House Energy and Commerce Subcommittee on Health
"Legislative Proposals to Support Patient Access to Medicare Services"
Thursday, January 8, 2026

Members of the Committee

Republicans

Morgan Griffith (VA) Chairman
Diana Harshbarger, PharmD (TN) Vice Chair
Gus Bilirakis (FL)
Buddy Carter, BSPharm (GA)
Neal Dunn, MD (FL)
Dan Crenshaw (TX)
John Joyce, MD (PA)
Troy Balderson (OH)
Mariannette Miller-Meeks, MD (IA)
Kat Cammack (FL)
Jay Obernolte (CA)
John James (MI)
Cliff Bentz (OR)
Erin Houchin (IN)
Nick Langworthy (NY)
Tom Kean (NJ)
Michael Rulli (OH)
Brett Guthrie (KY)

Democrats

Diana DeGette (CO) Ranking Member
Raul Ruiz, MD (CA)
Debbie Dingell (MI)
Robin Kelly (IL)
Nanette Diaz Barragán (CA)
Kim Schrier, MD (WA)
Lori Trahan (MA)
Marc Veasey (TX)
Lizzie Fletcher (TX)
Alexandria Ocasio-Cortez (NY)
Jake Auchincloss (MA)
Troy Carter (LA)
Greg Landsman (OH)
Frank Pallone (NJ)

Witnesses

Susan Van Meter
President,
American Clinical Laboratory Association

Thomas Ryan
President and CEO,
American Association for Homecare

Connie Sullivan
President and CEO,
National Home Infusion Association

David Lipschutz, JD
Attorney and Co-Director of Law and Policy,
Center for Medicare Advocacy

Legislation Considered

- **H.R. 1703**, Choices for Increased Mobility Act of 2025 (Rep. Joyce)
- **H.R. 2005**, DMEPOS Relief Act of 2025 (Rep. Miller-Meeks)
- **H.R. 2172**, Preserving Patient Access to Home Infusion Act (Rep. Buchanan)
- **H.R. 2477**, Portable Ultrasound Reimbursement Equity Act of 2025 (Rep. Van Duyne)
- **H.R. 2902**, Supplemental Oxygen Access Reform (SOAR) Act of 2025 (Rep. Valadao)
- **H.R. 5243**, To amend title XVIII of the Social Security Act to increase data transparency for supplemental benefits under Medicare Advantage. (Rep. McClellan)
- **H.R. 5269**, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025 (Rep. Hudson)
- **H.R. 5347**, Health Care Efficiency Through Flexibility Act (Rep. Buchanan)
- **H.R. 6210**, Senior Savings Protection Act (Rep. Matsui)
- **H.R. 6361**, Ban AI Denials in Medicare Act (Rep. Landsman)

Opening Statements

Chairman Griffith introduced the ten bills for discussion, aimed at improving Medicare patient access as the population ages. Several measures address durable medical equipment (DME): H.R. 1703 (Choices for Increased Mobility Act) would create a billing code to help cover ultra-lightweight wheelchairs; H.R. 2005 (DMEPOS Relief Act) seeks fairer DME supply rates amid competitive bidding pressures; and H.R. 2902 would remove supplemental oxygen from competitive bidding and set new reimbursement for oxygen supplies. H.R. 2477 would reimburse portable ultrasound transport and services. H.R. 2172 would modernize home infusion reimbursement to reflect current practice and protect patient access. H.R. 5269 proposes a streamlined process for setting clinical lab payment rates. Other items include H.R. 5243, a bill to extend ACO quality-data methods and pilot digital measures, H.R. 6210 to reauthorize programs for low-income beneficiaries, and H.R.6361, a ban on CMMI's WISeR model. Chair Griffith expressed optimism about advancing these legislative efforts to enhance Medicare beneficiaries' access to critical health care services.

