along with Congressman Bilirakis. This bipartisan bill reauthorizes funding for outreach in their own activities to help low-income Medicare beneficiaries understand all their options and enroll in the plan that works for them.

Mr. Lipschutz, how do State- and community-based organizations use these funds to help low-income Medicare beneficiaries?

Mr. Lipschutz. The MIPPA funds is spread between SHIP programs -- HICAP in California -- AAAs, ADRCs, and benefit enrollment centers. What these programs do is try to connect people in the community with Federal, State, and local programs that can help them pay for their daily needs.

Ms. Matsui. Right.

Mr. Lipschutz. That ranges from assistance with cost sharing like the Medicare Savings Programs and Part D LIS, and some of these other entities also help evaluate eligibility for LIHEAP services, heating and cooling, and SNAP benefits.

Ms. Matsui. Well, absolutely. And programs like this are really the only nonbiased way of -- source of medical enrollment assistance and especially as there is a lot of misleading and fraudulent advertising that runs rampant.

I really, really do emphasize, Mr. Chair, how important a bill like this is in order to make sure that Medicare beneficiaries are protected and understand what their resources are. So thank you, Mr. Chair. I hope we can advance this critical bipartisan bill to a markup soon, and I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Texas, Mr. Crenshaw, for his 5 minutes of questioning.

Mr. Crenshaw. Thank you. Thank you all for being here.

I will start with Mr. Ryan. You know, in a State like Texas, there is a large share of nursing homes and assisted living facilities located in rural areas. How does portable ultrasound help

ensure seniors receive that timely diagnostic care without being transported long distances?

Mr. Ryan. I mean, I don't know much about your bill. I am sorry, Congressman. But I, again, believe in care in the home. I think it is, you know, patient-preferred, cost-effective. So having the ability to have portable, you know, imaging in the home would be something that is very, very important.

Mr. Crenshaw. Okay. I thought you would have more of an answer for that. Would you think that being able to bring it to the patient would bring costs down?

Mr. Ryan. I am sorry. Could you repeat that, sir?

Mr. Crenshaw. Bringing this kind of technology to the patient, would that overall bring costs down?

Mr. Ryan. Newer technology that could be done in a home care setting, I think, at the end of the day, should certainly be able to bring costs down, not being a subject matter on this particular product.

Mr. Crenshaw. No problem.

Ms. Van Meter, what differences do you see in how current payment policies affect hospital-based laboratories, physician office laboratories, and independent laboratories, and why does that matter for patients?

Ms. Van Meter. Well, the current Medicare payment system, the Clinical Laboratory Fee Schedule, has suffered from years of deep reductions. It is the only Medicare payment system that is designed to be based on commercial market rates but has failed to do so because it has collected lackluster data. Only 1 percent of laboratory data was used to set rates, and we are still living under data that is from 2016.

So it has a compromising effect in terms of long-range innovation -- or investment in innovation. We appreciate that Congress has stepped in and has halted reductions. We believe that the RESULTS Act that has been discussed today is the right approach to allowing there to be

stability in that payment system to ensure patient access, to have swift turnaround times, innovation and testing, and broad patient access.

Mr. Crenshaw. Okay. Thank you.

And, Ms. Sullivan, from the patients' perspective, how does the availability of home infusion services influence where seniors ultimately receive care, particularly when managing complex and chronic conditions?

Ms. Sullivan. Thank you, Congressman. The range of medications that are available to patients in the home if you have commercial insurance reaches above 300 different individual medications. Unfortunately, for Medicare beneficiaries, they are limited to a handful of drugs that are -- that use the -- an item of DME or an infusion pump to be administered. So they live with much more restricted access under the Medicare program.

If they were to have access at least to IV antibiotics, we estimate it would change the lives of many beneficiaries and just open the options up for them to receive care at home rather than driving back and forth to facilities or being admitted to long-term care facilities.

Mr. Crenshaw. Can you comment on how that might effect long-term cost savings? Do you think it remains neutral? Do you think it saves costs?

Ms. Sullivan. Yes. Excellent question. Historically, the Congressional Budget Office has scored home infusion legislation as something that would generate savings. We are still waiting for an updated score on the provisions in this bill. However, you know, we have -- when we look at care in a setting such as hospital admission or in outpatient departments or urgent cares, generally, we feel confident that home would be a more efficient model for those patients.

