Center for Medicare Advocacy
Advancing Access to Medicare and Health Care

EXAMINING POLICIES to ENHANCE SENIORS' ACCESS TO BREAKTHROUGH MEDICAL TECHNOLOGIES

United States House Committee on Energy & Commerce
Subcommittee on Health Care

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TESTIMONY

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SUMMARY

The Center for Medicare Advocacy (CMA) is a national private, non-profit, non-partisan law organization. We offer our comments based on our experience assisting and representing Medicare beneficiaries since 1986. We do not have concerns about the bill relating to National Coverage Determinations or the bill that would expand access to diabetes self-management training. We do raise concerns about the other two bills.

H.R. 842, Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act includes built-in limitations to accessing care by limiting coverage to Medicare beneficiaries who attain a certain age by January 1 of the relevant year or received a multi-cancer screening test in the prior 11 months. The arbitrary exclusion of large segments of the Medicare population contemplated by this bill would set a dangerous precedent for future expansions of coverage. All beneficiaries should have equitable access to screenings and preventive care that is appropriate for them based on their medical needs, not based on the year of their birth.

The Ensuring Patient Access to Critical Breakthrough Products Act would allow devices granted breakthrough designation to be deemed "reasonable and necessary," despite not going through Medicare's usual and separate process of determining if complete evidence of efficacy, safety, or clinical benefit for use among Medicare beneficiaries has been met. We are concerned that this bill does not strike the appropriate balance between getting innovative, potentially helpful products to people who might need them and ensuring that such products are safe, effective and medically reasonable and necessary.

We also offer a number of suggestions for improving access to care for Medicare beneficiaries and safeguarding the Medicare program, including increasing oversight of Medicare Advantage plans, strengthening traditional Medicare and repealing the health-related provisions of H.R. 1.

TESTIMONY

Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and distinguished members of the Committee, thank you for the invitation to testify today. I am David Lipschutz, Co-Director of the Center for Medicare Advocacy (CMA). CMA is a national private, non-profit, non-partisan law organization based in Connecticut and Washington, D.C. with additional attorneys in Massachusetts, Wisconsin and California.

CMA works to advance access to comprehensive Medicare coverage, quality health care, and health equity. We provide education and legal assistance to Medicare beneficiaries throughout the United States. We respond to thousands of calls and emails annually, host a website, educational programs, webinars, and a national convening of Medicare beneficiary stakeholders and policymakers, publish a weekly electronic newsletter, and pursue thousands of Medicare appeals. Our policy work is based on the real-life experiences of the beneficiaries and families we hear from every day.

Our health care system is in dire need of reform, including Medicare. We have many ideas about how to do so, as I'm sure my fellow panelists and members of this Committee do as well. I'd like to touch on some of these ideas, but first, I'd like to address some concerns we have with a couple of the bills at issue in this hearing today.

Legislation Under Discussion Today

We do not have concerns about either the proposed bill concerning the national coverage determination process or H.R. 3826, the Expanding Access to Diabetes Self-Management

Training Act of 2025. We would like to provide the following feedback on the other two bills under consideration today.

H.R. 842, Nancy Gardner Sewell Medicare Multi-Cancer Early Detection Screening Coverage Act.

This bill would allow Medicare to cover emerging blood-based cancer screenings that are FDA-approved and determined by the Secretary of the Department of Health & Human Services to be "reasonable and necessary" for the prevention or early detection of an illness or disability for some Medicare beneficiaries, while denying access to other Medicare beneficiaries.

Aside from the question of whether such tests currently meet clinical standards,[1] we are significantly concerned about the built-in limitations on which Medicare beneficiaries can access care, and the alarming precedent it would set to exclude entire groups of beneficiaries from access to treatments based arbitrarily on their age. The legislation limits this coverage to Medicare beneficiaries who attain a certain age by January 1 of the relevant year or received a multi-cancer screening test in the prior 11 months. If enacted, starting in 2028, coverage would be available only for individuals who turned 68 years old, or are younger, with this age limitation increasing by 1 year each succeeding year. In other words, eligibility for coverage of these cancer screenings would be phased in over time based on age.