Ranking Member DeGette warned that health care affordability is a crisis made worse by the expiration of enhanced premium tax credits at the end of 2025, which will cause 2026 premiums to spike and force many Americans to drop coverage. She used her district as an example – where families will face huge premium hikes – and criticized the majority for failing to act, instead advancing legislation that would raise costs and cut coverage while neglecting meaningful fixes. She argued that enhanced tax credits, though not a permanent solution, substantially lowered premiums and expanded coverage during COVID. Frustrated by inaction, Democrats and a few GOP members bypassed leadership to put a three-year extension of enhanced ACA subsidies on the House floor, potentially cutting premium spikes by 80% on average, preventing five million people from losing insurance, and protecting lower-income families. She urged representatives, senators, and the President to support the extension.

Full Committee Chairman Guthrie focused on strengthening Medicare and improving seniors' access to care. He noted that the 2014 Protecting Access to Medicare Act, which reformed Medicare payments for lab services, was not operating as intended, and Congress had frequently modified or delayed aspects of the reform. The subcommittee looked to examine potential solutions for payment stability and consistency for lab services, encouraged innovation in diagnostic lab testing, and protected seniors' ability to receive these services while ensuring responsible use of federal taxpayers' dollars. He looked to the witness testimony on bills related to DME and home infusion therapy, which are critical for seniors, particularly in rural and underserved areas. Acknowledging frustrations with prior authorization, he also

warned current Medicare spending was unsustainable and urged creative use of CMMI and new technologies to reduce unnecessary care. He announced forthcoming hearings on health care affordability, including a January 22nd session with major insurers' CEOs, and emphasized bipartisan efforts to tackle rising prices so the U.S. system becomes more affordable for all.

Full Committee Ranking Member Pallone stated that the committee was holding a hearing on Medicare to supposedly strengthen the program, but their actions over the past year told a different story. He claimed Republicans cut over $1 trillion from Medicaid and refused to extend enhanced premium tax credits under the ACA, which helped low- and middle-income Americans afford health care coverage. As a result, insurance premiums skyrocketed for 24 million Americans. He argued that the Republicans' failure to address the affordability crisis was a major leadership failure. He supports some Medicare bills but believe they do not address the broader crisis. He emphasized that the failure to extend tax credits is particularly harmful to older Americans, who face significant premium increases and are at risk of financial ruin. He urged Republicans to support a discharge petition to extend the tax credits and make health care more affordable.

Witness Testimony

Ms. Van Meter testified in strong support of the RESULTS Act. She stated that the Clinical Laboratory Fee Schedule (CLFS), which is the Medicare payment system for laboratory tests, suffers from significant foundational flaws. The current payment rates are inaccurate, artificially low, and based on incomplete data from 2016. Ms. Van Meter expressed concern that Medicare cuts of up to 15% were imminent, affecting about 800 tests, and urged the committee to pass the RESULTS Act. She believes that this bill would reform the Clinical Laboratory Fee Schedule, prevent deep Medicare cuts, and ensure that laboratories can continue to provide essential diagnostic services to Medicare patients. Ms. Van Meter emphasized the importance of laboratory testing in healthcare decision-making and the need for a fair and predictable payment system.

Ms. Sullivan emphasized that home infusion is a preferred method of treatment for patients with serious conditions, as it allows for IV medication administration with minimal disruption to daily life, earlier hospital discharge, and reduced risk of complications. However, she noted that Medicare beneficiaries have limited access to home infusion due to a restrictive benefit design. Ms. Sullivan provided an example of a patient who, after being hospitalized for a serious infection, was unable to receive IV antibiotics at home due to Medicare's limited coverage, forcing them to either travel daily to a hospital or be admitted to a long-term care facility. She urged support for the Preserving Patient Access to Home Infusion Act (H.R. 2172), which aims to modernize the Medicare benefit and expand coverage for home infusion supplies and professional services.

