MEMORANDUM TO THE LEADER

TO: Leader Jeffries
FR: Cost-of-Living Healthcare Working Group
DT: Tuesday, September 1, 2026
RE: Cost-of-Living Healthcare Working Group Memo on Democratic Healthcare Action for the First 100 Hours, First 100 Days, and First Year of the 120th Congress

In 2025, President Trump, Vice President Vance, and Congressional Republicans passed H.R.1, the One Big Beautiful Bill Act, which cut $1 trillion from our health care system. The fallout from H.R.1 has been devastating. One year later, ACA marketplace premiums have increased by nearly 60 percent, contributing to a five million-person drop in enrollment, and premiums for employer-sponsored insurance have risen faster than inflation. When the bill is fully implemented, an estimated 15 million people will have lost their health coverage, one-third of all rural hospitals will have closed, and every state will have experienced significant economic and employment losses.

The damage goes far beyond H.R. 1. The Trump administration has undermined access to life-saving vaccines and preventive care. They have clawed back millions of dollars in public health funding from states and eliminated programs we rely on to prevent, detect, and contain disease outbreaks. At the same time, Republican attacks on reproductive rights have made contraception and essential reproductive care harder and more expensive to access. Taken together, these actions have destabilized the American healthcare system and directly driven up costs for patients, families, and taxpayers.

Even before Republicans instituted the largest cut to healthcare in American history, there was broad consensus that the healthcare system was failing working families. More than one third of U.S. adults are forced to skip or delay necessary medical treatment purely due to expense, an estimated 100 million Americans are saddled with medical debt, and nearly half of all Americans say it is difficult to afford health care. Decades of unchecked corporate consolidation, compounded by severe workforce shortages and a complete underinvestment in primary care, have left patients, employers, small businesses, and American taxpayers paying more for less.

To that end, undoing H.R. 1 is the floor, but not the ceiling. There is broad consensus in the Democratic caucus that the Democratic agenda must both reverse the immediate harms of the administration while also taking bold action to rein in corporate monopolies, invest in a durable healthcare system, and pursue an ambitious path towards universal coverage. Members of the Democratic Caucus hold a diversity of views on how to achieve universal coverage including Medicare for All, strengthening and expanding ACA subsidies, closing the Medicaid coverage gap, lowering the age of Medicare eligibility, and creating a robust public option available to every American.

Over the last few months, the Cost-of-Living Healthcare Working Group has held **93 meetings**, engaging with **139 Members** of the Democratic caucus, committee staff, and **145 stakeholder groups** across the country to solicit feedback on how Democrats can be responsive to our communities and address the healthcare needs of working people in the first 100 hours, first 100 days, and first year of the 120th Congress. The Healthcare Working Group has categorized that feedback into the following eight categories:

I. Reversing Trump's Destruction of the American Healthcare System
II. Building Towards Universal Coverage by Strengthening Traditional Medicare
III. Making Healthcare Affordable by Taking on Monopolies
IV. Expanding Access to Affordable, Preventive Care to Reduce Costs
V. Strengthening Women's, Maternal, and Reproductive Health
VI. Investing in the Health Care Workforce and Care Workers
VII. Reclaiming MAHA and Protecting American Families
VIII. Increasing Access to Affordable Innovations and Breakthroughs

I: Reversing Trump's Destruction of the American Healthcare System

In an effort to secure affordable, quality healthcare for all Americans, Democrats must first enact a complete legislative repeal of H.R. 1. This includes reversing Medicaid coverage losses, blunting the spike in ACA premiums, and undoing the over $1 trillion cut from safety-net funding. This plan establishes statutory firewalls to prevent the well-being of Americans and healthcare from being used as a political bargaining chip.

To achieve these goals and deliver immediate economic relief for working people, the Cost-of-Living Healthcare Working Group has identified the following policies that should be considered for advancement in the first 100 hours of the 120th Congress:

First 100 Hours:

- **Repeal Trump and Republicans' health care cuts:** Reverse H.R. 1's Medicaid cuts and coverage restrictions and permanently restore enhanced ACA premium tax credits to prevent millions from losing coverage or facing higher premiums.
- **Restore reproductive freedom nationwide:** Reestablish a federal right to abortion care and end restrictions that prevent people covered through federal health programs from receiving abortion coverage.
- **Keep medical debt from destroying Americans' financial futures:** Restore protections to keep medical debt off credit reports so getting sick does not prevent Americans from buying a home, financing a car, or accessing credit.
- **Put science back in charge of public health and medical research:** Protect vaccine recommendations from political interference, restore unlawfully withheld NIH funding, safeguard active research grants, and prevent political appointees from overriding scientific funding decisions.
- **Protect free vaccines from political interference:** Guarantee continued no-cost coverage of recommended vaccines across private insurance, Medicare, Medicaid, CHIP, and the Vaccines for Children program so changes to federal vaccine recommendations cannot suddenly put preventive care out of reach.
- **Restore basic protections for health care workers:** Reinstate minimum wage and overtime protections for home care workers, reverse H.R. 1 policies that make health professions education less affordable, and remove Trump's $100,000 H-1B program fee for physicians and other health care workers.
- **Protect the immigrant health care workers America depends on:** Pass the American Dream and Promise Act to provide permanent protections and a pathway to citizenship for TPS holders and Dreamers, preventing the loss of thousands of health care and care workers who are essential to hospitals, nursing homes, and patients.
- **Stop Trump's attacks on safety-net hospitals and community health centers:** Block the Administration's 340B rebate model from forcing cash-strapped providers to front millions of dollars for discounted medicines they already rely on to serve vulnerable patients.
- **Keep private companies and AI from denying care in Traditional Medicare:** End the WISeR prior authorization experiment that gives for-profit companies a financial incentive to restrict Traditional Medicare patients' access to care.
- **Protect seniors from another Medicare premium hike:** Preserve the Part D Premium Stabilization program so the Administration cannot abruptly end assistance that has helped hold down prescription drug premiums.

- **Keep ICE out of hospitals and protect immigrants seeking care:** Restore and formally codify policies protecting health care facilities and other sensitive locations from immigration enforcement operations and prevent public charge policies from forcing immigrant and mixed status families to choose between getting health care and pursuing immigration relief.

Potential Legislation for the First 100 hours:

- H.R. 4849, Protecting Health Care and Lowering Costs Act of 2025 (Rep. Adam Gray)
- Reproductive Health Care Package to include:
    - H.R. 12, Women's Health Protection Act (Rep. Judy Chu); and
    - H.R. 4611, Equal Access to Abortion Coverage in Health Insurance (EACH) Act (Rep. Ayanna Pressley)
- H.R. 4827, Medical Debt Relief Act of 2025 (Rep. Nikema Williams)
- H.R. 3701, Family Vaccine Protection Act (Ranking Member Frank Pallone)
- H.R. 4007, Prevent Halting of Active Research (PHARA) Act of 2025 (Rep. Bonnie Watson Coleman)
- H.R. 7173, Follow the Science Act (Rep. Diana DeGette)
- H.R. 2855, Protecting Medical Research Funding Act (Rep. Timothy Kennedy)
- H.R. 5448, Protecting Free Vaccines Act (Ranking Member Frank Pallone)
- H.R. 7917, Fair Wages for Home Care Workers Act (Rep. Alexandria Ocasio-Cortez)
- H.J.Res.189, Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Education relating to "Reimagining and Improving Student Education-Federal Student Loan Program Final Regulations". (Rep. Suzanne Bonamici)
- H.R.7961, H–1Bs for Physicians and the Healthcare Workforce Act (Reps. Mike Lawler and Sanford Bishop)
- H.R. 1589, American Dream and Promise Act of 2025 (Rep. Sylvia Garcia)
- H.R. __, Prevent Implementation of the Trump Administration's 340B Rebate Model pilot program (Rep. Doris Matsui)
- H.R. 5940, Seniors Deserve SMARTER Care Act (Rep. Suzan DelBene)
- H.R. __, Affordable Premiums for Seniors Act (Rep. Terri Sewell)
- H.R. 1061, Protecting Sensitive Locations Act (Rep. Adriano Espaillat)
- H.R. 10045, Protect American Values Act (Rep. Judy Chu)

II: Building Towards Universal Coverage by Strengthening Traditional Medicare

Medicare is our single most successful public health insurance program, with 82 percent of Americans approving of the program. Signed into law in 1965, Medicare now covers over 70 million older adults and younger people with disabilities. Despite the success of the program, Republicans have hollowed out Traditional Medicare in favor of Medicare Advantage—a privatized alternative run by for-profit health insurance companies under federal contract. Today, more than half of all Medicare beneficiaries are enrolled in Medicare Advantage.

The shift is because Traditional Medicare, also known as "original" Medicare, has been left with gaps Medicare Advantage can exploit. Traditional Medicare excludes coverage for dental, vision, and hearing care and does not have a yearly cap on out-of-pocket expenses, unlike most Medicare Advantage plans. This, alongside Republican efforts to continually weaken Traditional Medicare, has made Medicare Advantage falsely appear to be a fiscally advantageous alternative for millions of seniors living on fixed incomes.

Conversely, Medicare Advantage plans employ narrow provider networks and overuse prior authorization for critical services like chemotherapy and inpatient hospital stays, making it difficult for seniors to receive the care they need. Then taxpayers get overcharged: for-profit insurers with Medicare Advantage plans engage in billing fraud, overbilling the federal government for services not provided to their beneficiaries. This results in tens of billions of taxpayer dollars taken each year from Traditional Medicare.

Members of the Working Group have relayed increasing frustrations from providers and patients in their districts about Medicare Advantage denial rates. These denials are contributing to increased financial strain for providers and further compromising access in rural and underserved communities where margins are tight. A recent study found that between 2022 and 2023, hospitals saw a nearly 60 percent increase in Medicare Advantage care denials.

To strengthen Traditional Medicare and rein in Medicare Advantage waste, fraud, and abuse, the Cost-of-Living Healthcare Working Group has identified the following policies that should be considered for advancement:

First 100 Hours:

- **Cap Traditional Medicare out-of-pocket costs at $5,000:** Give beneficiaries financial protection from unlimited medical expenses and strengthen assistance for low-income seniors and people with disabilities.
- **Add dental, vision, and hearing benefits to Traditional Medicare:** Close longstanding coverage gaps and ensure seniors can access essential care without paying the full cost out of pocket.

First 100 Days:

- **Stop Medicare Advantage overpayments:** Crack down on insurer upcoding and improper payments to protect taxpayer dollars and redirect savings toward strengthening Traditional Medicare.

- **Strengthen protections for Medicare Advantage enrollees:** Reduce network barriers and unnecessary prior authorizations while increasing transparency and protections for individuals enrolled in Medicare Advantage programs.

First Year:

- **Commit to achieving universal coverage:** Unite around our shared goal of universal coverage through comprehensive examination of various single payer and public option models, including:
    - **H.R. 3069, Medicare for All Act** (cosponsored by 114 members of the Democratic Caucus)
    - **Public option models** (government-provided or -regulated coverage competing alongside private insurance)
        - **H.R. 7023, Affordable CHOICE Act** (Marketplace public option)
        - **H.R. 9702, Medicare-X Choice Act** (Comprehensive public option available beyond the Marketplace)
        - **H.R. 2881, Medicare Buy-In and Health Care Stabilization Act** (from the 117th Congress)
- **Make telehealth a permanent part of Medicare:** Permanently eliminate geographic and originating-site restrictions, expand the providers who can deliver telehealth, and remove unnecessary in-person requirements for telehealth so seniors can access primary and mental health care wherever they live.
- **Fully reform Medicare Advantage and invest in patient care:** Reform predatory Medicare Advantage practices by ending federal overpayments, strengthening oversight of abusive insurer practices, and investing dollars recouped in patient care.
- **Lower the Medicare eligibility age:** Lower the Medicare eligibility age to build toward universal coverage by expanding access to the nation's most successful public health insurance program.
- **Guarantee health coverage for children through age 26:** Establish universal coverage for children while reducing the burden of dependent coverage on families.
- **Keep children continuously covered by Medicaid and CHIP:** Prevent coverage disruptions caused by paperwork and administrative churn, ensuring children have consistent access to care.
- **Expand Medicare to cover care at home:** Make home-based care a core Medicare benefit so seniors and people with disabilities can receive the care they need where they prefer to live.
- **Expand access to prescription drugs and lower costs through a federally-administered Medicare prescription drug plan:** Give Traditional Medicare beneficiaries a federally-administered alternative for prescription drug coverage that strengthens negotiating power and reduces reliance on private middlemen.