[1] See, e.g., *STAT, First Opinion* "Blood tests for cancer detection aren't yet ready for prime time" By Sanket S. Dhruva and Rita F. Redberg (June 11, 2024) at: https://www.statnews.com/2024/06/11/blood-tests-for-cancer-detection-arent-yet-ready-for-prime-time/; also see *JAMA Internal Medicine*, "The Need for Randomized Clinical Trials Demonstrating Reduction in All-Cause Mortality With Blood Tests for Cancer Screening" by Sanket S. Dhruva, MD, MHS; Rebecca Smith-Bindman, MD; Rita F. Redberg, MD, MSc (published online Aug. 28, 2023) at https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2808653.

While Medicare does account for some age-based risk factors with respect to coverage of certain preventive and screening tests, such considerations are based on clinical evidence, factoring in both condition and type of preventive test or service.[2] The age cut-off contemplated in this bill, however, appears to be based solely on cost rather than clinical evidence.

The Medicare population is both growing and getting older; people 75 and older accounted for 40% of the Medicare population in 2022.[3] Yet under this bill the youngest members of this cohort would not be eligible for coverage until 10 years from now (it will be 20 years from now before people first turning 85 would be eligible for coverage). The arbitrary exclusion of large segments of the Medicare population contemplated by this bill is extremely problematic and would set a dangerous precedent for future expansions of coverage. All Medicare beneficiaries should have equitable access to screenings and preventive care that is appropriate for them based on their medical needs, not based on the year of their birth.

Ensuring Patient Access to Critical Breakthrough Products Act

This legislation would require FDA-designated medical breakthrough devices immediate and automatic coverage under Medicare during a four-year transitional period from the date the FDA grants breakthrough designation. During this transitional period these devices would be deemed to be "reasonable and necessary," despite not going through Medicare's usual and separate process of determining if complete evidence of efficacy, safety, and clinical benefit for use among Medicare beneficiaries has been met.

[2] See, e.g., Centers for Medicare & Medicaid Services (CMS), "Your Guide to Medicare Preventive Services" (May 2025), at: https://www.medicare.gov/publications/10110-your-guide-to-medicare-preventive-services.pdf
[3] Medicare Payment Advisory Commission (MedPAC), "Health Care Spending and the Medicare Program" (July 2025) at: https://www medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf.

As noted in a *JAMA Health Forum* article,[4] the FDA and CMS operate under different missions, whereby FDA assesses safety and effectiveness while CMS determined whether a product is medically reasonable and necessary for the Medicare population. The article states:

> the populations participating in studies guiding FDA approvals are generally younger, more often male, and less racially and ethnically diverse, and they typically have fewer comorbid conditions than the CMS beneficiary population. Study inclusion and exclusion criteria may demonstrate the safety and effectiveness of a product or service under idealized conditions but may lack applicability to the Medicare beneficiary population and the context in which they receive their care.

Further, a 2025 *JAMA Internal Medicine* study analyzing FDA authorization through the Breakthrough Devices Program (BDP) found that "uncertainty about benefits and risks for some devices raises questions whether BDP is consistently fulfilling program objectives to improve public health."[5]

In order to provide a pathway for coverage of emerging technologies and to strengthen the evidence necessary to provide coverage for such technology, CMS proposed the Transitional Coverage for Emerging Technologies (TCET) pathway. The TCET pathway allows CMS to collect real-world data, review available evidence and help address evidence gaps to support Medicare coverage. However, this bill would circumvent this important evidence-based process designed to provide adequate safeguards for Medicare beneficiaries.

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[4] *JAMA Health Forum* "Medicare's New Pathway for Transitional Coverage for Emerging Technologies" by Steven A. Farmer, MD, PhD; Lori M. Ashby, MA; Jonathan D. Blum, MPP (Published online Nov. 22, 2024) at https://jamanetwork.com/journals/jama-health-forum/fullarticle/2826271.

[5] *JAMA Internal Medicine*, "FDA Authorization of Therapeutic Devices Under the Breakthrough Devices Program" Kushal T. Kadakia, MD; Sanket S. Dhruva, MD, MHS; Joseph S. Ross, MD, MHS et al (Published Online June 30, 2025) at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2835682.