Mr. Ryan raised concerns about the Centers for Medicare and Medicaid Services' (CMS) proposed plans for competitive bidding, which would include ostomy and urological supplies, continuous glucose monitors, and other essential medical products. He argued that these plans would devastate small businesses, destabilize the national home medical equipment infrastructure, and undermine innovation in diabetes care. Mr. Ryan then discussed three bipartisan bills: H.R. 1703, H.R. 2005, and H.R. 2902. He stated that H.R. 1703 would restore beneficiaries' ability to upgrade to titanium or carbon fiber wheelchairs without incurring additional costs. H.R. 2005 aims to restore a 75-25 blended rate for non-bid, non-rural areas, ensuring that suppliers in these areas would not face significant cuts. Finally, H.R. 2902 addresses long-standing access problems in the Medicare oxygen benefit, particularly for patients requiring liquid oxygen. Mr. Ryan emphasized that home medical equipment is critical to keeping people

healthier, more independent, and in their homes, while reducing costly hospitalizations and emergency room visits. He expressed his appreciation for the bipartisan leadership on these bills and looked forward to working with the committee to move them forward, ensuring that millions of Medicare beneficiaries continue to have access to essential care.

Mr. Lipschutz expressed support for three bills aimed at improving access to care for Medicare beneficiaries. Firstly, he backed H.R.6210, the Senior Savings Protection Act, which would reauthorize critical funding for state health insurance assistance programs and other community-based organizations that provide essential outreach and enrollment assistance to low-income older adults and individuals with disabilities. Lipschutz also supported H.R.5243, which aims to increase data transparency for supplemental benefits under Medicare Advantage, and H.R. 6361, the Ban AI Denials and Medicare Act, which would prohibit the implementation of payment models that test prior authorization in traditional Medicare. Lipschutz emphasized the importance of these bills in ensuring that Medicare beneficiaries have access to necessary care and can make informed decisions about their healthcare.

Questions and Answers

Chairman Griffith: Ms. Van Meter, in your testimony, you mentioned a Complete Blood Count (CBC) test that regularly is furnished by 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% on January 31st, absent a change in the law. What does this mean for patient access to this test and others like it if we don't act? **Ms. Van Meter:** 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. For smaller laboratories that focus really on those essential common tests, we have significant concerns about them being able to weather these deep Medicare cuts. **Rep. Griffith:** If you're in a big city and you're doing a thousand of those tests today, you might be able to justify the $7.77, maybe a little bit of a cut. But if you're in a rural area where you're doing five of those tests per day, there's no way you can possibly manage it for that amount of money. You've either got to decide whether you close shop or just stop doing that test. Is that what I'm hearing? **Ms. Van Meter:** 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. ACLA members are committed to doing so, but we worry profoundly about the impact of those reductions. **Rep. Griffith:** Mr. Ryan, my district is considered very rural by many metrics. 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? **Mr. Ryan:** A lot of people can't figure that out. Medicare used a set of zip codes, and in the zip codes, they chose what areas of the country were going to be competitively bid, the CB 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. H.R. 2005 would help with that. The SOAR Act would help with that because you get increased reimbursement for those product categories **Rep. Griffith:** Can you explain what has already been done to help rural areas subject to competitive bidding? **Mr. Ryan:** Yes, we had worked with Congress in the past and we've enacted the 75-25 blended rate, which was in effect until the end of 2023. 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.

Ranking Member DeGette: One of the themes that goes through these bills is an attempt to reduce costs for beneficiaries and for Americans. On January 1st, thanks to our bill that we passed under the Inflation Reduction Act, negotiated drug prices went into effect under Medicare Part D. Mr. Lipschutz, what reduction in list price did this first round of negotiations achieve? **Mr. Lipschutz:** When the prices were

first announced, the discounts depended on the drug and ranged from roughly 40% to 80%. **Rep. DeGette:** How much is this projected to save people on Medicare? **Mr. Lipschutz:** It's projected to save Medicare beneficiaries about $1.5 billion in out-of-pocket expenses this year. **Rep. DeGette:** That's 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. This is a little out there, but does that sound sort of like extortion to you? **Mr. Lipschutz:** Kind of sounds like it, yeah. **Rep. DeGette:** And why is that? **Mr. Lipschutz:** Well, I believe the negotiation tactics were exchanging the lack of pursuing tariffs to extract promises from different companies. **Rep. DeGette:** Are the deals details public that you know of? **Mr. Lipschutz:** No. **Rep. DeGette:** Companies that have made deals with the Trump administration 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:** Doesn't sound like it.