Potential Legislation for the First 100 Hours:

- S.4886, Medicare Cost Cap Act of 2026 (Sen. Lisa Blunt Rochester)
- H.R. 2045, Medicare Dental, Vision, and Hearing Benefit Act of 2025 (Rep. Lloyd Doggett)

Potential Legislation for the First 100 days:

- S.1105, No UPCODE Act (Sens. Bill Cassidy and Jeff Merkley)

- H.R.___, Risk Adjustment Data Validation (RADV) Audit Act (Rep. Alexandria Ocasio-Cortez)
- H.R. 8375, Medicare Advantage Improvement Act of 2026 (Reps. John Joyce and Kim Schrier)

Potential Legislation for the First Year:

- H.R. 4206, CONNECT for Health Act of 2025 (Reps. Mike Thompson and David Schweikert)
- H.R. 9544, Save MEDICARE Act of 2026 (Rep. Lloyd Doggett)
- Lowering the Medicare Eligibility Age
- H.R.___, Medicare for Kids Act (Rep. Alexandria Ocasio-Cortez)
- H.R. 4641, Keep Kids Covered Act (Rep. Kathy Castor)
- H.R.10020, Medicare at Home Act (Rep. Debbie Dingell)
- Policy Idea: Federally-Administered Medicare Part D Prescription Drug Coverage

III: Making Healthcare Affordable by Taking on Monopolies

Private equity, health insurance monopolies, hospital consolidation, and pharmaceutical pricing practices have transformed health care from a public good into a profit center. As a result, American families are left paying some of the highest prices for health care in the world, with a recent survey finding 92 percent either delaying or forgoing care due to cost. This consolidation does not just impact patients—employers and small businesses are left paying higher prices to provide employer-based coverage.

Today, there are six health care monopolies, including UnitedHealth, CVS Health, and Cigna, listed in the top 15 companies of the Fortune 500—more than Big Tech or any other sector. Drug wholesalers, such as McKesson, Cencora, and Cardinal Health, are also in the top 15 and control 98 percent of the drug wholesale market. A generation ago, there were no health care companies in the top 15 of the Fortune 500, and only one in 2010. Decades of unchecked power, coupled with aggressive merger and acquisition strategies have allowed these companies to grow to own every part of the health care system, making it almost impossible for the American people to avoid receiving care from massive for-profit health care monopolies.

Americans across the political spectrum are increasingly finding health care monopolies as central to the health care affordability crisis and public opinion research points to hospitals, insurers, and pharmaceutical companies as the groups they most want held responsible for high costs. In fact, a recent poll found that 90 percent of Americans believe large health insurers have too much control of our health care system and should be broken up. As such, Congress must intervene to break up health care monopolies, cap hospital prices, limit out-of-pocket costs, reform prior authorization, and address Big Pharma and pharmacy benefit manager (PBM) practices that raise drug prices while closing community pharmacies. Public health care dollars should be directed toward patient care, not corporate returns.

To achieve these goals, the Cost-of-Living Healthcare Working Group has identified the following policies that should be considered for advancement:

First 100 Hours:

- **Expand Medicare drug negotiation to private insurance and cap prescription costs:** Expand the savings of the Inflation Reduction Act to Americans with private coverage, ensuring families can afford the medications they need without facing crushing out-of-pocket costs.
- **Cap the cost of lifesaving medications:** Extend Democrats' successful $35 insulin cap to EpiPens and inhalers, ensuring no one has to choose between essential lifesaving treatment and basic household expenses.

First 100 Days:

- **Stop PBMs from driving up drug costs and squeezing pharmacies:** Reform the practices of pharmacy benefit managers that increase drug costs for patients and threaten the viability of independent community pharmacies.
- **Ensure access to critical primary care and mental health services:** Provide three free primary care and mental health visits to all Americans with private insurance, ensuring no one is forced to delay the treatment they need due to cost.

- **Break up vertically-integrated healthcare monopolies:** Restore competition in health care by preventing corporate monopolies from acquiring and operating multiple parts of the health care system and using that power to raise prices and limit patient choice.
- **Cap excessive hospital prices and establish site-neutral payments:** Bring down hospital costs by limiting excessive prices and ensuring patients are not charged more simply because care is delivered in a hospital-owned facility.
- **Separate PBMs from the pharmacies they control:** End conflicts of interest that allow the largest health care companies to profit from both managing prescription benefits and dispensing the medications patients need.
- **Keep private equity out of hospitals and nursing homes and separate medical decision-making from corporate financial interests:** Protect patients and taxpayers from private equity firms and for-profit health care corporations that prioritize short-term profits over quality care and responsible use of taxpayer dollars.
- **Protect patient privacy:** Ban brokers from selling or transferring Americans' most sensitive personal information—their health and location data.

First Year:

- **Cap health care costs at eight percent of household income:** Build on the ACA's tax subsidies to establish a meaningful ceiling on what families can be required to spend on health care, regardless of how they receive their coverage.

Potential Legislation for the First 100 Hours:

- H.R. 6166, Lowering Drug Costs for American Families Act (Ranking Members Frank Pallone, Richard Neal, and Bobby Scott)
- Policy Idea: $35 Out-of-Pocket Cap for EpiPens and Inhalers

Potential Legislation for the First 100 Days:

- H.R. 6609, Pharmacists Fight Back in Medicare and Medicaid Act and H.R. 6610, Pharmacists Fight Back [in Federal Employee Health Benefit Plans Act] (Rep. Jake Auchincloss)
- H.R. 9257, Primary and Behavioral Health Care Access Act of 2026 (Rep. Lauren Underwood)
- H.R. ___, Break Up Big Medicine Act (Rep. Alexandria Ocasio-Cortez)
- Policy Idea: Enacting Site-Neutral Payments and Capping Outlier Hospital Prices
- H.R. 8779, Patients Before Monopolies Act (Reps. Jake Auchincloss and Diana Harshbarger)
- H.R. 7920, Take Back Our Hospitals Act of 2026 (Rep. Mary Gay Scanlon)
- H.R.___, Stop Corporate Takeovers of Physicians Act (Rep. Val Hoyle)
- H.R. 9482, Health and Location Data Protection Act of 2026 (Rep. Mary Gay Scanlon)

Potential Legislation for the First Year:

- Policy Idea: Expand ACA Protections to Limit Total Health Care Costs

IV: Expanding Access to Affordable, Preventive Care to Reduce Costs

Approximately 129 million Americans live with at least one major chronic disease, with chronic and mental health conditions accounting for approximately 90 percent of the nation's $5.3 trillion in annual health care expenditures. Yet, too many Americans face barriers to primary and preventive care that could help them avoid or better manage chronic disease. Cost remains one of the biggest obstacles: uninsured and underinsured Americans are more likely to delay or forgo care because of cost, while high deductibles and other out-of-pocket expenses can discourage even insured patients from seeking care. These challenges are compounded by provider shortages, long wait times, and the lack of nearby providers, particularly in rural, low-income, and historically underserved communities.

When Americans can access affordable primary and preventive care, they are more likely to receive vaccinations and screenings, detect disease earlier, and manage chronic conditions before they become more serious and require more intensive and expensive emergency care. The benefits of consistent access to primary care extend beyond individual health: preventing disease and avoiding costly complications can reduce unnecessary hospitalizations, emergency department visits, and other high-cost care.

Expanding coverage is therefore necessary but not sufficient. Democrats must build a health care system in which Americans can access the care their coverage promises, when and where they need it. This means ensuring that every American can access affordable vaccines, screenings, primary and mental health care, and early treatment regardless of their insurance status; closing the Medicaid coverage gap and strengthening the ACA Marketplaces; and investing in Federally Qualified Health Centers (FQHCs), rural hospitals, and the primary care workforce. We must also address access to healthcare for immigrants. This includes reversing harmful public charge policies and lifting arbitrary restrictions on immigrants' access to public health insurance and essential services. It also means strengthening access to mental health and substance use disorder treatment, expanding home- and community-based services (HCBS) so Americans can age with dignity, and protecting children's access to comprehensive preventive and specialized care. If we want to lower health care costs over the long term, we must invest in keeping Americans healthy before they need the most expensive forms of care.

To achieve this, the Cost-of-Living Healthcare Working Group has identified the following policies that should be considered for advancement:

First 100 Hours:

- **Eliminate medical debt:** Provide immediate economic relief to the tens of millions of Americans saddled with medical debt.
- **Close the Medicaid coverage gap:** Provide affordable ACA Marketplace coverage with significantly reduced cost sharing for low-income Americans in states that refuse to expand Medicaid, while giving states stronger financial incentives to finally expand coverage.

First 100 Days:

- **Keep rising practice costs from becoming a barrier to care:** Modernize Medicare physician payment to keep pace with the cost of providing care, strengthen primary care,

and help independent practices stay open so patients can continue to access affordable primary and specialized care in their communities.

- **Stop insurers and junk plans from leaving patients without the care they were promised:** Strengthen protections against short-term plans, fixed-indemnity products, and health care sharing ministries that can leave families exposed to enormous medical bills.
- **Protect safety-net hospitals and community health centers from corporate interference:** Stop insurers and PBMs from discriminating against 340B providers and protect the resources safety-net providers use to deliver affordable medicines and care in underserved communities.
- **Overhaul and revamp the Rural Health Transformation Fund (RHTF) and create an intra-agency relief infrastructure to keep rural hospitals and providers open:** Increase and extend funding for the RHTF and reform how dollars are distributed to prioritize rural hospitals and providers at greatest risk of closure, ensuring federal resources reach the communities with the greatest need.
- **Make early detection and chronic disease management more affordable:** Eliminate Medicare cost sharing for chronic care management, preserve access to clinical laboratory testing, and expand hereditary cancer testing, screening, and preventive interventions so disease can be caught and managed before it becomes more serious and expensive.
- **Make health coverage easier to get and harder to lose:** Automatically connect eligible uninsured Americans with Medicaid, CHIP, and zero-premium Marketplace coverage using information the government already has, while eliminating the arbitrary five-year waiting period that keeps lawful permanent residents from accessing health care and other essential services.
- **Make the federal poverty measure reflect what it actually costs to live in America:** Modernize the federal poverty line to account for health care, housing, child care, transportation, and other basic expenses so families are not denied assistance because the government understates what it costs to make ends meet.
- **Bring mental health care to children before they reach a crisis:** Expand school-based, trauma-informed mental health services and allow Medicaid to cover physical and behavioral health services delivered during the same visit, making it easier for children and families to get coordinated care.
- **Ensure access to diagnostic tools for children living with genetic diseases:** Guarantee Medicaid access to whole genome and whole exome sequencing for children with suspected genetic, rare, or unexplained conditions so they can receive earlier diagnoses and more targeted treatment.
- **Help families prepare for the real cost of aging:** Give Americans clear information about long-term care costs, financing options, caregiving, home- and community-based services, and institutional care so families can plan before a crisis forces expensive decisions.
- **Remove barriers that keep lawfully present immigrants from affordable health coverage:** End the five-year waiting period for Medicaid and CHIP and reverse restrictions that prevent eligible families from accessing health care coverage.

<u>First Year:</u>

- **Make primary care free at the point of service:** Eliminate cost sharing for the first three annual primary care visits under Medicare and Medicaid – including physical,

mental, and behavioral health care – so cost does not keep patients from getting care early.