Mr. Crenshaw. Okay. Thank you for those answers. I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Indiana, Mrs. Houchin, for her 5 minutes of questioning.

Mrs. Houchin. Thank you, Mr. Chairman. Thank you to our witnesses for being here today

to discuss a fundamental responsibility of this committee to ensure that the Medicare program actually works for patients and the providers who rely on it every day.

In States like Indiana where rural hospitals and community health centers and independent providers are often the primary source of care, Medicare payment policy determines whether services are available at all. Community health centers and rural providers are often the first to feel the downstream effects of reimbursement cuts, the administrative burden, and rigid coverage rules. These pressures also trickle down to patients and show up in real and tangible ways, for example, with our durable medical equipment providers as well.

During COVID, my State cut benefits to home health oxygen and cut reimbursement rates for home health oxygen during a time when people were required to stay home and even during research that suggested that putting people on ventilators in hospitals was maybe not the best course of treatment.

So I want us to -- I want to thank the committee and the chairman for bringing these issues to the attention of the committee in a legislative manner. I know that some colleagues have discussed home infusion therapy, so I want to touch on that a little bit.

As we have heard, it allows seniors to receive medically necessary treatment safely in their homes, helping them avoid more costly or facility-based care. Yet, the Medicare current home infusion benefit often falls short of supporting the kind of care patients deserve much like we saw during the home health durable medical equipment cuts that we saw during COVID. Under current policy, Medicare generally only pays for home infusion services on days when a clinician is physically present in the home even though patients still require care coordination, monitoring, and clinical oversight on non-infusion days.

Ms. Sullivan, can you explain how the Preserving Patient Access to Home Infusion Act helps make it more realistic for Medicare patients to receive infusion therapy at home when their doctor wants them to be treated there?

Ms. Sullivan. Thank you so much, Congresswoman. Basically, the Preserving Patient Access to Home Infusion Act is going to do a couple fundamental things. Number one, it is going to eliminate some of the fragmentation that exists in the current benefit and remove the restriction for the face-to-face requirements. We find that, basically, those restrictions are so limiting that there are fewer than 70 providers across the country that are participating in the benefit today, which essentially means that patients in most areas are not accessing this benefit and, in some States, there are no patients accessing this benefit and no providers offering the benefit. It is just simply unsustainable and is not creating access.

Mrs. Houchin. Does that lead to -- the face-to-face requirements, does it lead to unnecessary treatment delays?

Ms. Sullivan. I think it is probably closer to no treatment versus a delayed treatment. It is so limited in terms of the scope that it leaves out -- I have spoken a lot about IV antibiotics, which is the largest subset of medications that are the most common home infusion drugs today. Infections are common. They happen. And we find that because those are just off the table with Medicare -- that those patients just don't -- aren't presented with the option at all to go home, so they have to go somewhere else to get that care.

Mrs. Houchin. Understood. Thank you.

And, to Ms. Van Meter, community health centers and other providers in rural areas rely on local and independent laboratories to deliver timely diagnostic services. How have repeated delays and uncertainty around the Clinical Laboratory Fee Schedule affected labs that serve rural areas of the country in particular?

Ms. Van Meter. Thank you for the question. For small independent laboratories, these are often laboratories that offer the most common, routine tests upon which Medicare beneficiaries and their physicians rely. Those are core services, and it is those types of tests that are going to bear the brunt of the next fourth round of reductions under PAMA that will take place on December

31 -- or pardon me -- January 31, and that is after 3 years of reductions. So we worry about the capacity of the laboratories to have as broad a menu as possible and, in some cases, to really continue to operate in a small community.

Mrs. Houchin. Thank you. I look forward to working with my colleagues to provide long-term healthcare funding that protects patients and their access to comprehensive primary care that includes home healthcare.

Thank you so much. I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentlelady from Florida. She passes.

I recognize -- actually, it goes over here. I recognize the gentlelady from Virginia for her 5 minutes of questioning.

Ms. McClellan. Thank you, Chairman Griffith, and to Ranking Member DeGette for holding this timely hearing.