Vice Chair Harshbarger: 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 them and change that for rural patients and families? **Ms. Sullivan:** If a patient needs IV antibiotics, the first question that is asked by 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?” because it completely rules out home infusion in most cases. **Rep. Harshbarger:** Mr. Ryan, I'm a co-sponsor 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. How did these reimbursement cuts undermine Medicare's goal of keeping safely at home and avoiding costly emergency room visits in hospital stays, especially in rural communities with limited hospital access? **Mr. Ryan:** The industry has been cut by over 60 percent since competitive bidding came into place. And we've thwarted technology. We've seen that technology has really gone down over the years. Patents have decreased significantly. Innovation has been problematic. The service model has changed tremendously. Repairs have gone up significantly because the quality of the equipment is not the same. H.R. 2005 and the SOAR Act- essentially, we'll put some of those savings back in place that makes some sense, particularly for access to liquid oxygen, which has been devastating. **Rep. Harshbarger:** Ms. Van Meter, absent statutory reform, do you expect the next data collection cycle to year materially better or more representative results in the last one and why or why not? **Ms. Van Meter:** That's a fundamental flaw within PAMA right now has to do with CMS's lack of access to robust and representative commercial market data. We're tremendously concerned that the reporting would be lackluster. The first time that data were reported, fewer than 1% of laboratories across the country reported data. And those data were used to set rates.

Rep. Schrier criticized the CDC’s changes to the childhood immunization schedule recommendations and the Chairman’s unwillingness to call an oversight hearing, before turning to healthcare costs. “Mr. Lipschutz, in your testimony, you point out that Medicare is projected to spend about 20% more for Medicare Advantage (MA) enrollees than it would spend if those enrollees had traditional Medicare. Yet, Medicare Advantage plans say that they must use prior authorization to keep costs down. Can you explain that contradiction, please?” **Mr. Lipschutz:** Medicare Advantage plans can employ prior authorization ostensibly to weed out medically unnecessary care. But in our experience, far too often they weed out medically necessary care. Plenty of studies cited in my written testimony, including the HHS Office of Inspector General, have found widespread problems with inappropriate denials and their own assessment of claims found about 13% of claims that were denied that were medically necessary in their estimation.

Full Committee Chair Guthrie: Can you describe the data collection and reporting process for lab and how does this administrative burden ultimately affect the accuracy of private payer-based Medicare

payments? **Ms. Van Meter:** The original data upon which the assumption that Medicare rates were significantly higher than commercial market rates was – there was a dearth of data to suggest such, just an analysis looking at three FEHBP plans and only 20 tests. 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 understands commercial market rates and can appropriately set the Medicare rates based on those commercial market data. **Rep. Guthrie:** Can you speak to this idea of using independent claims database and how it would improve accuracy? **Ms. Van Meter:** 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 come directly from private health plans. That would give CMS tremendously robust data for the most widely available tests under the bill. **Rep. Guthrie:** As more personalized and targeted treatments come to market, can you discuss the importance of innovation in the clinical space and how payment reform will affect patient access to care and innovation? **Ms. Van Meter:** Innovation in diagnostics is really driving personalized medicine. We can determine in a cancer the exact 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 in research and development. With an unstable payment system and a threat of reductions that constantly hang over the head of clinical laboratories, you compromise the capacity to have long-range R&D.

Rep. Ruiz criticized the Chairman for not holding a hearing in months while Americans are suffering from the "Republican-fabricated health care affordability crisis." He gave an example of one constituent facing a premium increase of 165% and expressed support for H.R. 2172. Rep. Ruiz asked Ms. Sullivan, "what does that look like for patients and families on the ground and how would this bill make home infusion a more dependable option for Medicare beneficiaries, reducing repeated travel, caregiver strain, and unnecessary time and facilities?" **Ms. Sullivan:** 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're going to get this treatment. And it just puts everyone in an impossible position. Home infusion removes the burden on the family to be able to bring that care to the home and provide all the services that make it possible for that family to perform the infusions confidently, safely, effectively, and cost-effectively.