- **Reform step therapy to protect access to affordable, effective treatment:** Give patients a clear and timely exceptions process when step therapy could cause harm, delay effective care, or require them to abandon a treatment that is already working.
- **Strengthen the ACA and help families afford the coverage they already qualify for:** Restore robust funding for ACA Navigators and fix premium assistance for households split between Medicare and Marketplace coverage so families can enroll in and afford comprehensive insurance.
- **Guarantee dental care regardless of age or where you live:** Make comprehensive adult dental care a mandatory Medicaid benefit and eliminate CHIP benefit limits that can leave children and pregnant women without medically necessary dental treatment.
- **Make community health centers a cornerstone of affordable primary and behavioral health care:** Double federal funding for community health centers and make mental health and substance use disorder treatment a required health center service, expanding comprehensive care in rural, low-income, and medically underserved communities.
- **Reform our broken long-term care system and protect families from catastrophic costs:** Establish a federal long-term care insurance benefit for people with serious, lasting disabilities so seniors can receive care at home and in their communities without being forced to exhaust their savings.

Potential Legislation for the First 100 Hours:

- Policy Idea: Eliminate Medical Debt
- H.R. 3257, Bridge to Medicaid Act of 2025 (Rep. Terri Sewell)

Potential Legislation for First 100 days:

- H.R. 9693, Patients First Act (Reps. John Joyce and Kim Schrier)
- Previously Introduced Bill: H.R. 711, Throw Away Junk Plans Act (Rep. Kathy Castor)
- Policy Idea: Strengthen oversight over Health Care Sharing Ministries (HCSMs)
- H.R.___, Preserving Rules Ordered for The Entities Covered Through (PROTECT) 340B Act of 2026 (Rep. Doris Matsui)
- Policy Idea: Strengthen and Reform the Rural Health Transformation Fund
- H.R. 8261, Chronic Care Management Improvement Act of 2026 (Reps. Suzan DelBene and Mike Kelly)
- H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025 (Reps. Richard Hudson and Scott Peters)
- H.R. 4752, Reducing Hereditary Cancer Act (Reps. Debbie Wasserman Schultz and Mariannette Miller-Meeks)
- H.R. 1428, Poverty Line Act of 2025 (Reps. Kevin Mullin and Brian Fitzpatrick)
- H.R. 3947, Easy Enrollment in Health Care Act (Rep. Ami Bera)
- H.R. 5557, Mental Health Services for Students Act of 2025 (Reps. Andrea Salinas and Brian Fitzpatrick)
- H.R. 9847, Improving Coordination and Access to Resources Equitably (CARE) for Youth Act (Reps. Neal Dunn and Troy Carter)
- H.R. 7118, Genomic Answers for Children's Health Act of 2026 (Reps. Scott Peters and Gus Bilirakis)

- H.R. 8867, Planning for Long-term Aging Needs (PLAN) Act of 2026 (Reps. Thomas Suozzi and Aaron Bean)
- H.R. 9432, LIFT the BAR Act (Rep. Pramila Jayapal)

Potential Legislation for the First year:

- H.R. 1096, Helping Out Patients for Emotional (HOPE) and Mental Wellbeing Act (Rep. Andrea Salinas)
- H.R. 5509, Safe Step Act (Reps. Rick Allen and Lucy McBath)
- H.R. 3907, Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act of 2025 (Rep. Kathy Castor)
- H.R. 6455, Health Insurance Premium Fairness Act of 2025 (Rep. Mike Levin)
- H.R. 9831, Medicaid Dental Benefit Act of 2026 (Rep. Nanette Diaz Barragán)
- H.R. 9833, Ensuring Kids Have Access to Medically Necessary Dental Care Act (Rep. Nanette Diaz Barragán)
- H.R. 8201, Expanding Community Access to Health Services Act (Rep. Susie Lee)
- Policy Idea: Double Funding for Community Health Centers
- H.R. 2082, Well-Being Insurance for Seniors to be at Home Act (WISH) Act (Reps. Thomas Suozzi and John Moolenaar)

V: Strengthening Women's, Maternal, and Reproductive Health

The United States has the highest maternal mortality rate of any high income nation, and Black women die from pregnancy-related conditions at over three times the rate of white women in the U.S. Women in rural areas are also disproportionately impacted with maternal mortality rates in their areas more than 80 percent higher than in cities. This is due in part to poor access to care—one in three U.S. counties are maternity care deserts, or areas with no birthing facilities or obstetric clinicians.

In his second term, President Trump has unleashed unprecedented attacks on maternal, reproductive, and family health care, including through cuts to Medicaid, which covers 40 percent of all births in the U.S., and the withholding of federal funding from providers like Planned Parenthood who participate in Title X Family Planning Program, the only federal program dedicated to providing high-quality reproductive care regardless of an individual's ability to pay. These actions have exacerbated the longstanding crisis of maternal mortality and morbidity in this country.

There are an estimated 85 million mothers in this country. If they are not well, their families are not either. Democrats have always been the party of families, and should lead accordingly. Access to comprehensive and affordable maternal and reproductive health care gets at the heart of public health. Democrats must pass legislation that holistically addresses these gaps in care. That means eliminating out-of-pocket costs for prenatal and postnatal care; expanding access to midwives, doulas, and freestanding birth centers; stopping the closure of rural labor and delivery units; and guaranteeing abortion, contraception, and fertility care as core components of comprehensive health care. We must also invest in maternal mental health and reproductive psychiatry—investment and access to these services is critical not only during the prenatal and postpartum periods but beyond. Ultimately, women's health is family health, and our policies should reflect that.

First 100 Hours:

- **Protect every woman's right to contraception:** Guarantee the right to obtain and use birth control and protect health care providers' ability to prescribe and provide contraception without political interference.
- **Confront America's maternal mortality crisis:** Advance the maternal health Momnibus to reduce preventable deaths and severe complications, close racial disparities, strengthen the maternal health workforce, and improve care before, during, and after pregnancy.
- **Bring maternity care back to communities that have been left behind:** Expand access to doulas, midwives, mobile obstetric care, and community-based maternal health services so women in rural communities and maternity care deserts can receive high-quality care closer to home.

First 100 Days:

- **Make pregnancy and childbirth more affordable:** Eliminate out-of-pocket costs for prenatal and postnatal care and expand access to high-quality maternity services so the cost of having a baby does not become another financial burden on families.

- **Make maternal mental health care a core part of maternal health care:** Guarantee no-cost mental health and substance use disorder treatment during pregnancy and throughout the postpartum year, strengthen reproductive psychiatry and maternal mental health services, and protect women from disruptions in care during one of the most vulnerable periods of their lives.
- **Stop the disappearance of maternity care in rural America:** Strengthen rural and high-need hospitals and maternity providers so communities can keep labor and delivery services open, and women are not forced to travel hours to safely give birth.
- **Restore the family planning care Trump has put at risk:** Protect and stabilize Title X funding so low-income and uninsured patients can continue receiving contraception, cancer screenings, STI testing and treatment, and other essential reproductive health services regardless of their ability to pay.
- **Stop preventable heart disease and stroke deaths among women:** Expand access to cardiovascular screening, risk assessment, and early intervention, particularly for pregnant and postpartum women and women facing the greatest health disparities.
- **Make lifesaving breast cancer screening and follow-up care free:** Guarantee Medicaid coverage without cost sharing for breast cancer screening and medically necessary diagnostic and follow-up services so an abnormal screening does not become a financial barrier to getting answers and treatment.
- **Finally treat menopause and mid-life women's health as a national health priority:** Expand research, provider education and training, public health initiatives, and access to evidence-based care for menopause and other health conditions affecting women in mid-life.

First Year:

- **Guarantee Americans the freedom to build a family:** Establish a nationwide right to IVF and IUI and expand insurance coverage for fertility treatment so the ability to have a child does not depend on a family's income, employer, insurance plan, or ZIP code.

Potential Legislation for the First 100 hours:

- H.R. 999, Right to Contraception Act (Rep. Lizzie Fletcher)
- H.R. 7973, Momnibus Act (Rep. Lauren Underwood)
- H.R. 6303, CARE for Moms Act (Rep. Robin Kelly)

Potential Legislation the First 100 days:

- H.R. 3762, Supporting Healthy Moms and Babies Act (Rep. Jared Golden)
- H.R. 7227, Mental Health and Making Access More Affordable (MAMA) Act of 2026 (Rep. Gwen Moore)
- H.R. 3942, Keeping Obstetrics Local Act (Rep. Suzanne Bonamici)
- HR 2762, Expanding Access to Family Planning Act (Rep. Sharice Davids)
- H.R. 7417, Women's Heart Health Expansion Act (Rep. Joyce Beatty)
- H.R. 8729, No-Cost Breast Examinations in Medicaid Act of 2026 (Rep. Greg Landsman)
- H.R. 9090, Advancing Menopause Care and Mid-Life Women's Health Act (Rep. Yvette Clarke)

Potential Legislation for the First year:

- H.R. 9941, Right to IVF Act (Rep. Lori Trahan)

VI: Investing in the Health Care Workforce and Care Workers

Health care workers are the backbone of our health care system. Their education, where they work, how they work, and how much they are paid are major drivers of access and cost. The United States is projected to face a shortage of more than 141,000 physicians by 2038, including nearly 71,000 primary care physicians, while millions of Americans face shortages of mental health providers. When there are not enough workers, patients wait longer, travel farther, or go without care.

Physician reimbursement and working conditions directly affect the workforce. Medicare physician payment has declined 33 percent since 2001 after adjusting for inflation, pushing physicians toward large, consolidated health systems and making primary care and pediatrics less attractive to new physicians. Nurses – the largest segment of the health care workforce – face low wages, burnout, understaffing, and unsafe working conditions, causing nearly 200,000 registered nurses to leave the workforce during the COVID-19 pandemic. Mental health providers and direct care workers, including home care workers, nursing assistants, and direct support professionals, face similar challenges. To build a strong workforce, we must ensure fair compensation, safe working conditions, and a sustainable path for healthcare workers.

Workforce shortages are particularly acute in rural communities, driving up costs while making care harder to access. Medicare's Area Wage Index (AWI), which adjusts payments based on geographic differences, can leave rural hospitals with lower reimbursement for the same care, making it harder to recruit and retain nurses and other workers. Only approximately two percent of Medicare-supported graduate medical education occurs in rural areas, despite physicians being more likely to practice where they train. The result is fewer providers, longer travel times, and greater reliance on more expensive hospital and emergency care.

Investing in the health care workforce is essential to ensuring Americans can access high-quality care without paying more for less. To achieve this, the Cost-of-Living Healthcare Working Group has identified the following policies that should be considered for advancement:

First 100 Hours:

- **Add thousands of doctors where America needs them most:** Expand Medicare-supported residency training by 14,000 positions and prioritize new slots for rural and medically underserved communities.
- **Protect nurses from unsafe staffing:** Establish minimum nurse-to-patient ratios, prohibit mandatory overtime used to meet staffing requirements, and protect nurses who report unsafe conditions.

First 100 Days:

- **Train more doctors in underserved communities:** Expand community-based medical education in rural and underserved communities by connecting medical schools with rural health clinics, community health centers, and other high-need providers.
- **Recognize the workers providing essential disability care:** Establish a federal occupational classification for direct support professionals so policymakers can accurately track the workforce and develop policies to address persistent shortages.

- **Fix unfair Medicare payments that put rural hospitals at risk:** Increase Medicare reimbursement for hospitals in low-wage areas so rural hospitals can compete for health care workers, remain financially stable, and preserve access to care.
- **Stop forcing Americans into institutions when they want to age at home:** Make home- and community-based services a mandatory Medicaid benefit while investing in the workers needed to provide that care.
- **Let healthcare workers take a better job:** Ban noncompete agreements that prevent doctors and other health care professionals from changing jobs, negotiating better compensation, or practicing in communities where they are most needed.
- **Protect nursing home residents and the workers who care for them:** Require minimum staffing in nursing homes to improve resident and worker safety and guarantee dignified, high-quality care for residents.