As we have already talked about, across the country, millions of Americans are facing soaring healthcare premiums and higher out-of-pocket costs as the new year is beginning, and today, approximately 22 million Americans who rely on the Affordable Care Act marketplace coverage have lost their enhanced premium tax credits that kept that coverage affordable due to the Republicans' refusal to act before now.

In Virginia, this includes small business owners, their employees, the self-employed, farmers, retailers, restaurateurs, and people like my constituent Bobby Conner from rural Brunswick County who is 3 years away from Medicare. Last year, he paid \$34 a month for his premium. This year, with the tax credit, it would have gone to \$92 a month. Without the tax credit, he is facing a premium that is \$1,700 a month.

Lester and Yolanda Johnson and their 3-year-old daughter, who are the owners of the Mama J's restaurant in Richmond, have gone from paying \$700 a month for their family of three to now

\$1,400 a month. And this comes at the height of an affordability crisis in the United States as groceries, gas, rent, and now healthcare costs are rising, squeezing families' budgets and prompting impossible choices between coverage and basic necessities. More than half of American families lack the resources to live securely in their communities with grocery prices up 32 percent since 2019 and the lowest-price ACA marketplace Silver plan up 41 percent.

This affordability crisis isn't limited to working-age Americans. Seniors enrolled in Medicare Advantage, which now covers more than half of all Medicare beneficiaries, are also navigating rising costs and making difficult choices to afford prescriptions and provider visits.

I am glad the committee is considering my H.R. 5243 which would require companies that offer Medicare Advantage plans to submit enrollee-level data on supplemental benefits to the Department of Health and Human Services, thereby increasing transparency around Medicare Advantage supplemental benefits and helping seniors make better-informed decisions amid this ongoing affordability crisis.

So, with that, Mr. Lipschutz, from your work with Medicare beneficiaries, how often do seniors choose Medicare Advantage plans because of promised supplemental benefits like dental, vision, or transportation that they have seen advertised on television only to later find out that those benefits are difficult to access or far more limited than advertised?

Mr. Lipschutz. In our experience, quite often. Supplemental benefits really drive a lot of decision-making when it comes to planned enrollment, but people don't realize that these supplemental benefits are not standardized and they vary considerably by plan and they can change from year to year.

So, as you note, advertisements are full of articulating the supplemental benefits as a means to draw people in, but oftentimes, when people get in the plans, they find that they have more difficulty than they anticipated trying to access those benefits.

Ms. McClellan. And, sticking with you, if Medicare Advantage is going to continue to grow

as a major part of Medicare, what role should transparency and accountability around supplemental benefits play in ensuring the program truly serves seniors and not just insurers?

Mr. Lipschutz. I think transparency and accountability are paramount when we look at the program. These are public dollars going to private plans to administer benefits for the Medicare population. We need a lot more accountability and transparency. This is a start. So thank you for introducing this bill.

Ms. McClellan. I agree. Thank you. And would requiring carriers to report enrollee-level data on supplemental benefits to the Department of Health and Human Services better align advertised benefits with what seniors actually need and leading to greater participation, more meaningful coverage, and better health outcomes for beneficiaries?

Mr. Lipschutz. Agreed.

Ms. McClellan. Thank you.

And, with that, I will yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from California, Mr. Obernolte, for his 5 minutes of questioning.

Mr. Obernolte. Well, thank you very much, Mr. Chairman, and thank you to our witnesses. This is a really critically important topic, and we very much appreciate you contributing your expertise.

Ms. Van Meter, I would like to start with you. I was really interested in the part of your testimony where you were talking about improving Medicare's payment structure for clinical labs and the way that doing that could help foster innovation for diagnosis. I have long been interested in the application of artificial intelligence to that particular space.

I chaired the House Task Force on AI last Congress. This is, you know, one -- we always said -- we had a whole chapter in our task force report just on healthcare because we really think

that, of all of the applications of AI, really the low-hanging fruit -- the way it can most immediately contribute to the well-being of people -- is through the healthcare space and certainly through the lab space as well. So can you tell us a little bit more about how AI is being utilized in the diagnostic lab industry?

Ms. Van Meter. Thank you, Congressman. Really, in two key facets. One is to improve and create efficiencies within the operation of the laboratory, and that could also move into the business side with the administration -- right -- as we have to deal with huge volumes of claims and the like.