We recognize that there is a need to find a balance between getting innovative, potentially helpful products to people who might need them and ensuring that such products are safe, effective and medically reasonable and necessary; we are concerned that this bill does not strike that right balance.

Policy Proposals to Increase Access to Care in Medicare

We appreciate the Committee's focus on access to care for Medicare beneficiaries. In addition to the above feedback on the bills addressed at this hearing, we would like to offer a number of suggestions for improving access to care for Medicare beneficiaries and safeguarding the Medicare program.

Increase Oversight of Medicare Advantage (MA) Plans

More than half of all Medicare beneficiaries are now enrolled in Medicare Advantage (MA), the private plan option for Medicare beneficiaries. There are trade-offs between enrolling in an MA plan vs. traditional Medicare. While MA plans often provide additional benefits not offered through traditional Medicare and are mandated to cap out-of-pocket expenses for covered services, they often restrict the providers that enrollees see for non-emergency services, and make extensive use of prior authorization, which can result in inappropriate denials of and delays in obtaining medically necessary care.

Medicare pays more to MA plans for enrollees than their costs would be in traditional Medicare. According to the Medicare Payment Advisory Commission (MedPAC),[6] the federal government

[6] Medicare Payment Advisory Commission (MedPAC), "Report to Congress" (March 2025), at: http://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf.

pays MA plans 20% more for MA enrollees than it pays for similar individuals in traditional Medicare, costing $84 billion in 2025 alone. These overpayments put major stress on Medicare's finances, and lead to $13 billion higher Part B premiums for all Medicare beneficiaries in 2025.

Reining in overpayments to MA plans due to rampant upcoding and a flawed quality bonus system – which has neither successfully improved quality in the MA program nor helped beneficiaries compare plans[7] – could be redirected to shore up and strengthen traditional Medicare, as discussed below. The *No UPCODE Act* would be an important first step in recouping some of these overpayments but would still only save a portion of current wasteful spending. Congress could pursue other measures holding MA plans accountable for wasted spending, such as the *Guarantee Utilization of All Reimbursements for Delivery of (GUARD) Veterans' Health Care Act* which would close a loophole prohibiting the Veterans' Administration from recouping payments made on behalf of veterans enrolled in both VA plans and MA plans.[8]

Despite significant overpayments, private MA plans do not produce better quality outcomes for enrollees,[9] nor are they, on average, more affordable for their enrollees than traditional

[7] See, e.g., Urban Institute, "The Medicare Advantage Quality Bonus Program" by Laura Skopec and Robert A. Berenson (June 2023), available at: https://www.urban.org/sites/default/files/2023-06/The%20Medicare%20Advantage%20Quality%20Bonus%20Program.pdf; see also, e.g., KFF "Medicare Advantage Quality Bonus Payments Will Total at Least $12.7 Billion in 2025" by Jeannie Fuglesten Biniek, Anthony Damico and Tricia Neuman (June 2025), available at: https://www.kff.org/medicare/medicare-advantage-quality-bonus-payments/.

[8] See, e.g., Center for Medicare Advocacy "Issue Brief: Closing the VA-Medicare Advantage Payment Loophole" (Aug. 2025), at: https://medicareadvocacy.org/issue-brief-closing-the-va-medicare-advantage-payment-loophole/.

[9] See, e.g., Commonwealth Fund, "Medicare Advantage: A Policy Primer" by Christina Ramsay, Gretchen Jacobson, Steven Findlay, Aimee Cicchiello (Jan. 2024) at: https://www.commonwealthfund.org/publications/explainer/2024/jan/medicare-advantage-policy-primer; also see KFF, "Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature" by Nancy Ochieng and Jeannie Fuglesten Biniek (Sept. 2022), at: https://www.kff.org/medicare/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/.

Medicare.[10] While there are certainly barriers to care in traditional Medicare that need to be addressed by policymakers, including access to home care for individuals with chronic conditions, in our experience, MA enrollees can face denials and premature termination of care that would otherwise be covered under traditional Medicare.