First Year:

- **Let qualified military medics put their skills to work:** Create pathways for military medics to translate their training and credentials into civilian health care jobs instead of forcing them to start over.
- **Make mental health careers more affordable:** Provide up to $250,000 in student loan repayment for mental health professionals who commit to working in federally designated shortage areas.
- **End the shortage of nurses before it becomes a crisis:** Strengthen federal nursing workforce programs to expand faculty, clinical training, and pathways for licensed practical nurses to become registered nurses.
- **Improve direct care job quality and address the workforce crisis in long-term care:** Address the workforce shortages in long-term care by raising wages and improving benefits, training, and career advancement, making it a sustainable career for the millions of individuals who serve as the backbone of our long-term care system.
- **Build a permanent pipeline of health care workers:** Make sustained federal investments in training, recruitment, retention, and career advancement for doctors, nurses, mental health professionals, and direct care workers, with resources targeted to the communities facing the greatest shortages.

Potential Legislation for the First 100 hours:

- H.R. 4731, Resident Physician Shortage Reduction Act of 2025 (Reps. Terri Sewell and Brian Fitzpatrick)
- H.R. 3415, Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2025 (Rep. Janice Schakowsky)

Potential Legislation for the First 100 days:

- H.R. 3885, Community Training, Education, and Access for Medical Students (TEAMS) Act of 2025 (Reps. Carol Miller and Marc Veasey)
- H.R. 6137, Recognizing the Role of Direct Support Professionals Act (Reps. Brian Fitzpatrick and Joseph Morelle)
- H.R. 8109, Save Struggling Hospitals Act (Reps. Terri Sewell and David Kustoff)
- H.R. 8540, HCBS Access Act (Rep. Debbie Dingell)
- H.R.___, Workforce Mobility Act of 2026 (Reps. Scott Peters and Thomas Kean)

- H.R. 8100, Safe Staffing Saves Lives Act (Rep. Lloyd Doggett)

Potential Legislation for the First year:

- H.R. 9140, MEDIC Careers Act of 2026 (Reps. Maxine Dexter and Abraham Hamadeh)
- H.R. 6672, Mental Health Professionals Workforce Shortage Loan Repayment Act of 2025 (Reps. Andrea Salinas and Brian Fitzpatrick)
- H.R. 5052, Train More Nurses Act (Reps. Zachary Nunn and Susie Lee)
- H.R. 8541, Long-Term Care Workforce Support Act (Rep. Debbie Dingell)
- H.R. 8629, Developing the Community Health Workforce Act of 2026 (Reps. Raul Ruiz and Gus Bilirakis)

VII: Reclaiming MAHA and Protecting American Families

Americans' concerns about chronic disease and food safety, especially that which is linked to corporate influence over environmental regulation and public health, are legitimate and long overdue for a serious legislative response. The Make America Healthy Again (MAHA) movement has galvanized a significant segment of the Republican Party and attracted many previously apolitical and non-traditional voters, yet many of the concerns raised by the movement are bipartisan in nature. Seventy-five percent of Americans want stricter food additive rules and 64 percent want stricter pesticide rules. Another survey found that 76 percent of Americans in battleground districts believe that banning cancer-causing chemicals in food would improve Americans' health.

Unfortunately, HHS Secretary RFK, Jr. and the Trump Administration have used the legitimate concerns of American consumers about food safety to spread misinformation about vaccines, public health, and science. Their rhetoric has systematically led to the erosion of trust in public health, the science community, and decreased vaccination rates, leading to fatal outbreaks in some cases.

At the same time, the Trump Administration's deregulatory policies clash with the goals of those who supported RFK, Jr. and the MAHA movement. Time and again, the Administration has rolled back regulations protecting our air quality, water supply, and food safety, often at the behest and financial benefit of Trump's corporate donors and, at times, of the political appointees who steer these decisions. From the current Cyclospora outbreak to the fatal Texas and Pennsylvania measles outbreaks in 2025 and 2026, we are experiencing the direct consequences of misinformation and deregulation.

Preventing illness and reducing environmental risks lowers long-term healthcare costs while improving quality of life. Democratic priorities must include pursuing evidence-based and science-backed food, drug, and environmental safety policy. We must also ensure that everyone can access healthy food free of toxins and that corporations are held accountable when their products endanger the health of Americans.

In addition to restoring the regulations that protect our water and air quality and advancing policies that keep toxins out of our food supply, Democrats need to expand Food is Medicine policies and those that provide produce prescriptions to American families.

First 100 Hours:

- **Put families before profits:** Close loopholes that allow corporations to put potentially harmful chemicals and additives into the products Americans consume without meaningful federal oversight.
- **Protect babies from preventable threats:** Strengthen infant formula safety standards and require manufacturers to detect and report contamination before another preventable crisis puts infants at risk.
- **Get toxic heavy metals out of baby food:** Establish enforceable federal limits on lead, arsenic, cadmium, and mercury in foods marketed to babies and give the FDA stronger authority to recall contaminated products.

First 100 Days:

- **Finally make the food system work for families, not corporations:** End the GRAS loophole that allows manufacturers to determine for themselves that new food additives are safe, giving the FDA meaningful authority to review what enters the American food supply.
- **Make nutrition a tool for preventing chronic disease:** Expand federal investment in Food is Medicine, produce prescriptions, and nutrition interventions that can prevent and manage diabetes, obesity, hypertension, and other chronic conditions.
- **Give every child access to healthier school meals:** Invest in local, minimally processed foods and scratch cooking in schools so nutritious meals are available to children regardless of where they live or their family's income.
- **Know what is in the supplements Americans take:** Require supplement manufacturers to register their products with the FDA so consumers and regulators know what is being sold and what those products contain.
- **Protect children from environmental threats:** Permanently establish the EPA's Office of Children's Health Protection and ensure federal environmental policy accounts for children's unique vulnerability to toxic exposures.

First Year:

- **Take on the toxic chemicals that other countries have already banned:** Strengthen pesticide protections, ban some of the most dangerous pesticides, close regulatory loopholes, and protect farmworkers and families from chemicals that threaten their health.
- **Get cancer-causing chemicals out of the food supply:** Ban dangerous chemicals from food packaging and processing materials and prevent manufacturers from replacing one harmful chemical with another similar compound.
- **Protect children from harmful food additives:** Establish national standards to keep harmful synthetic dyes and other additives out of school meals, ensuring that every child – not just those in states that have acted – has access to safer food.
- **Give families the information they need to make healthier choices:** Require clear front-of-package warnings on foods and beverages that contribute to diet-related disease and restrict the marketing of unhealthy products to children.

Potential Legislation for the First 100 hours:

- H.R. 7601, No Immunity for Glyphosate Act (Reps. Thomas Massie and Chellie Pingree)
- H.R. 7867, Infant Formula Safety Modernization Act of 2026 (Rep. Rosa DeLauro)
- H.R. 8429, Baby Food Safety Act of 2026 (Rep. Raja Krishnamoorthi)

Potential Legislation for the First 100 days:

- H.R. 4958, Grocery Reform And Safety Act (GRAS Act) (Ranking Member Frank Pallone)
- H.R. 7906, Fueling Optimal Outcomes through Diet (FOOD) for Health Act (Reps. Robin Kelly and Jennifer Kiggans)
- H.R. 8390, National Food as Medicine Program Act of 2026 (Rep. Raul Ruiz)
- H.R. 5439, Medically Tailored Home-Delivered Meals Program Pilot Act (Reps. Jim McGovern and Nicole Malliotakis)
- H.R. 7267, Produce Prescriptions for Veterans Act (Reps. Chellie Pingree and Vern Buchanan)

- H.R. 9474, Local Foods for Healthy Schools Act of 2026 (Rep. Kristen McDonald-Rivet)
- H.R. 8928, Scratch Cooked Meals for Students Act (Rep. Jahana Hayes)
- H.R. 8370, Dietary Supplement Listing Act of 2026 (Rep. Maxine Dexter)
- H.R. 2339, Children's Health Protection Act of 2025 (Rep. Jerry Nadler)

Potential Legislation for the First year:

- H.R. 5085, Protect America's Children from Toxic Pesticides Act (Rep. Jim McGovern)
- H.R. 9231, No Toxic Chemicals in Food Packaging Act of 2026 (Rep. Jan Schakowsky)
- Policy Idea: Banning Harmful Additives in School Meals
- H.R. 6294, Childhood Diabetes Reduction Act of 2025 (Reps. Donald Beyer and Michael Lawler)

VIII: Increasing Access to Affordable Innovations and Breakthroughs

Americans shouldn't be priced out of medical breakthroughs and the medicines they need. Forty-three percent of adults report taking steps to reduce their prescription drug costs, including not filling prescriptions, skipping doses, or cutting pills in half. Yet science is rapidly expanding our ability to diagnose and treat some of the most severe, burdensome, and costly diseases. More than 30 million Americans live with rare diseases, fewer than five percent of which have an FDA-approved treatment. In 2024 alone, the FDA approved 50 novel drugs, including 26 for rare diseases, while advances in genomic medicine, precision diagnostics, and cancer screening are giving patients new opportunities to identify disease earlier and receive more targeted treatment.

Innovation only matters if patients can access it. Rural and underserved communities face particular barriers to specialists, advanced diagnostics, clinical trials, and cutting-edge treatments.Congress should modernize clinical trials to remove unnecessary barriers to participation and ensure that research reflects the patients who will ultimately use these therapies, while strengthening pathways for new drugs and diagnostics to receive timely, affordable coverage after FDA approval. Patients also deserve relief from insurance practices that leave them paying more than necessary.

Democrats must also ensure that Americans can access medicines that are already available. When essential medicines are in short supply, patients pay the price: drug shortages can force the use of more expensive alternatives, increase treatment costs, and disrupt care. At the same time, practices that delay or limit generic and biosimilar competition keep lower-cost alternatives out of reach. Biosimilars alone generated $56 billion in savings from 2015 through 2024, demonstrating the power of competition to lower costs. Congress should strengthen the drug supply chain, prevent shortages, remove barriers to generic and biosimilar competition, and continue to incentivize innovation – ensuring that medical breakthroughs translate into affordable, timely treatment for every patient who needs them.

First 100 Days:

- **Open clinical trials and medical innovation to more Americans:** Reduce travel, financial, and geographic barriers to clinical trial participation and strengthen research, early detection, and treatment for rare diseases that disproportionately affect underserved communities.
- **Stop drug shortages before patients feel them:** Require manufacturers to give the FDA earlier warning of supply disruptions and strengthen oversight of pharmaceutical supply chains so shortages can be prevented before patients are forced onto more expensive alternatives or left without treatment.
- **Expand Medicare coverage for pharmacist services:** Allow Medicare beneficiaries to receive timely testing and treatment for common illnesses through their local pharmacists.
- **Ensure patient assistance is counted towards copays:** Require insurers to count copay assistance toward patients' deductibles and out-of-pocket limits so people with chronic and complex conditions are not forced to pay twice before their coverage kicks in.
- **Ensure access to innovative kidney care:** Expand kidney disease screening and education while ensuring Medicare patients can benefit from innovative drugs, biologics, devices, and other advances in kidney care.

- **Make it easier for seniors to spread prescription drug costs throughout the year:** Allow Medicare beneficiaries to enroll in the Medicare Prescription Payment Plan in real time at the pharmacy and strengthen outreach so more seniors can avoid large upfront drug costs.

First Year:

- **Reform pharmaceutical companies' gaming of the patent system:** Close the loopholes in our drug patenting system that pharmaceutical companies exploit to inflate their profits and keep prices high for patients, including through pay-for-delay deals and abuse of the FDA petition process.
- **Get breakthrough medical technologies to Medicare patients faster:** Provide temporary Medicare coverage for qualifying breakthrough devices while CMS completes its coverage review, closing the gap between FDA approval and patients' ability to actually access new technology.