Rep. Bilirakis: One of my top priorities, of course, is improving access to cutting-edge medical innovation. 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? **Ms. Van Meter:** It's incredibly important that a patient and their physicians have access to a comprehensive set of tests that also tests for rare diseases. Let me give an example of a rare disease. A patient that has autoimmune encephalitis may present with symptoms of confusion, memory loss, maybe psychiatric symptoms. Those types of symptoms mimic common conditions like dementia. But that patient with autoimmune encephalitis, that is an autoimmune triggered swelling of the brain. 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 and diagnose unique and rare conditions. Rapid-hold genomic sequencing can diagnose hundreds, thousands of conditions. This yields actionable results 50%-60% of the time. That is the kind of information that patients and their families deserve.

Rep. Barragan: Mr. Lipschutz, last year, Republicans' priority was to give tax cuts to the rich and take away health care through Medicaid. 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. 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, and reorganization of the way that people access health care. **Rep. Barragan:** If older Americans are forced to delay care because they can't afford it, doesn't that mean they're going to be sicker and need more expensive care by the time they need Medicare? **Mr. Lipschutz:** Very likely. Right now, the expiration of the enhanced subsidies means premiums are skyrocketing.

Rep. Carter (GA) started by advocating for two other bills that he believed were also essential to "ensuring Medicare beneficiaries have access to critical services," the Ensuring Community Access to Pharmacist Services (ECAPS) Act and the Preserving Patient Access to Long-Term Care Pharmacies Act. He asked Ms. Sullivan to describe what home infusion pharmacies do to ensure patients receive safe support at home over the course of treatment. **Ms. Sullivan:** 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. **Rep. Carter:** We're considering today the Preserving Patient Access to Home Infusion Act. Will that make home options better? Will 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.

Rep. Fletcher voiced concerns over cuts to Medicaid funding and the elimination of Affordable Care Act funding, and how that has affected the Texas Medical Center. She asked Mr. Lipschutz to discuss how an increase in the overall number of people across the country who are not insured impacts access to care for Medicare beneficiaries. **Mr. Lipschutz:** If you have a significant group of people that don't have insurance at all, many people will defer care until they absolutely need it. It'll increase pressure in emergency rooms and on frontline providers. It affects the entire healthcare system.

Rep. Joyce discussed his legislation, H.R. 1703, the Choices for Increased Mobility Act. He asked Mr. Ryan to speak to the benefits of lighter weight wheelchairs for those with disabilities. **Mr. Ryan:** These are patients with serious diseases, spinal cord disease, and they ambulate on their own the best they can, if they have the ability. 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. That is the way it had been in Medicare previously. **Rep. Joyce** pivoted to his support for the RESULTS Act and how cuts in reimbursement for lab tests have impacted seniors across the country. He asked, "Ms. Van Meter, can you speak briefly to the impact that these sustained cuts will have on access?" **Ms. Van Meter:** We are tremendously concerned that these sustained cuts 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.

Rep. Ocasio-Cortez criticized Secretary Kennedy for no longer recommending certain childhood vaccinations and making cuts to scientific research. She asked Mr. Lipschutz, "you're a patient advocate, correct? 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. **Rep. Ocasio-Cortez** continued by discussing examples of how corporations could profit from Secretary Kennedy's decisions and funding cuts, citing Johnson & Johnson's talcum powder containing asbestos and DuPont polluting waterways. She focused on how J&J had previously testified that their

talcum powder was not toxic and alleged that the Secretary was abusing his position to benefit other private companies.

Rep. Balderson: 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. Can you discuss how the SOAR Act would help address this problem? **Mr. Ryan:** Usage of liquid oxygen has gone down significantly over the years. The reason for this is the reimbursement. The reimbursement under the competitive bidding program would not allow suppliers to provide liquid oxygen. The SOAR Act would take all oxygen out of competitive bidding, which would be very helpful to get more technology in the sector. **Rep. Balderson:** According to HHS, Medicare paid between 18% and 30% more than other insurers for 20 high volume and/or high expenditure lab tests in 2011. 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 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:** That OIG report focused on, as you mentioned, 20 high-volume tests, but looked at only three plans within the FEHBP. 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 the 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. **Rep. Balderson:** The RESULTS Act would prevent a 15% Medicare reimbursement cut for nearly 800 common clinical laboratory tests. How could this 15% cut and reimbursement impact rural hospitals and patients around the country? **Ms. Van Meter:** It would dramatically curtail access, increase turnaround time, and suppress innovation. We worry significantly about any reduction in access to those patients that are served by rural hospitals.