But, when it comes to clinical care, particularly in the space of genomics, leveraging AI tools to look at enormous data sets that can't be consumed by a human on its own allows us to open up discoveries both in terms of improving personalized diagnostics but then driving therapies on an individualized basis for patients. So, really, there is tremendous promise that exists today with AI tools and diagnostics.

Mr. Oberholte. Sure. Well, it is interesting that that mirrors the use of AI in other spaces in the healthcare industry where, initially, we are seeing the biggest returns in terms of improving administration. I mean, for example, physicians' automated note-taking is the number-one way that they are using AI right now, which is not what you would think of when you first think of the application of AI to healthcare, but all of those other concomitant uses for AI are coming, and we hope they come to the diagnostic lab space as well.

Mr. Ryan, I was really interested in the part of your testimony when you said that the reimbursement rates for liquid oxygen are far below supplier costs. Could you talk a little bit more about that gap between the CMS reimbursement rates and the actual supplier expenses? Because I am very interested in that.

Mr. Ryan. You know, like I said earlier -- thank you, Congressman, for the question -- that Medicare's reimbursement for oxygen is based on, you know, all product categories, and different

product categories have different cost points to them. Liquid oxygen is one of the most expensive product categories due to the nature of the FDA oversight and the infrastructure that the company must build to provide liquid oxygen.

Back before competitive bidding, Medicare would pay per pound for liquid oxygen. My company probably had -- when I was in business before competitive bidding, 30 to 40 percent of the patients would be on liquid oxygen. It was extremely convenient for the patient. They could ambulate and get out and about. You could fill it from your liquid canister -- portable canister and go out and about. You know, you didn't have to be limited by the number of hours and limited hours of a gaseous oxygen tank.

But the reimbursement changed drastically and then, because of that, everybody -- like my company, some -- I didn't survive the competitive bidding -- but they got out of the business. And now technology has evolved. So you do have things like portable oxygen concentrators where you can get, you know, lower-flow oxygen from a portable concentrator device that, you know, provides a battery, and the battery is your lifeblood. Do I have enough batteries to make sure I can go out and about and get my chores done?

But there is a subset of patients who require a higher liter flow, and that higher liter flow in today's technology is not able to be accomplished with a POC, and it can be accomplished with a gaseous tank, but the amount of oxygen that you would need to use -- that gaseous tank would empty out in 30 minutes. I said earlier that, you know, one cubic foot of liquid oxygen expands to 860 cubic feet of gaseous oxygen. So old technology but very, very useful for a subset of patients that has been completely taken off the market due to the reimbursement structure.

Mr. Oberholte. Right. Well, I think sometimes we forget as we negotiate these reimbursement rates that the end goal is not just greater efficiencies for the taxpayer. We are trying to strike this balance between providing world-class healthcare with positive healthcare outcomes, you know, at the lowest cost to taxpayers. And achieving that balance can be tricky, but

that is why all of you being here today is so important. So thanks very much for your testimony.

I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Florida, Mrs. Cammack, for her 5 minutes of questioning.

Mrs. Cammack. Thank you, Mr. Chairman, and thank you to our witnesses and everyone for being here today.

I know that we are looking at several proposals that all point to the same reality: Medicare is struggling to keep pace with how care is delivered for people who live with chronic conditions and disabilities. For many seniors and individuals with complex needs, the goal is not a cure. It is a maintaining of their independence, whether it is staying at home and avoiding unnecessary trips to the hospital or ending up in a nursing facility. Home-based services play a critical role in making that possible.

But we continue to hear from providers and patients that outdated payment structures and rigid policies are limiting access to care that is often safer and more cost-effective when delivered in the home. So, whether it is lab testing, home infusion, or durable medical equipment, these services are essential for people who depend on them every single day.

When Medicare does not reflect the real cost and realities of care delivery, providers are forced to make difficult decisions. In rural areas like my district, there are fewer options, longer delays, and tougher challenges for patients who already face an extraordinary amount of difficulty in accessing care.

So I am going to start with you, Mr. Ryan. Your testimony highlights that home-based care can both reduce costs and improve quality of life particularly for seniors and people living with disabilities and chronic conditions. I have introduced H.R. 3864, the Protecting Healthcare For All Patients Act of 2025, to address concerns that some Federal healthcare decision-making tools may not fully capture the value of care for these populations.