Potential Legislation for the First 100 days:

- H.R. 3521, Clinical Trial Modernization Act (Reps. Raul Ruiz and August Pfluger)
- H.R. 1750, Health Equity and Rare Disease (HEARD) Act of 2025 (Rep. Marilyn Strickland)
- S. 2665, Drug Shortage Prevention Act of 2025 (Sens. Amy Klobuchar and Susan Collins)
- H.R. 3164, Ensuring Community Access to Pharmacist Services Act (Reps. Adrian Smith and Brad Schneider)
- H.R. 6423, Help Ensure Lower Patient (HELP) Copays Act (Reps. Thomas Kean and Nanette Diaz Barragán)
- H.R. 6214, Kidney Care Access Protection Act (Reps. Carol Miller and Terri Sewell)
- Policy Idea: Allow Medicare and Medicaid to participate in subscription-based payment models for high per-patient cost drugs
- Policy Idea: Expand Medicare beneficiary access to Medicare Prescription Payment Plan (M3P)

Potential Legislation for the First year:

- Drug Patent Reform Package to include:
    - H.R. 8908, Stop GAMES Act (Reps. Eric Sorenson and Stephanie Bice)
    - H.R. 3269, ETHIC Act (Reps. Jodey Arrington and Lloyd Doggett)
    - S. 1096, Preserve Access to Affordable Generics and Biosimilars Act (Sens. Amy Klobuchar and Chuck Grassley); and
    - S. 1040, Drug Competition Enhancement Act (Sens. John Cornyn and Richard Blumenthal)
- H.R. 5343, Ensuring Patient Access to Critical Breakthrough Products Act (Reps. Blake Moore and Suzan DelBene)

Addendum

I: Reversing Trump's Destruction of the American Healthcare System

First 100 hours:

Existing Bill: H.R. 4849, Protecting Health Care and Lowering Costs Act of 2025 (Rep. Adam Gray)

- Status: Existing bill
- Description: This bill would roll back the harmful health care provisions passed in Republicans' H.R.1 by reversing the draconian cuts to Medicaid and permanently extending the Affordable Care Act's enhanced premium tax credits.
- Cosponsors: 141 (119th Congress)
- Committee(s) of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: As a result of the passage of H.R. 1, an estimated 15 million people will lose their health insurance, millions more will face skyrocketing premiums, and hospitals, pharmacies, and clinics will struggle to stay open and continue serving our communities. Throughout the Healthcare Working Group's conversations across stakeholders, communities, and the Democratic caucus, this legislation was consistently raised as the first item that should be on Democrats' agenda so we can truly begin rebuilding our healthcare system.
- Stakeholder Supporting: The Disability and Aging Collaborative & Consortium for Constituents with Disabilities, Economic Security Project Action.

Reproductive Health Care Package to include:

- **Existing Bill: H.R. 12, Women's Health Protection Act (Rep. Judy Chu); and**
- **Existing Bill: H.R. 4611, Equal Access to Abortion Coverage in Health Insurance (EACH) Act (Rep. Ayanna Pressley)**
- Status: Existing bills; H.R. 12 passed the House twice in the 117th Congress.
- Description: H.R. 12 would create a nationwide statutory right for patients to receive abortion care and for health care providers to supply it, free from state and local restrictions. H.R. 4611 would ensure that every person who receives care or insurance through the federal government could receive abortion services at no cost to the patient. It also prohibits political interference in decisions by private health insurance companies, including ACA marketplace coverage, to offer coverage for abortion care.
- Cosponsors: 208 for H.R. 12 and 188 for H.R. 4611 (both 119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce and Judiciary for H.R. 12; Energy and Commerce, Ways and Means, Natural Resources, Armed Services, Veterans' Affairs, Judiciary, Oversight and Government Reform, and Foreign Affairs for H.R. 4611
- Justification: These bills would directly address the overturning of Roe v. Wade, which disproportionately impacts rural communities, lower-income folks, and women of color. H.R. 12 creates a nationwide statutory right to abortion care, overriding the patchwork of state bans which makes access depend on geography. H.R. 4611 ends the Hyde Amendment, which has blocked abortion coverage for people insured through the federal government, including Medicaid enrollees, service members, veterans, and Native Americans.
- Stakeholders Supporting: H.R. 12 Catholics for Choice, Leadership Conference for Civil and Human Rights, American Public Health Association, ACLU, ACP, National Council for Jewish Women, NNU, American College of Obstetricians and Gynecologists,

American College of Physicians, American Medical Women's Association, YWCA, Center for Reproductive Rights, and Unite for Reproductive & Gender Equity; H.R. 4611 National Women's Law Center, Center for American Progress, and over 70 other groups.

Existing Bill: H.R. 4827, Medical Debt Relief Act of 2025 (Rep. Nikema Williams)

- Status: Existing bill
- Description: This bill would codify federal protections enacted by the Biden administration to ban all medical debt from appearing on credit reports and prohibit creditors from considering Americans' medical debt in their decisions on whether to extend them credit. In 2025, the Trump administration rolled back these protections.
- Cosponsors: 17 (119th Congress)
- Committee(s) of Jurisdiction: Financial Services
- Justification: Medical debt is the most common type of consumer debt in collections and accounts for over $88 billion of all consumer debt reported on traditional credit reports. If enacted, this bill would provide relief to an estimated 15 million Americans who are burdened with medical debt, which impacts their ability to buy a car, a home, or take out a personal loan.
- Stakeholders Supporting: National Consumer Law Center, Consumer Action, California Low-Income Consumer Coalition, Justice in Aging, Center for Responsible Lending, Consumer Federation of America, and Americans for Financial Reform.

Existing Bill: H.R. 3701, Family Vaccine Protection Act (Ranking Member Frank Pallone)

- Status: Existing bill
- Description: This bill would remove political interference from the Advisory Committee on Immunization Practices (ACIP). The bill writes ACIP into statute, requires ACIP recommendations to rest on the best available peer-reviewed evidence, and requires the CDC Director to adopt them, unless the Director publicly explains, on the evidence, why not. If the Secretary or Director overrides ACIP, they must publish the basis and notify Congress.
- Cosponsors: 78 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: For decades, ACIP has been the trusted, science-based body that decides which vaccines Americans are recommended to receive and, in turn, which insurers must cover. It exists by administrative practice, a vulnerability the current administration has exploited by removing the sitting members and installing appointees who reject the scientific consensus, throwing routine childhood immunization schedules into doubt. This bill writes ACIP into statute, requires its recommendations to follow the evidence, and forces any political override into the open with public, evidence-based justification and notice to Congress.
- Stakeholders Supporting: American Academy of Pediatrics, American Academy of Family Physicians, American Public Health Association, Infectious Disease Society of America, and Vaccinate Your Family.

Existing Bill: H.R. 4007, Prevent Halting of Active Research (PHARA) Act of 2025 (Rep. Bonnie Watson Coleman)

- Status: Existing bill
- Description: This bill would require the NIH to release funding owed under existing grants, pay pending reimbursements, and prohibit termination of awards supporting active research. Future NIH grants could generally be terminated only for specified

reasons, such as material breach or changed circumstances, rather than because they no longer align with agency priorities.

- Cosponsors: 62 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: The bill responds to the Trump Administration's 2025 termination and withholding of NIH grants, including research involving health disparities, diversity, and other areas the Administration determined no longer aligned with agency priorities. By June 2025, the Administration had terminated roughly 2,100 NIH grants totaling about $9.5 billion, with courts subsequently finding substantial portions of the terminations unlawful. This bill would protect active research from abrupt policy-driven cancellations while preserving NIH's ability to terminate grants for legitimate contractual reasons.

Existing Bill: H.R. 7173, Follow the Science Act (Rep. Diana DeGette)

- Status: Existing bill
- Description: This bill would prohibit most political appointees from participating in NIH operations or the review, scoring, selection, and awarding of NIH and Advanced Research Projects Agency for Health funding. It would also prohibit NIH from canceling, delaying, or suspending research awards unless there are written findings of financial mismanagement, research fraud, debarment, or malfeasance.
- Cosponsors: 42 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: The Trump Administration's cancellation of thousands of NIH grants and efforts to redirect research priorities raised concerns that political considerations could influence which federally funded research continues. The Administration also proposed reducing NIH funding to approximately $27.9 billion for FY2026, roughly 39 percent below FY2025 funding, although Congress rejected that proposed level. This bill would strengthen NIH's scientific independence by limiting political involvement in grant decisions and establishing objective grounds for terminating research awards.
- Stakeholders s=Supporting: American Public Health Association, Blood Cancer United (formerly Leukemia & Lymphoma Society), 27UNIHted, Science and Freedom Alliance.

Existing Bill: H.R. 2855, Protecting Medical Research Funding Act (Rep. Timothy Kennedy)

- Status: Existing bill
- Description: This bill would prohibit congressionally appropriated NIH funding from being impounded, transferred, or reprogrammed unless Congress subsequently enacts legislation expressly authorizing the action. It would also require annual certification to Congress that the Department of Health and Human Services and NIH are complying with these restrictions.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: The bill responds to Trump Administration efforts to freeze, withhold, and redirect NIH funding already appropriated by Congress, alongside its proposed roughly 39 percent reduction in NIH funding for FY2026. Although the Impoundment Control Act of 1974 already restricts executive withholding of appropriated funds, this bill would create an explicit NIH-specific safeguard requiring congressional authorization before research funding could be withheld or redirected.

Existing Bill: H.R. 5448, Protecting Free Vaccines Act (Ranking Member Frank Pallone)

- Status: Existing bill
- Description: This bill would preserve cost-sharing-free coverage through 2029 for vaccines that were recommended by the CDC's Advisory Committee on Immunization Practices (ACIP) as of October 25, 2024, even if those recommendations are subsequently revoked or changed. It would apply across private health insurance, Medicare, Medicaid, CHIP, and the Vaccines for Children program, while continuing to cover updated versions of qualifying vaccines approved by the FDA.
- Cosponsors: 82 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means; Education and Workforce
- Justification: Federal law generally ties cost-sharing-free vaccine coverage to ACIP recommendations, meaning changes to those recommendations can affect whether patients receive vaccines without out-of-pocket costs. In 2025, HHS Secretary Robert F. Kennedy, Jr. removed all 17 sitting members of ACIP and replaced the committee, and the reconstituted panel subsequently reconsidered recommendations for several vaccines, creating uncertainty about future coverage. Vaccines are one of the most effective tools for preventing infectious disease, and imposing new out-of-pocket costs could create additional barriers to immunization. This bill would protect access by preserving no-cost coverage through 2029 for vaccines recommended under the preexisting ACIP schedule, regardless of subsequent changes to those recommendations.
- Stakeholders Supporting: American Public Health Association, March of Dimes, Vaccinate Your Family, American College of Obstetricians and Gynecologists, American College of Physicians, American Academy of Family Physicians, and American Academy of Pediatrics.

Existing Bill: H.R. 7917, Fair Wages for Home Care Workers Act (Rep. Alexandria Ocasio-Cortez)

- Status: Existing bill
- Description: This legislation would codify minimum wage and overtime protections for home care workers in federal labor law.
- Cosponsors: 78 (119th Congress)
- Committee(s) of Jurisdiction: Education and Workforce
- Justification: In the U.S., there are more than three million home care workers who support almost 10 million people with disabilities and older adults with everyday tasks like eating, dressing, and bathing. Home care workers enable individuals to live independently in their homes and communities where the vast majority prefer to age. Despite their essential role in our long-term care system, in July 2025, the Trump administration took action to strip home care workers' right to minimum wage and overtime pay. When this action is finalized, home care workers who reside in states with no additional wage protections—more than one-quarter of all home care workers in the country—will lose their right to minimum wage and overtime protections. Basic employment standards should be the floor, especially for a workforce that is primarily financed through public dollars.
- Stakeholders Supporting: National Domestic Workers Alliance, SEIU, American Federation of State, County, and Municipal Employees and 85 other organizations.

Existing Bill: H.J.Res.189, Providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Department of Education relating to "Reimagining and Improving Student Education-Federal Student Loan Program Final Regulations". (Rep. Suzanne Bonamici)

- Status: Existing bill
- Description: This bill would repeal the Trump Administration's finalized rule that caps federal student loans, limits the definition of a professional degree to exclude nurses, social workers, teachers, firefighters, and physical and occupational therapists, among others from federal financial aid, eliminates the Grad PLUS program, and creates new, more expensive loan repayment options for all borrowers.
- Cosponsors: 65 (119th Congress)
- Committees of Jurisdiction: Education and Workforce
- Justification: Trump's Department of Education has established an arbitrary list of 11 fields, including nursing, social work, and other health professionals that are now subject to new borrowing limits, which will exacerbate healthcare workforce shortages and disincentivize students from entering high-need fields. This rule, along with the accompanying changes to student loan repayments that will increase monthly payments by hundreds of dollars per month, must be urgently repealed. Democrats should take action to protect students from predatory, high-interest private lenders and keep graduate degrees accessible.
- Stakeholders Supporting: Nearly 200 organizations including NEA, NNU, and NASW.