Rep. Veasey criticized President Trump and Secretary Kennedy's handling of America's health care, claiming they have manufactured a health care crisis. This included actions like allowing RFK Jr. to revoke vaccine recommendations, freezing childcare funding, and cutting cancer research and Medicare dollars, calling these actions "anti-child, anti-family, and anti-American."

Rep. Miller-Meeks: As a physician and nurse, I have seen firsthand how critical timely access to oxygen equipment, mobility devices, and home medical supplies are to keep patients healthy and out of hospitals. When access to these services is disrupted, patient outcomes suffer and cost to the health care system increases. That is why I introduced H.R. 2005, the DMEPOS Relief Act. DMEPOS supplies, particularly for small independent providers and those serving rural communities, are under growing financial pressure due to inflation, workforce shortages, supply chain disruptions, and Medicare reimbursement rates that have not kept pace with real-world costs. 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:** One of those rate cuts came into effect again. We did a survey around the country of our membership, and some of the key findings were that 65% of the companies reduced the amount or type of products they offered, 46% reduced their service areas, 53% laid off staff, and 35% used personal savings to maintain the business. I know that route, I did that myself. And over 1 in 10 surveyed said it'll be out of business probably within a year. So those areas of the country, the non-bid, non-rural areas of the country, they woke up overnight and got a significant decrease, a 30% decrease, without getting an increase in market share. **Rep. Miller-Meeks:** Mr. Lipschutz, you were asked some

questions about the ACA premiums. Are the premiums for those who are not on the ACA exchanges increasing for those 130 to 160 million Americans? **Mr. Lipschutz:** I'm more of an expert on Medicare than I am on the ACA. **Rep. Miller-Meeks:** The ACA is Medicaid and not Medicare, but the answer would be yes. Can you tell me that COVID-enhanced tax credits with no income limits are going directly to profitable insurance companies 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.

Rep. Auchincloss continued Rep. Veasey's remarks about how the subcommittee has failed to exercise oversight and accountability over HHS before continuing to Mr. Lipschutz. "You've talked in depth in both your written and oral testimony about the use of AI, how it can be instrumental and lifesaving, but also dangerous if used inappropriately or excessively, and that's the case with the use of AI to evaluate prior authorization requirements. Mr. Lipschutz, just hearing those broad outlines, do you think that could be an effective addition to prior authorization legislation for Medicaid MCOs and Medicare Part D?" **Mr. Lipschutz:** Yes, it would be an important start on trying to rein in inappropriate use of AI. **Rep. Auchincloss:** Anything I'm missing that I should be considering? **Mr. Lipschutz:** I think we should ask whether these tools learn from their own mistakes. **Rep. Auchincloss:** What I think I hear you saying is whether the models are purely tokenized LLMs where they're making just predictions or whether they have a worldview, whether they're world models that feel like they have inherent logic. **Mr. Lipschutz:** 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 with no changing condition. We're unconvinced that the machine learning tools are learning from their own mistakes and accounting for them.

Rep. Carter (LA): Louisiana has one of the highest percentages of MA enrollees in the country, many of whom live in my district. Given how many of my constituents get their health care through MA plans, it's important that they have the information they need to make the best decision about their health care, 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's important for these plans to notify beneficiaries of their benefits? **Mr. Lipschutz:** MA 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. This bill would help gather information to give the public and 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 getting value out of these services for which we pay plans considerably. **Rep. Carter:** How do we do a better job at making sure that we educate people on these MA options? **Mr. Lipschutz:** We just discussed one of the bills being evaluated today that would increase requirements for collection of data on supplemental benefits. I'll pivot to the other bill that would extend funding for key community organizations like state health insurance assistance programs and others. 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 there have no stake in someone's decision.