Virtually all MA enrollees are required to obtain prior authorization for some services, usually higher cost services such as skilled nursing facility stays and chemotherapy administration.[11] Many MA enrollees encounter barriers to accessing medically necessary care. The Department of Health & Human Services' Office of Inspector General (OIG) reported in 2022 that Medicare's annual audit of MA plans "have highlighted widespread and persistent problems related to inappropriate denials of services and payment."[12] Despite efforts to curb inappropriate use of prior authorization by MA plans, including a CMS rule finalized in 2023,[13] significant barriers to care remain for many MA enrollees. As noted in an October 2024 report issued by the Senate Permanent Subcommittee on Investigations examining MA plans' use of prior authorization and ongoing denials regarding post-acute care, MA plans:

> are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities. Insurer denials at these facilities, which help people recover from injuries and illnesses, can force seniors to make difficult choices about their health and finances in the vulnerable days after exiting a hospital.[14]

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[10] See, e.g., *JAMA Viewpoint*, "How Affordable is Medicare Advantage?" by David Blumenthal, MD, MPP; Gretchen Jacobson, PhD (Aug. 2024), at: https://jamanetwork.com/journals/jama/article-abstract/2822916; also see Commonwealth Fund, "Medicare's Affordability Problem: A Look at the Cost Burdens Faced by Older Enrollees" by Faith Leonard, Gretchen Jacobson, Sara R. Collins, Arnav Shah, Lauren A. Haynes (Sept. 2023) at: https://www.commonwealthfund.org/search?search_api_fulltext=Medicare%E2%80%99s%20Affordability%20Problem:%20A%20Look%20at%20the%20Cost%20Burdens%20Faced%20by%20Older%20Enrollees.

[11] KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023" (Jan. 28, 2025), available at: https://www kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.

[12] Department of Health & Human Services, Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (April 2022, OEI-09-18-00260), available at: https://oig hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[13] CMS, Final Rule, 88 Fed. Reg. 22120 (April 12, 2023).

[14] Majority Staff Report, U.S. Senate Permanent Subcommittee on Investigations, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care" (Oct. 17, 2024), at:

Congress can act to further protect MA enrollees from inappropriate denials of care. The *Improving Seniors' Timely Access to Care Act of 2025* would be an important first step, including the transparency requirements relating to data that MA plans would have to report. More action would be necessary, however, since many of the worst abuses are in Part A care settings – hospitals, skilled nursing facilities, inpatient rehabilitation hospitals and other settings which are not likely to be services deemed to be "routinely approved" and therefore subject to real-time decisions under the bill.

Misconduct in the marketing and sale of MA plans is ripe for redress. For example, in May 2025 the Department of Justice filed a suit against several insurers alleging improper kickbacks to large insurance brokerages as incentives to steer individuals to the insurers' MA plans while also discouraging enrollment of individuals with disabilities.[15] A federal judge in Texas recently issued a decision vacating key provisions of a 2024 CMS rule designed to align agent and broker commissions with beneficiary health needs.[16] Congress should codify these provisions into law, or, at the very least, urge HHS to appeal this decision. Further, in order to promote beneficiary education and informed decision-making, Congress should support and expand funding for the nationwide State Health Insurance Assistance Programs (SHIPs), which provide free and unbiased counseling to Medicare beneficiaries.

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https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

[15] See, e.g., *KFF Health News*, "Trump's DOJ Accuses Medicare Advantage Insurers of Paying 'Kickbacks' to Brokers" by Julie Appleby (May 23, 2025) at: https://kffhealthnews.org/news/article/the-week-in-brief-medicare-advantage-insurance-trump-doj-insurance-brokers/.

[16] See, e.g., Center for Medicare Advocacy, "Court Strikes Down Key Medicare Marketing Regulations" (Aug. 28, 2025), at: https://medicareadvocacy.org/court-strikes-down-key-medicare-marketing-regulations/.

Strengthen Traditional Medicare

The traditional Medicare program is a national treasure that should be strengthened and preserved. As Medicare becomes more privatized through growing MA enrollment, Congress must recognize what is at stake if traditional Medicare "withers on the vine." A Medicare program administered through private plans would not be able to achieve the many public purposes that Medicare has served for the entire health care system in our country.[17] Among other things, traditional Medicare provides critical support for graduate medical education and providers in underserved areas, as well as setting payment and quality benchmarks.[18]

As outlined in a recent paper by CMA, legislation passed over the last couple of decades has tended to neglect traditional Medicare in favor of Medicare Advantage.[19] A major course correction is needed to both strengthen traditional Medicare and better protect those enrolled in MA plans.