Existing Bill: H.R. 7961, H–1Bs for Physicians and the Healthcare Workforce Act (Reps. Mike Lawler and Sanford Bishop)

- Status: Existing bill
- Description: This legislation would exempt employers that petition for an H-1B visa to hire physicians and other healthcare workers from the new $100,000 fee, which was instituted by the Trump administration in 2025, and prohibits additional fees beyond those already established under existing law.
- Cosponsors: 62 (119th Congress)
- Committees of Jurisdiction: Judiciary
- Justification: Hospitals, community health centers, and other health care facilities face serious workforce shortages that threaten access to care. To address these shortages, many facilities, including those in rural and underserved areas, recruit physicians, nurses, and other critical health care professionals from other countries to serve their communities. The addition of a $100,000 fee for each additional health care worker needed to maintain or strengthen access to care is untenable for most institutions and effectively shuts them out from the H-1B visa program entirely. This threatens one of the most viable pathways to shoring up our strained health care workforce. Prior to the introduction of this legislation, Representatives Lawler and Clarke sent a letter, alongside 100 bipartisan members of Congress, calling on the Trump administration to exempt healthcare workers from the new H-1B visa fee.
- Stakeholders Supporting: Association of American Medical Colleges, American Medical Association, Physicians for Americans Healthcare Access, Association for Advancing Physician and Provider Recruitment, American Hospital Association, Healthcare Association of New York State, Greater New York Hospital Association, American Academy of Neurology, American Pharmacists Association, American Medical Association, American Society of Echocardiography, American College of Surgeons.

Existing Bill: H.R. 1589, American Dream and Promise Act of 2025 (Rep. Silvia Garcia)

- Status: Existing bill, received 210 signatures on a discharge petition in the 119th Congress; Versions of this bill have passed the House in the 116th and 117th Congresses.
- Description: This bill would provide individuals with Temporary Protected Status (TPS) or Deferred Enforcement Department (DED) and eligible Dreamers and DACA-recipients with a pathway to citizenship.
- Cosponsors: 220 (119th Congress)
- Committees of Jurisdiction: Judiciary; Education and Workforce
- Justification: Since President Trump took office, his administration has continued to launch unprecedented attacks on immigrant communities across the country. Now, after the Supreme Court empowered the Trump administration's efforts to strip legal protections for TPS holders, hundreds of thousands of immigrants are facing job loss, detention, family separation, and deportation. TPS was created by Congress more than 35 years ago to provide work authorization and protection from deportation for those who face dire conditions in their home countries. Apart from the cruelty of separating families and deporting individuals to places where their lives may be at risk, the abrupt elimination of TPS will have drastic impacts on the U.S. health care system and on the patients and families they serve. TPS holders make up 15 percent of noncitizen health care workers in the U.S. and an even greater share of the caregiving workforce. For example, 21,000 of the 330,000 Haitians with TPS worked as caregivers and nursing assistants, serving 77,000 patients. According to a recent Senate report, eliminating TPS will exacerbate the workforce shortage in hospitals, nursing homes, and other health care facilities. This will reduce critical services, increase wait times, and endanger patients. H.R. 1589 would provide a pathway to citizenship for TPS holders and others who have established their lives and careers here, allowing them to live and work without fear and ensuring our health care system can retain these experienced health care professionals.
- Stakeholders Supporting: United We Dream, Home is Here Coalition, AFL-CIO, SEIU, and nearly 120 other organizations.

Existing Bill: H.R. __, Prevent Implementation of the Trump Administration's 340B Rebate Model pilot program (Rep. Doris Matsui)

- Status: Provision in larger forthcoming Protect 340B bill
- Description: This bill would prevent the Trump administration's 340B Rebate Model pilot program from going into effect. The model will be implemented on January 1, 2027.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The 340B program allows certain health care facilities, including those that operate on thin margins like community health centers and safety net hospitals, to purchase medications from drug manufacturers at a discounted price. This allows providers to stretch limited resources, invest in expanding care, and serve more patients. The 340B Rebate Model Pilot Program would require participating health care providers to pay the full wholesale drug price upfront and receive a rebate on the backend. This means that safety net providers will be required to float millions of dollars to pharmaceutical manufacturers while absorbing new administrative costs and the risk of rebate denials or delays. This essentially shifts the financial responsibility from manufacturers to providers and would create significant cash flow issues that many safety net providers are unable to absorb.
- Stakeholders Supporting: The American Hospital Association

Existing Bill: H.R. 5940, Seniors Deserve SMARTER Care Act (Rep. Suzan DelBene)

- Status: Existing bill
- Description: This bill would block President Trump's new pilot program, the Wasteful and Inappropriate Services Reduction (WISeR) model, which requires Traditional Medicare providers to obtain approval from for-profit companies prior to administering certain health services. The program is currently in effect in six states and incentivizes for-profit companies to use artificial intelligence (AI) to automate prior authorizations for services newly subject to pre-approval under the pilot. The Trump administration plans to pay these for-profit companies a portion of the "savings" collected from denied care.
- Cosponsors: 45 (119th cosponsors)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: This is yet another example of the Trump administration prioritizing profits over patients and pushing Project 2025's stated goal of making Medicare Advantage "the default enrollment option" nationwide. Thus far, this pilot program has eroded the quality of coverage provided by Traditional Medicare, resulted in the delay and denial of necessary health care, and opened the door to further erosion of our Medicare system.
- Stakeholders Supporting: American Podiatric Medical Association, Physicians for a National Health Program, The Center for Health and Democracy, Social Security Works, Just Care USA, Washington State Medical Association, Washington State Hospital Association, Texas Medical Association, Washington Community Action Network, Healthcare is a Human Right Coalition, Puget Sound Advocates for Retirement Action, Health Care for All – Washington, and Social Security Works WA.

Existing Bill: H.R. __, Affordable Premiums for Seniors Act (Rep. Terri Sewell)

- Status: Exiting bill to be introduced
- Description: This bill would require CMS to continue the Part D Premium Stabilization Demonstration for standalone prescription drug plans through calendar year 2029 and continue the demonstration in subsequent years if terminating it would increase beneficiary premiums. It would also require CMS to issue guidance for calendar year 2027 within 30 days of enactment.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The Inflation Reduction Act (IRA) redesigned Medicare Part D by capping beneficiaries' out-of-pocket drug spending and shifting a greater share of prescription drug costs to plans, creating upward pressure on standalone Part D plan premiums. CMS established the Part D Premium Stabilization Demonstration in 2025 to ease that transition, and CMS estimated that the demonstration lowered average monthly standalone Part D premiums by approximately $26 in 2025 and $16 in 2026 relative to what they otherwise would have been; average standalone premiums fell from $39 to $36 between 2025 and 2026. However, CMS announced in July 2026 that it will terminate the demonstration after 2026. Without the additional stabilization, some beneficiaries could face larger premium increases in 2027, while standalone plans already average more than four times the Part D premium of Medicare Advantage drug plans ($36 versus $8 in 2026). This bill would preserve premium assistance through 2029 and prevent CMS from ending it thereafter when doing so would increase premiums, helping protect beneficiaries from abrupt premium increases and maintain affordable standalone Part D options.
- Stakeholders Supporting: Medicare Rights Center, AARP.

Existing Bill: H.R. 1061, Protecting Sensitive Locations Act (Rep. Adriano Espaillat)

- Status: Existing bill
- Description: This bill would prohibit ICE enforcement at healthcare facilities, schools, public benefits agencies, childcare facilities, emergency and disaster response agencies, places of worship, courthouses and lawyers' offices, polling places, and labor union facilities, among others.
- Cosponsors: 156 (119th Congress)
- Committee(s) of Jurisdiction: Judiciary
- Justification: On January 20, 2025, the Trump Administration rescinded the Protected Areas policy that kept immigration enforcement away from schools, hospitals, and places of worship, and instead directed immigration officials to use "common sense" when carrying out enforcement operations in these areas. The consequences were immediate and well-documented, with agents attempting to enter elementary schools, hospitals, courthouses, and church food distribution. The predictable result is that now immigrant and mixed-status families avoid the very institutions meant to serve them, skipping medical care and foregoing emergency help. This bill is an immediate step Democrats must take to help improve access to healthcare for immigrants and U.S. citizen children in mixed status households.
- Stakeholders Supporting: Center for Law and Social Policy (CLASP), National Low Income Housing Coalition and over 400 other organizations.

Existing Bill: H.R. 10045, Protect American Values Act (Rep. Judy Chu)

- Status: Existing bill
- Description: This bill would prohibit federal funding from being used to implement executive "public charge" rules put forth by the Trump administration that penalize legal immigrants for accessing basic public health, nutrition, and housing support.
- Cosponsors: 56 (119th Congress)
- Committee(s) of Jurisdiction: Judiciary
- Justification: The public charge test is intended to determine whether an individual is likely to become primarily dependent on the government for support and use that as grounds for denying admission to the United States or adjustment of status to that of lawful permanent resident. The Trump administration's new public charge rule will go into effect on September 18, 2026, and is expected to result in many immigrants forgoing necessary care and support for their families, including families with U.S. citizens, for fear that it may impact their future legal status. Immigrants should not be forced to choose between accessing essential services or pursuing legal status in our country.
- Stakeholders Supporting: Center for Law and Social Policy (CLASP), National Immigration Law Center, Protecting Immigrant Families Coalition and over 100 other organizations.

II: Building Towards Universal Coverage by Strengthening Traditional Medicare

First 100 hours:

Existing Bill: S.4886, Medicare Cost Cap Act of 2026 (Sen. Lisa Blunt Rochester)

- Status: Existing bill with no House companion
- Description: This bill would create a $5,000 cap on out-of-pocket expenses for individuals with Traditional Medicare coverage. This bill also enhances programs that protect low-income seniors and people with disabilities from rising monthly Part B premiums and out-of-pocket costs. Under the Trump Administration, Traditional Medicare's Part B monthly premiums topped $200 for the first time.
- Cosponsors: 16 Senators, including Leader Schumer and Senator Wyden (119th Congress)
- Expected Committees of Jurisdiction in the House: Energy and Commerce; Ways and Means
- Justification: One of the most critical limitations in Traditional Medicare is the lack of an annual cap on the total amount of out-of-pocket spending for beneficiaries. This means that beneficiaries could be confronted with unlimited health care costs in the face of a serious illness or an accident. If enacted, this bill would immediately improve the economic security of 3.2 million Traditional Medicare beneficiaries who are projected to exceed $5,000 in out-of-pocket spending on medical care in 2028, and is estimated to save individuals, on average, $1,255 annually. This bill would also expand and streamline critical savings programs for low-income individuals on Traditional Medicare.
- Stakeholders Supporting: Access Ready, AELP, California Physicians Alliance, Caring Across Generations, Center for Health and Democracy, Center for Medicare Advocacy, Justice in Aging, Just Care USA, Social Security Works, United States of Care, Well Spouse Association.

Existing Bill: H.R. 2045, Medicare Dental, Vision, and Hearing Benefit Act of 2025 (Rep. Lloyd Doggett)

- Status: Existing bill; A similar version passed the House as part of H.R. 3 in the 116th Congress.
- Description: This bill would provide coverage for dental, vision, and hearing care in Traditional Medicare. Such coverage would include dentures; comprehensive vision care including eye exams and prescription eyeglasses; comprehensive hearing care for moderate or profound hearing loss; and dental cleanings, x-rays, fillings, and other procedures.
- Cosponsors: 131 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The lack of dental, vision, and hearing coverage in Traditional Medicare is one of the biggest drivers of high health care costs for seniors and a key barrier to care. As a result, nearly one-in-five seniors over the age of 75 have lost all of their natural teeth; more than one-in-three Medicare beneficiaries have difficulty seeing; and close to half of all Medicare beneficiaries have difficulty hearing. Expanding Traditional Medicare to cover these additional benefits is overwhelmingly popular across the American public, with 92 percent in favor.
- Stakeholders Supporting: Center for Medicare Advocacy, Community Catalyst, Public Citizen, Social Security Works, Center for Health and Democracy, MoveOn.org, Families

USA, CareQuest Center for Oral Health, Justice in Aging, People's Action, Medicare Rights Center and Advocates for Community Health.