Rep. Landsman provided some context for his bill and how Medicare tested the WISeR system on Ohio's seniors. "Adding AI and for-profit companies, 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's 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 health care, particularly with the Medicare population.

Rep. Kean expressed support for the RESULTS Act, stating "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 a diagnosis of more complex conditions like cancer. In New Jersey, there were over 2,300 laboratories. In my district, there were over 200. Ms. Van Meter, can you articulate the urgency of reform needed for Medicare's clinical lab fee schedule?" **Ms. Van Meter:** On January 31st, about 800 tests will get cut by up to 15%. 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. It will also stifle innovation and the next generation of diagnostics those same patients need and deserve. **Rep. Kean:** 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 to patients, including those with rare diseases? **Ms. Van Meter:** Biomarker tests can be used in a variety of conditions and diseases, and it is the foundation for precision medicine. In other words, being able to plot a personalized course for patients on the best medicines, best treatments for their condition. **Rep. Kean:** And can you explain how the current Medicare Clinical Lab Free 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. **Rep. Kean:** In your testimony, you write that around one-third of lab tests and 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 determine the price of each one of these codes, and what impact further delays on these repricings would have? **Ms. Van Meter:** There have 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 1st. 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.

Rep. Trahan: 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. Unlike portable x-ray, Medicare does not reimburse transportation costs for portable ultrasounds, making it harder to bring timely diagnoses to patients or 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:** It's very important. As I continue to talk about today, care in the home is extremely important. It's where the dollars should be going these days. **Rep. Trahan:** Under current law, Medicare reimbursement 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? **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.

Rep. Langworthy: When Medicare doesn't make the home option dependable, the system too often defaults patients into a more inconvenient setting. 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 long ways away from their hospital campus or infusion center? **Ms. Sullivan:** Home infusion operates on a model that is incredibly efficient in that we rely on the pharmacy to provide that support, 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's healing properly. But the support really comes from the pharmacy daily and largely happens behind the scenes. **Rep. Langworthy:** Ms. Van Meter, 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:** The infrastructure that exists in rural or frontier communities may not be as robust as is ideal. If the cuts go into effect, we worry that that infrastructure will be compromised. **Rep. Langworthy:** Mr. Ryan, could you briefly summarize your findings from a survey on the impact of the 2024 payment cuts on durable medical equipment? **Mr. Ryan:** Congress intervened twice to make sure those cuts were not in place, and the 75-25 rate remained in place. Since they've stopped, key findings are that 65% of the products have been reduced. The companies are offering fewer products. One in 10 surveyed stated that they'll be entirely out of business within a year.

Rep. Matsui discussed her bill, the Senior Savings Protection Act, and criticized Republicans for Americans facing a health care crisis and skyrocketing premiums. She asked Mr. Lipschutz, "how do programs like the low-income subsidy or extra help and the IRA smoothing provision help seniors afford their health care?" **Mr. Lipschutz:** As you noted, Congress created these programs to help Medicare beneficiaries afford some of their health care expenses. The Part D low-income subsidy for those who meet the income and asset tests can 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 a calendar year. **Rep. Matsui:** My bipartisan bill reauthorizes funding for outreach and enrollment activities to help low-income Medicare beneficiaries understand all their options and enroll in a 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 funding is spread between SHIP programs and benefit enrollment centers and others. And 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.

Rep. Crenshaw: How does portable ultrasound help ensure seniors receive that timely diagnostic care without being transported long distances? **Mr. Ryan:** I don't know much about your bill. I believe in care in the home. It's patient preferred and cost effective. **Rep. Crenshaw:** Would you think that being able to bring it to the patient would 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 product. **Rep. Crenshaw:** Ms. Van Meter, what differences do you see in how current payment policies affect hospital-based laboratories, physician office laboratories, and independent laboratories? Why does that matter for patients? **Ms. Van Meter:** The current Medicare payment system has suffered from years of deep reductions. It's 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. 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 broad patient access. **Rep. Crenshaw:** Ms. Sullivan, from the patient's perspective, how does the availability of home infusion services influence where seniors ultimately receive care, particularly when managing complex and chronic conditions? **Ms. Sullivan:** The range of medications that are available to patients in the home if you have commercial insurance reaches above 300 different individual medications. Medicare beneficiaries are limited to a handful of drugs that use an item of DME or an infusion pump to be administered. 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. **Rep.**

Crenshaw: Can you comment on how that might affect long-term costs and savings? Do you think it remains neutral? Do you think it saves costs? **Ms. Sullivan:** Historically, the Congressional Budget Office has scored home infusion legislation as something that would generate savings. We're still waiting for an updated score on the provisions in this bill.