Reining in overpayments to Medicare Advantage plans alone could fund a significant expansion of traditional Medicare, including an out-of-pocket cap, reduced Part D premiums and coverage of much-needed dental, vision and hearing care.[20] In recent years, Congress did, briefly, entertain a significant expansion of traditional Medicare. H.R. 3, *The Elijah Cummings Lower Drug Costs*

[17] See, e.g., *JAMA Network*, "Medicare Advantage Enrollment Growth - Implications for the US Health Care System" by Gretchen A. Jacobson, PhD; David Blumenthal, MD (May 2022), at: https://jamanetwork.com/journals/jama/article-abstract/2792809.
[18] *Journal of Health Politics, Policy and Law*, "Medicare at 60: A Popular Program Facing Challenges" by Tricia Neuman; Jean Fuglesten Biniek; Juliette Cubanski (August 2025) at: https://read.dukeupress.edu/jhppl/article/50/4/549/396991/Medicare-at-60-A-Popular-Program-Facing-Challenges.
[19] Center for Medicare Advocacy, "Issue Brief: Decades of Legislation Has Favored Medicare Advantage Over Traditional Medicare" (Aug. 2025) at https://medicareadvocacy.org/wp-content/uploads/2025/08/2025-August-CMA-Issue-Brief-Legislation-Favored-Medicare-Advantage.pdf.
[20] *New England Journal of Medicine (NEJM) Perspective*, "The Opportunity Costs of Medicare Advantage Plan Rebates" by Cori Uccello, M.P.P., Gretchen Jacobson, Ph.D., and Melinda J.B. Buntin, Ph.D. (Oct. 2024) at: https://www nejm.org/doi/10.1056/NEJMp2405572.

Now Act, passed by the House in December 2019 but not taken up by the Senate, would have reinvested significant savings from changes in Medicare drug payment policies into expanding traditional Medicare benefits, including adding oral, vision, and dental coverage for all beneficiaries, expanding rights to purchase Medigap coverage, and expanding eligibility for low-income assistance. We urge Congress to revisit this approach.

There are a host of other policies that could improve access to care for Medicare beneficiaries, including the following:

- Enforce existing law concerning the Medicare home health benefit - if the law was properly enforced, and the benefit administered as intended, there would be transformational change for many people who could obtain the care they need to live well and safely at home;[21]
- Require Medigap plans to be available to all individuals in traditional Medicare, regardless of pre-existing conditions and age ("Guarantee Issue" and "Community Rating");
- Simplify enrollment in traditional Medicare, Part D and Medigap, and ease transitions from other insurances to Medicare (including providing the same rights to change stand-alone Part D plans (PDPs) during the first 3 months of the calendar year that currently exists for MA enrollees through the Medicare Advantage – Open Enrollment Period (MA-OEP));
- Strengthen Part D coverage by incorporating the same criteria for off-label use as exists for drugs covered under Part B;

[21] See, e.g., Center for Medicare Advocacy testimony before the Senate Finance Committee at a hearing titled "Aging in Place: The Vital Role of Home Health and Access to Care" (Sept. 19, 2023) at: https://www finance.senate.gov/download/09192023-stein-testimony.

- As is the case in most MA plans, waive the 3-day prior hospital stay requirement in traditional Medicare for skilled nursing facility coverage, or at least count all time in spent in observation status toward this requirement, as would be required by the *Improving Access to Medicare Coverage Act of 2025*;
- Ensure the Medicare appeals system is cost-effective, accessible, and fair;
- Increase low-income protections in the Medicare Savings Program (at least on par with Affordable Care Act subsidies); and
- Long-term Care – Add coverage over time. For now, make incremental improvements (for example, repeal the homebound requirement for home health coverage, repeal the requirement that individuals need skilled care to qualify for home health aide coverage, and repeal the requirement that durable medical equipment (DME) generally be needed in the home).

Repeal Health-Related Provisions of H.R. 1

Finally, in order to foster public health and access to care for Medicare beneficiaries and the broader population, Congress must reverse the harmful cuts to health care from the recently enacted H.R. 1 reconciliation bill, also known as the "One Big Beautiful Bill Act".