First 100 days:

Existing Bill: S.1105, No UPCODE Act (Sens. Bill Cassidy and Jeff Merkley)

- Status: Existing bill with no House companion
- Description: Traditional Medicare provides payment to the provider based on the services provided. Alternatively, Medicare Advantage uses a risk adjustment model, where plans are paid a standard rate based on the health of the patient. In other words, Medicare Advantage plans are paid more for enrollees who are sicker. This incentivizes plans to make enrollees look sicker than they are by more aggressively coding diagnoses, or "upcoding." This bill would address Medicare Advantage upcoding by developing a risk adjustment model that uses two years of data instead of one, limiting the ability of plans to use old or unrelated medical conditions when determining cost of care, and only providing payment for treatments related to relevant medical conditions.
- Cosponsors: 1 (Sen. Jeff Merkley)
- Expected Committees of Jurisdiction in the House: Energy and Commerce; Ways and Means
- Justification: This bill would crack down on some of the corporate profiteering and billing fraud occurring in Medicare Advantage. This would save the Medicare program at least $124 billion over the next 10 years, with another estimate finding the savings closer to $250 billion. Democrats can then use those savings to expand covered services in Traditional Medicare or shore up the program for future generations.
- Stakeholders Supporting: Alliance of Specialty Medicine, AARP, National Taxpayers Union.

Existing Bill: H.R.___, Risk Adjustment Data Validation (RADV) Audit Act (Rep. Alexandria Ocasio-Cortez)

- Status: Existing bill to be introduced
- Description: To reduce waste, fraud, and abuse in Medicare Advantage, the federal government employs Risk Adjustment Data Validation (RADV) audits, by which they review medical records to verify the accuracy of diagnoses submitted by Medicare Advantage plans for payment. In 2023, the Biden administration finalized a rule to audit a small sample of an insurer's Medicare Advantage enrollees and then use statistical extrapolation to calculate alleged overpayments across the entire contract population. In September 2025, a federal court vacated the Biden administration's RADV audit ruling, citing violations of the Administrative Procedures Act. Notably, the Trump administration has continued to defend this rule in court. This bill would codify the Biden administration's rule to allow for the use of extrapolation in RADV audits.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Through this rule, the Centers for Medicare & Medicaid Services estimates that they would recover an additional $4.7 billion in overpayments over the next 10 years. Similar to the No UPCODE Act, this bill would crack down on billing fraud by Medicare Advantage insurers and free up the savings to be used to strengthen Traditional Medicare.
- Stakeholders Supporting: This bill has not yet been circulated for endorsements.

Existing Bill: H.R. 8375, Medicare Advantage Improvement Act of 2026 (Reps. John Joyce and Kim Schrier)

- Status: Existing bill
- Description: This bill would require standard prior authorization approvals in Medicare Advantage within 72 hours; require Medicare Advantage plans to publicly report prior authorization data; prevent Medicare Advantage plans from applying stricter medical necessity standards than Traditional Medicare; strengthen network adequacy requirements for Medicare Advantage plans; and add a consumer protection rating into the star ratings program, which allows seniors to see if a plan is consumer friendly and has less prior authorization denials.
- Cosponsors: 23 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: This bill would correct some of the administrative barriers and profit-seeking behaviors in Medicare Advantage, such as the overuse of prior authorization that has led to delayed approval for care, surprise denials, confusing appeals processes, and disruptions to care.
- Stakeholders Supporting: Ascension, American Medical Rehabilitation Providers Association, PAM Health, Community Health Systems, and Encompass Health.

First year:

Existing Bill: H.R. 4206, CONNECT for Health Act of 2025 (Reps. Mike Thompson and David Schweikert)

- Status: Existing bill; Congress has passed and enacted multiple telehealth extensions on a bipartisan basis, with the most recent extension for non-behavioral health care through December 31, 2027.
- Description: This bill would permanently expand Medicare coverage of telehealth by removing geographic and originating-site restrictions, expanding the types of providers and facilities that can provide telehealth services, and eliminating the six-month in-person requirement for telemental health. It would also strengthen telehealth program integrity, quality measurement, and resources for patients and providers.
- Cosponsors: 241 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: When Congress and CMS temporarily expanded access during the COVID-19 pandemic, it allowed beneficiaries to receive telehealth from their homes and expanded eligible providers; in 2024, 25 percent of Medicare fee-for-service beneficiaries used a telehealth service. Telehealth use is associated with $82 less in 30-day Medicare spending than in-person care, while expanded telehealth access has helped maintain access to primary care and reduce in-person visits. This bill would make these flexibilities permanent, helping patients get care earlier and at lower cost.
- Stakeholders Supporting: American Medical Association, Urology Group Practice Association.

Existing Bill: H.R. 9544, Save MEDICARE Act of 2026 (Rep. Lloyd Doggett)

- Status: Existing bill
- Description: This bill would comprehensively address the ways in which for-profit insurers with Medicare Advantage plans are paid. In particular, this bill would prevent upcoding; improve benchmark payments; end the Quality Bonus Program; permit the VA to collect reimbursement from Medicare Advantage plans for care delivered to

dually-enrolled veterans, just as the VA already does with other commercial insurance; and enhance oversight of Medicare Advantage plans.

- Cosponsors: 52 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce; Veterans Affairs
- Justification: It is clear that Medicare Advantage has not lived up to its promise of delivering high-quality care and lowering Medicare program costs. Instead, for-profit insurers with Medicare Advantage plans have cherry-picked lower-cost enrollees, used more intensive diagnostic coding than is found in Traditional Medicare to increase federal payments, and overused prior authorization to deny medically necessary care. In fact, Medicare Advantage is more costly—federal payments to Medicare Advantage plans have been consistently higher than the cost of providing benefits through Traditional Medicare. This bill would implement much-needed and bold reform to the Medicare Advantage program, saving taxpayers $2.5 trillion over the next 10 years.
- Stakeholders Supporting: Public Citizen, Families USA, Center for Medicare Advocacy, Medicare Rights Center, National Committee to Protect Social Security and Medicare, Justice in Aging, Center for Health and Democracy, Social Security Works, Healthcare NOW.

Lower the Medicare Eligibility Age

Description: Lower the Medicare eligibility age so more individuals can access Medicare coverage.

- Expected Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Despite efforts through the Affordable Care Act, health care coverage continues to remain out of reach for millions of Americans. Even today, millions more have already lost or are expected to lose coverage due to the passage of Republicans' One Big Beautiful Bill Act. For more than 60 years, Medicare has proven to be our most successful health insurance program. It provides near-universal coverage to those 65 years and older and to many people with disabilities, and once individuals are enrolled, they are covered for the remainder of their life. As a result, Medicare is a logical place to begin expanding access to health coverage and building towards a universal system. The vast majority of Americans also support lowering the age with 63 percent supporting an eligibility age beginning at 50 and 65 percent supporting lowering the eligibility to 60.

Existing Bill: H.R.___, Medicare for Kids (Rep. Alexandria Ocasio-Cortez)

- Status: Existing bill to be introduced
- Description: This bill would create the Medicare for Kids Program, which would provide universal, federally-funded health coverage to all children through the age of 26, regardless of income, pre-existing conditions, employment status, or parental insurance status.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Over 4.4 million children in the U.S. have no health insurance, and almost 24 million are underinsured. Medicaid, the Children's Health Insurance Program (CHIP), the Affordable Care Act Marketplaces, and employer-sponsored insurance have thus far been unable to close the coverage gap and provide affordable health care for children, demonstrating that achieving universal coverage of children requires more than a patchwork of reforms. Early intervention matters most for children and, as such, they are particularly vulnerable to inadequate access to care. In addition, children who are uninsured have poorer health outcomes, which results in lifetime costs to themselves and

the entire American economy. Beyond ensuring that every young American has access to the care they need, this legislation would lift the burden of dependent premiums off of parents' shoulders, which can cost hundreds of dollars per month. This legislation would expand a program that has proven to be successful for the last 61 years and help Democrats' build the path towards a universal system.

- Stakeholders Supporting: This bill has not yet been circulated for endorsements.

Existing Bill: H.R. 4641, Keep Kids Covered Act (Rep. Kathy Castor)

- Status: Existing bill
- Description: This bill would require states to provide continuous Medicaid and CHIP coverage for children from enrollment until age six and extend continuous eligibility to 24 months for children ages six through 18. It would also provide continuous Medicaid coverage for former foster youth through age 26 and require states to periodically update beneficiaries' contact information during longer enrollment periods.
- Cosponsors: 25 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: While this bill expands Medicaid for children, it is a complementary proposal to the Medicare for Kids Act, with both bills seeking to ensure all children are covered. The Consolidated Appropriations Act, 2023 required states to provide children with 12 months of continuous Medicaid and CHIP eligibility beginning in 2024, but children can still lose coverage during annual renewals because of paperwork barriers or temporary changes in family circumstances. Research found that Medicaid churn among children more than doubled around annual renewal, rising from 4.0 percent at month 12 to 10.5 percent by month 15, suggesting that many eligible children experience unnecessary coverage disruptions. Several states have already received federal approval to provide multi-year continuous eligibility for young children. This bill would establish these stronger protections nationwide, helping children maintain consistent access to preventive care, medications, and other health services while reducing administrative churn.
- Stakeholders Supporting: American Academy of Pediatrics, Association for Community Affiliated Plans, First Focus Campaign for Children, Protect Our Care, Children's Hospital Association.

Existing Bill: H.R.10020, Medicare at Home Act (Rep. Debbie Dingell)

- Status: Existing bill
- Description: This bill would expand the Traditional Medicare Part B benefit to include coverage of home care and in-home support so seniors and people with disabilities can receive care in their homes, which the vast majority prefer.
- Cosponsors: 1 (119th Congress)
- Expected Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Medicare does not cover home care. Alternatively, Medicaid, which does provide home care coverage, has waitlists with hundreds of thousands of individuals in need of care. Privately-funded home care costs more than $60,000 a year for 40 hours a week of care and more than $280,000 for round-the-clock care. Simply put, individuals and families cannot afford this. Millions are either on a Medicaid waiting list or spending down their savings to qualify for Medicaid, and many of their families are forced out of the workforce to provide care themselves, unpaid. Access to long-term care must remain a core element of all health care affordability proposals put forth by Democrats.

- Stakeholders Supporting: Caring Across Generations, Justice in Aging, LeadingAge, SEIU, and Allies for Independence.

Policy Idea: Medicare Part D Federally-Administered Prescription Drug Plan

- Status: New idea with no legislative text; However, Senators Durbin and Brown and Rep. Schakowsky introduced the Medicare Prescription Drug Savings and Choice Act in the 116th Congress, which would have required CMS to establish at least one publicly-administered prescription drug plan to compete with privately-administered Medicare Part D plans.
- Description: This bill would create a new Prescription Drug Part D plan run by the federal government, which seniors on Traditional Medicare could choose for their prescription drug coverage. Like Traditional Medicare, a publicly-run Part D plan would offer a standard benefit, including a fixed deductible and coinsurance, an out-of-pocket cap, a limited but standardized prior authorization protocol, and no restrictions on pharmacy networks. The plan would also contract directly with drug manufacturers and manage the formulary, eliminating the need for predatory PBMs.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Currently, Traditional Medicare beneficiaries can only access prescription drug coverage through a Part D prescription drug plan, in which the federal government contracts with for-profit insurance companies to administer those benefits. Whereas Traditional Medicare's Parts A and B (i.e. the medical benefits) were built to be publicly administered where Medicare directly sets prices and reimburses providers, the Part D prescription drug benefit is private-only. By completely privatizing the prescription drug benefit, Traditional Medicare has become reliant on PBMs for price negotiation. Currently, three PBMs control the Part D market, giving them even more power over what seniors pay at the pharmacy counter. Enacting a public Part D program will allow for bold drug price negotiation to bring prices down. The Biden administration enacted positive reforms to the Part D program by capping out-of-pocket costs for patients at $2,100 as of this year and requiring plans to cover more of the costs of insurance, rather than placing the burden on the patients. However, in response to the prescription drug out-of-pocket cap, for-profit insurers offering Part D plans have begun to raise premiums and many are exiting the market altogether, a trend that is likely to continue. This, alongside Americans' increasing dissatisfaction with for-profit insurers, PBMs, and rising prescription drug prices, makes a strong case for a federally-run public option in Medicare Part D.