From your perspective, do policy metrics such as the Quality-Adjusted Life Years that influence coverage and payment decisions across Federal health programs risk undervaluing the needs of patients receiving home-based services?

Mr. Ryan. Yes. As I said earlier -- Congresswoman, thank you for the question -- we have seen actually a decrease in the amount of dollars put in, you know, home -- for my particular industry -- from 2.2 percent to 1.3 percent. We are continuing to see a downward decrease in reimbursement for programs like competitive bidding. And then the Managed Care Organizations certainly pay a percentage of that, so we see -- even see a lower point of care dollars.

And one of the things that we have seen over this period of time is -- again, I keep talking about the thwarting of technology, but it is very, very significant. When no dollars have been put into the DMEPOS sector, we see the 95 percent decrease in patents. We have seen many of our products now go offshore. I mean, when I -- back in the day, you know, most of my products I bought from an American manufacturer right here in the United States.

Mrs. Cammack. Just because I want to be sensitive to time, I just want to just really put a button on it. So things like QALYs, a formula that would effectively define the value of someone's care or life -- that is a policy that we need to move away from in all of our Federal programs, correct?

Mr. Ryan. That certainly is happening in my industry which I can speak to.

Mrs. Cammack. Okay. Perfect. And I do have a follow-up. Now, many of my rural counties cover a large geographic area, and suppliers often have to drive long distances to deliver oxygen or make equipment repairs. When reimbursement does not reflect those real-world costs, what happens to service reliability? I think we all know. So touch on just some real-world examples there. But then, also, what types of access issues do you expect to see if suppliers further consolidate or just leave the program?

Mr. Ryan. The access issues -- as I talked in the survey we have done -- is that people that are living in service areas -- we are losing suppliers. Thirty seven percent of the industry has gone

out of business. We are reimbursing in the non-bid, non-rural area, which is -- the chairman mentioned his district potentially is really, really rural. At the same rate, we are reimbursing for products in a competitive bid program, and that is unfair.

The bill that we have out here, H.R. 2005, will put reimbursement back for a short period of time. I hope we can convince the agency like they did in the rural portion of America -- that they determined was a rural portion -- make it in regulation a 50/50 blended rate. Again, our bills, both H.R. 2005 and the SOAR Act -- which would take oxygen out of the competitive bidding and take that 50/50 blended rate and make it permanent but also take that 75/25 rate and make it permanent -- would certainly be help when it comes to making sure we are getting the proper care and technology and outcomes that these patients deserve.

Mrs. Cammack. And I just want -- because when people watch this video clip back, I want folks at home to really understand. Hit that 37 percent number once again.

Mr. Ryan. Thirty seven percent of the DMEPOS providers have gone out of business since 2013.

Mrs. Cammack. That is a staggering number. Staggering. And so, for folks at home and people in underserved communities and rural communities, you need to understand that consolidation and services are going away. I think they are living it every day, but people in America need to understand that this is at a tipping point. Would you agree?

Mr. Ryan. I think the un-thought-out remote item delivery program that came out in this final rule that is looking to take categories like ostomy and CGMs and limit it to eight to 10 players is going to be devastating. It is not thought out. It is very problematic. We have to make a change before that goes into effect.

Mrs. Cammack. I appreciate your testimony and your time here today, and my time has expired.

With that, Mr. Chairman, I yield back.

Mr. Griffith. The gentlelady yields back.

I now, at long last, recognize the gentleman from Colorado, Mr. Evans, for his 5 minutes of questioning.

Mr. Evans. Thank you, Mr. Chairman. Thanks for letting me waive on to this committee.

Of course, thanks to my fellow Coloradoan, the ranking member, and to our witnesses for coming today so we can talk about something that is deeply personal to me and to many of my constituents, and that is supplemental oxygen.

I have a bipartisan bill that I helped introduce. It is included in today's discussion: The Supplemental Oxygen Access Reform Act, or the SOAR Act. I have had family members rely on supplemental oxygen, and representing a State like Colorado where we have high altitude, we know that many of our constituents also rely on supplemental oxygen. House Republicans have been laser-focused on affordability this Congress, but affordability goes hand in hand with accessibility, which is the centerpiece of the SOAR Act.