This sweeping legislation cuts over $1 trillion from health programs, primarily from Medicaid, which will result in an estimated 10 million people losing health insurance.[22] Cuts to Medicaid

[22] Congressional Budget Office (CBO), "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.

directly impact over 12 million individuals who are dually eligible for Medicare and Medicaid.[23] As discussed below, the bill also has direct, negative impacts on Medicare beneficiaries.

Section 71201 of H.R. 1 limits Medicare eligibility and terminates coverage of certain lawfully present non-citizens – marking the first time in the program's history that Medicare coverage has been stripped from entire categories of eligible individuals. Undocumented individuals have never been eligible for Medicare, but prior to H.R. 1, lawfully present non-citizens could qualify for Medicare by meeting work history requirements, or if they lacked the required work credits, by meeting length of residency requirements. Qualified non-citizens who worked and contributed payroll taxes for the required number of years were eligible for Medicare coverage on the same basis as U.S. citizens.[24] Effective immediately, H.R. 1 eliminates Medicare eligibility for certain lawfully present immigrants, regardless of how long they have worked and paid into the system, including: refugees and people granted asylum, people with Temporary Protected Status, survivors of human trafficking, survivors of domestic violence, and, individuals granted humanitarian parole.

Section 71101 of H.R. 1 ends implementation of a 2023 CMS rule that streamlined eligibility and enrollment in Medicare Savings Programs (MSPs) that help people pay for their Medicare expenses. The Congressional Budget Office (CBO) estimates that this will save over $66 billion

[23] See, e.g., Justice in Aging, Medicare Rights Center, Center for Medicare Advocacy and Community Catalyst, "A Cut to Medicaid is a Cut to Medicare" (March 2025), at: https://medicareadvocacy.org/wp-content/uploads/2025/03/A-Cut-to-Medicaid-is-a-Cut-to-Medicare-Issue-Brief.pdf.
[24] See, e.g., Justice in Aging, "Older Immigrants and Medicare" (Sept. 2025), at: https://justiceinaging.org/wp-content/uploads/2024/09/FINAL_Older-Immigrants-and-Medicare.pdf.

over 10 years due to fewer people enrolling in MSPs, even though they are eligible for these programs.[25] As recently noted by KFF,[26]

> the recently enacted tax and spending bill includes provisions that are projected to result in fewer low-income Medicare beneficiaries accessing these benefits, and reduce household resources for individuals in the bottom of the income distribution, including households with Medicare beneficiaries. And even today, not all low-income Medicare beneficiaries who are eligible for these benefits are receiving them, while others may have income or assets just above the qualifying thresholds.

H.R. 1 also blocks implementation of national minimum staffing requirements for nursing homes that were designed to improve quality of care and save lives,[27] and limits Medicare's ability to negotiate the cost of certain medications for rare diseases. These provisions should also be reversed to prevent harm and advance public health.

Conclusion

Thank you again for the invitation to testify and for considering our recommendations, particularly the significant cost-saving measures we identify that would also foster access to necessary care and advance public health.

[25] CBO, "Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to the Budget Enforcement Baseline for Consideration in the Senate" (July 21, 2025), available at: https://www.cbo.gov/publication/61569.

[26] KFF, "Health Costs Consume a Large Portion of Income for Millions of People with Medicare" by Nancy Ochieng, Juliette Cubanski, Tricia Neuman, and Anthony Damico (Aug. 21, 2025), at: https://www kff.org/medicare/health-costs-consume-a-large-portion-of-income-for-millions-of-people-with-medicare/.

[27] An analysis by University of Pennsylvania experts calculated that an additional 13,000 residents would die each year if the staffing rule did not go into effect. Letter (Jul. 8, 2024) from Rachel M. Werner, Professor, Health Care Management and Economics, Professor, Medicine, University of Pennsylvania, Norma B. Code, Director of Research, LDI, Professor, Medical Ethics and Health Policy, University of Pennsylvania, to Senator Elizabeth Warren, at: https://www.warren.senate.gov/imo/media/doc/letter_from_researchers_to_sen_warren_070824.pdf.