Rep. Houchin: 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:** The Preserving Patient Access to Home Infusion Act aims to eliminate benefit fragmentation and remove face-to-face requirements, which currently limit provider participation and patient access to home infusion benefits. **Rep. Houchin:** Does that lead to the face-to-face requirements? Does it lead to unnecessary treatment delays? **Ms. Sullivan:** I think it's probably closer to no treatment versus a delayed treatment. **Rep. Houchin:** 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? **Ms. Van Meter:** For small independent laboratories, these are often laboratories that offer the most common routine tests upon which Medicare beneficiaries and their physicians rely. 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 small communities.

Rep. McClellan: 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've 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 plan enrollment. **Rep. McClellan:** 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. **Rep. McClellan:** Would requiring carriers to report enrollee-level data on supplemental benefits to HHS better align advertised benefits with what seniors need, leading to greater participation, more meaningful coverage, and better health outcomes for beneficiaries? **Mr. Lipschutz** agreed.

Rep. Obernolte: Ms. Van Meter, can you tell us a little bit more about how AI is being utilized in the diagnostic lab industry? **Ms. Van Meter:** Really in two key facets. One is to improve and create efficiencies within the operation of the laboratory. 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 discoveries, both in terms of improving personalized diagnostics, but also driving therapies on an individualized basis for patients. **Rep. Obernolte:** 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? **Mr. Ryan:** Liquid oxygen is one of the most expensive product categories due to the nature of FDA oversight and the infrastructure that the company must build to provide liquid oxygen. 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% of the patients would be on liquid oxygen. I didn't survive the competitive bidding port.

Rep. Cammack: Mr. Ryan, your testimony highlights that home-based care can both reduce costs and improve quality of life. 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:** We've seen a decrease in the amount of dollars put in, from 2.2% to 1.3%. We're continuing to see a downward decrease in reimbursement through programs like competitive bidding. **Rep. Cammack:** 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 our federal programs, correct? **Mr. Ryan:** That certainly is happening in my industry, which I can speak to. **Rep. Cammack:** When reimbursement does not reflect those real-world costs, what happens to service reliability? **Mr. Ryan:** The access issues, as I talked in the survey we've done, are that people are living in their service areas. We're losing suppliers. We believe 37% of the industry (DMEPOS providers) has gone out of business. Both H.R. 2005 and the SOAR Act would help when it comes to ensuring we're getting the proper care, technology, and outcomes that these patients deserve.

Rep. Evans: Mr. Ryan, can you describe the dilemma and the real human impacts that patients face when the existing system that we have significantly limit access to liquid oxygen? **Mr. Ryan:** The reality is the decrease in both liquid portable oxygen and stationary portable oxygen has been significant. The SOAR Act provides a payment structure to get paid for respiratory therapy. We competed on service and service alone, and our standard of care was excellent. But compressing prices has taken the service model and changed it severely. This bill is supported by well over 30 pulmonary groups. We have a letter for the record that shows the 30 groups and the pulmonary community working hand in hand to get this legislation passed into law. **Rep. Evans:** Can you speak to the SOAR Act and how it balances those guardrails with the needs of patients, providers, and CMS, and makes sure that we're being good stewards of the money? **Mr. Ryan:** The SOAR Act would make it easier for CMS to grant fraudulent and abusive claims by requiring Medicare contractors to adopt electronic data elements. To date, contractors have refused to adopt this commonsense approach. Adopting an electronic process in lieu of using physician chart notes would provide much more needed clarity and accuracy in the review process.

Closing Statements

Chairman Griffith thanked the witness and adjourned the hearing. Questions for the record are due January 23.