So, Mr. Ryan, I wanted to thank you and your organization for supporting this legislation. We know how important supplemental oxygen is -- liquid supplemental oxygen at times -- for people battling a variety of conditions. And I actually wrote down the number you just threw out: 860 times more oxygen in the liquid form in the same volume as you get in gaseous form.

Can you describe the dilemma and the real human impacts that patients face when the existing system that we have with the Medicaid -- excuse me -- Medicare DME program significantly limits access to liquid oxygen?

RPTR KRAMER

EDTR HUMKE

[1:22 P.M.]

Mr. Ryan. Yeah. The reality is, looking at Medicare claims data, the decrease in both liquid

portable oxygen and stationary portable oxygen has been significant. It is down 80 percent. So there, again, is a subset of patients that require high flow liquid oxygen, and essentially, because of a poor reimbursement program, a failed competitive bid program, those patients no longer get that service.

When I provided oxygen, we had a -- I am a respiratory therapist. The SOAR Act provides a payment structure to get paid for respiratory therapy. I think that is important. We competed on service and service alone, and our standard of care was excellent. But compressing prices, completely compressing them down, again, has taken the service model and changed it severely. It has taken the opportunity to have a respiratory therapist that could go into their home and do the proper services it would need. It has taken it away. The SOAR Act could bring that back. It is concerned about our patients. It has got a patient's bill of rights in there.

It is also leveraging technology. It is using something called e-prescribing where we could not go to the subjective medical record and we could simply have a template that is agreed upon by the pulmonary community, and it will be the basic components of what is a medical necessity for oxygen.

This bill is supported by well over 30 pulmonary groups; American Thoracic Society, CHEST, American Association of Respiratory Care. We have a letter for the record that shows the 30 groups in the pulmonary community working hand in hand with the DMEPOS community to get this legislation passed into law.

Mr. Evans. Thank you for that. I think one of the key phrases you used there was just the quality of care. And so we know that that quality of care happens when we balance affordability and accessibility. And a big part of that is making sure that these programs work, making sure that the money goes where it is supposed to while also rooting out the fraud, waste, and abuse.

And so can you speak to the SOAR Act and specifically how it has some of those guardrails in place but also takes a light touch via the creation of a national standardized electronic template to

appropriately balance the needs of patients, providers, CMS, and make sure that we are being good stewards of the money?

Mr. Ryan. Yeah. Well, again, I think the current problem is that the Medicare program relies on medical records which are written to support patient follow-up care, not to provide the legal support for a Medicare claim.

The SOAR Act would make it easier for CMS to prevent fraudulent and abusive claims by requiring Medicare contractors to adopt electronic -- electronic data elements, i.e., a template. To date, contractors have refused to adopt this commonsense approach. Adopting an electronic process in lieu of using physician short notes would provide much more needed clarity and accuracy in the review process. And I think it would help in the fraud and abuse.

Mr. Evans. Thank you so much for that. And again, I -- obviously I am supporting the bill. I knew it was a good bill. But I am just struck by that 860 number that you threw out there, people that need this high flow oxygen. Sometimes there is really only one answer to that, and that is that liquid oxygen.

And so I just want to thank you. Thank the chairman and the ranking member for, again, for letting me waive onto this and be able to talk to this issue that is so critically important to me, to many of my constituents, and I look forward to working with everybody on both sides of the aisle and the coalition that you mentioned to continue to advance this bill. And I yield back. Thank you.

Mr. Griffith. The gentleman yields back.

I ask unanimous consent to insert in the record the documents included on the staff hearing document list. Without objection, so ordered.

[The information follows:]

***** COMMITTEE INSERT *****

Mr. Griffith. I would like to thank all of our witnesses again for being here today. You saw a lot of members showed up, and that tells you how important this hearing was to the members and it was glad to have all that input.

Members may have additional written questions for you. I will remind members that they have 10 business days to submit those questions for the record. And I ask the witnesses to respond to the questions promptly. Members should submit their questions by the close of business on Friday, January 23rd.

Without objection, the subcommittee is adjourned.

[Whereupon, at 1:26 p.m., the subcommittee was adjourned.]