III: Making Healthcare Affordable by Taking on Monopolies

First 100 hours:

Existing Bill: H.R. 6166, Lowering Drug Costs for American Families Act (Ranking Members Frank Pallone, Richard Neal, and Bobby Scott)

- Status: Existing bill; This bill has provisions that trace back to H.R. 3, the Lower Drug Costs Now Act, which passed the House in the 116th Congress.
- Description: This bill broadens the drug pricing provisions passed through the Inflation Reduction Act (IRA) by expanding the drug price negotiation program to include Americans with private coverage, expanding the number of drugs negotiated from 20 to 50, limiting out-of-pocket costs for insulin to $35 per month for all Americans with private insurance, and capping annual out-of-pocket costs at $2,000 for Americans with private coverage, mirroring the cap in Medicare.
- Cosponsors: 58 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means; Education and Workforce
- Justification: Pharmaceutical companies and PBMs rake in record profits year over year, but Americans are left paying, on average, four times more than people in other high-income countries for the same brand-name prescription drugs. An estimated 43 percent of Americans have reported cutting back their medication due to cost either by rationing or skipping it altogether. Yet, federal taxpayer dollars through the National Institutes of Health are the backbone of our drug development system, having funded 99 percent of all new drugs approved in the U.S. between 2010 and 2019. It is time that Americans start benefiting from the investment of their taxpayer dollars with lower costs at the pharmacy counter.
- Stakeholders Supporting: Patients for Affordable Drugs Now.

Policy Idea: $35 Out-of-Pocket Cap for EpiPens and Inhalers

- Status: New idea with no existing legislative text. There are separate bills to reduce the cost of EpiPens (H.R. 5139 - the EPIPEN Act, Rep. Frost) and the cost of inhalers and nebulizers (H.R. 5278 - the Affordable Inhalers and Nebulizers Act, Rep. Mfume).
- Description: A bill to establish a $35 cap on EpiPens and inhalers for Americans with both public and private health insurance.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: By instituting a $35 cap on insulin through the Inflation Reduction Act, Democrats successfully increased access to this lifesaving medication for those on Medicare. Four million older adults and other Medicare patients no longer have to choose between buying their insulin and cutting back on other critical expenses. Democrats must build upon this success by extending the $35 cap to other critical medications so no American has to make the choice between their health and putting food on the table.
- Stakeholders Supporting: This policy idea was raised by members of the Democratic caucus during the closed door member meetings. In addition, Health Care for All Massachusetts and Patients for Affordable Drugs Now expressed support for this idea.

First 100 days:

Existing Bill: H.R. 6609, Pharmacists Fight Back in Medicare and Medicaid Act and H.R. 6610, Pharmacists Fight Back [in Federal Employee Health Benefit Plans Act] (Rep. Jake Auchincloss)

- Status: Existing bills; H.R. 6610 was marked up and reported favorably out of Oversight and Government Reform in the 119th Congress.
- Description: These bills would create a standardized reimbursement mechanism for pharmacies and prevent PBMs—the corporate middlemen of drug pricing—from engaging in practices that drive up costs, price-gouge community pharmacists, and limit patient choice. This legislation is split into two separate bills to address federal health plans and Medicare and Medicaid.
- Cosponsors: H.R. 6609 41; H.R 6610 42 (119th Congress)
- Committees of Jurisdiction: H.R. 6609 Energy and Commerce and Ways and Means; H.R. 6610 Oversight and Government Reform
- Justification: Over the last several years, numerous Congressional hearings, independent studies, and investigative reports have detailed the concerning practices of PBMs. These practices have allowed PBMs to determine which drugs are available to patients, at which pharmacies, and at what price. In fact, the three largest PBMs, which are owned by CVS Health, UnitedHealth, and Cigna, manage nearly 80 percent of all prescription drug claims and, in 2025, were found to have marked up medications to treat cancer and HIV by hundreds and thousands of percent. While Congress successfully passed PBM reform in 2026, additional reform is needed to rein in the profiteering tactics of corporate middlemen, which have led to the closure of 300 independent pharmacists since January 2025 alone.
- Stakeholders Supporting: For H.R. 6609: American Pharmacy Cooperative, Center for Health and Democracy, Pioneer Institute and Global Health Living Foundation, Coalition of State Rheumatology Organizations, and AMAC Action. For H.R. 6610: National Community Pharmacists Association and 62 other organizations.

Existing Bill: H.R. 9257, Primary and Behavioral Health Care Access Act of 2026 (Rep. Lauren Underwood)

- Status: Existing bill
- Description: This bill would require private insurance plans to cover three annual primary care visits and three annual outpatient mental health or outpatient substance use disorder treatment visits without charging a copayment, coinsurance, or a deductible-related fee.
- Cosponsors: 1 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Education and Workforce; Ways and Means
- Justification: A survey released earlier this year found that one-third of Americans—or more than 80 million people—cut back on driving, skipped meals, or borrowed money in order to afford routine health care. Others had delayed major life events like starting a family, buying a home, changing jobs, or retiring due to health care costs. Americans should not have to choose between basic necessities or major life events and receiving needed care. All Americans should have access to affordable primary care and mental health care to treat health conditions earlier and prevent costlier issues down the line.
- Stakeholders Supporting: Clinical Social Work Association, American Association of Nurse Practitioners, and 27 other organizations.

Existing Bill: H.R. ___, Break Up Big Medicine Act (Rep. Alexandria Ocasio-Cortez)

- Status: Existing bill to be introduced
- Description: This bill would prohibit health insurers, PBMs, and drug wholesalers from owning or controlling health care providers and management service organizations, or MSOs, and require divestment within one year of enactment.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Energy and Commerce; Judiciary
- Justification: Health care corporations like UnitedHealth Group and CVS Health dominate the American health care system, owning or controlling every part—from health insurance plans, pharmacies, drug manufacturers, PBMs, physicians, to even claims processing operations. This unprecedented wave of consolidation not only stifles competition and enables corporate profiteering, but allows massive health care monopolies to raise prices on the American people. It also harms independent doctors and pharmacies, with thousands of independent pharmacies closing since 2019, and almost 80 percent of physicians now working for a major health care corporation. This proposal would address the corporatization of the healthcare system by breaking up these monopolies, resulting in lower costs for patients and better jobs for health care workers.
- Stakeholders Supporting: AELP; Alliance of Independent Dentists; American Academy of Allergy, Asthma & Immunology; Center for Health and Democracy; Coalition for Patient-Centered Care; and various members of the Break Up Big Medicine coalition.

Policy Idea: Enacting Site-Neutral Payments and Capping Outlier Hospital Prices

- Status: New idea with no existing legislative text
- Description: This policy would equalize Medicare payments for routine outpatient services regardless of whether they are delivered in a hospital outpatient department or a physician's office, with protections for rural and safety-net hospitals. It would also cap outlier hospital prices at 200 percent of Medicare rates.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Hospital care is the single largest source of national health care expenditures and the single largest driver of premium increases. One out of every two dollars from commercial health insurance goes to hospital care. While hospital care is essential, providing specialized and time-sensitive emergency treatment, consolidation among larger hospital chains has allowed facilities to charge astronomical prices—prices that are four and five times what Medicare charges. In addition, hospital chains will often charge higher rates for services provided at an affiliated outpatient facility compared to the same service provided at a physician's office. States like Indiana have already begun to implement some of these changes by implementing direct price regulation of hospitals. A vast majority of voters, including 82 percent of Democrats and 74 percent of Republicans support limiting the prices that hospitals can charge to no more than two times what Medicare pays and 63 percent believe that this would lower health care costs for them. In addition, 84 percent support a same price or "site neutral" payment policy to reduce hospital consolidation that can lead to higher prices for patients.
- Stakeholders Supporting: Third Way, Center for American Progress, Families USA, and the Committee to Protect Health Care have publicly expressed support for policies that address hospital pricing.

Existing Bill: H.R. 8779, Patients Before Monopolies Act (Reps. Jake Auchincloss and Diana Harshbarger)

- Status: Existing bill
- Description: This bill would prohibit health insurers and PBMs from owning pharmacies and require those with pharmacies under their ownership to divest their pharmacy businesses.
- Cosponsors: 8 (119th Congress)
- Committees of Jurisdiction: Judiciary
- Justification: Over the past decade, PBMs have grown so large that they now exercise control over almost every part of the prescription drug delivery system. Today, the largest health care corporations own both the PBM, which pays for pharmacy services, and the pharmacy chains, which provide those services. This creates an inherent conflict of interest, where profit is the primary motive, leading patients to pay higher drug costs and fewer independent pharmacies able to keep their doors open. In absence of federal action, states have been taking the lead. For example, in 2025, Arkansas passed a law to prevent the joint ownership of PBMs and pharmacies, and Tennessee passed a similar law in 2026. In addition, nearly 40 state attorneys general have called on Congress to pass federal legislation that bars PBMs, their parent companies, or their affiliates from owning or operating pharmacies. Democrats need to follow states' lead to lower prescription drug costs for Americans across the country and ensure community pharmacists can continue serving our constituents.
- Stakeholders Supporting: American Pharmacy Cooperative, Pharmacists United for Truth and Transparency, Coalition of State Rheumatology Organizations, AELP, Alliance for Transparent & Affordable Prescriptions, American Pharmacies, and National Community Pharmacists Association.

Existing Bill: H.R. 7920, Take Back Our Hospitals Act of 2026 (Rep. Mary Gay Scanlon)

- Status: Existing bill
- Description: This bill would prohibit private equity ownership of hospitals and skilled nursing facilities by prohibiting them from receiving Medicare reimbursements.
- Cosponsors: 12 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: In the last two decades, private equity acquisitions of hospitals and nursing homes has significantly increased, with private equity firms investing $750 billion in health care between 2010 and 2019. Today, more than 450 hospitals and nursing homes are owned and operated by private equity firms. Because private equity firms' primary goal is to generate high profit returns over the short-term, firms routinely prioritize aggressive cost-cutting strategies over patient care. After private equity takeovers, hospitals and nursing homes slash services, staffing, and supplies, and overcharge patients while degrading the quality of care. Patients in private equity-owned hospitals are more likely to experience infections and complications while older adults in nursing homes owned by private equity face a higher mortality rate. In addition, many hospitals and nursing homes receive federal funding through Medicare payments. That means that private equity firms are essentially cutting back on patient care in order to profit off of taxpayer dollars. Democrats have a duty to be responsible stewards of taxpayer dollars and ensure those funds are directly benefiting patients over profits.
- Stakeholders Supporting: Pennsylvania Association of Staff Nurses and Allied Professionals.

Existing Bill: H.R.___, Stop Corporate Takeovers of Physicians Act (Rep. Val Hoyle)

- Status: Existing bill to be introduced; Senators Warren and Wyden are leading the Senate companion.
- Description: This bill would end the corporate practice of medicine by enacting a federal ban, modeled on Oregon's 2025 law, that explicitly closes loopholes that private equity firms and wholesalers use to circumvent state-level prohibitions.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Energy and Commerce, Ways and Means, and Judiciary
- Justification: Laws banning the corporate practice of medicine currently exist in several states and prohibit corporate ownership of certain types of medical practices by requiring them to be owned and operated by licensed medical professionals. This is to avoid the commercialization of medical care and prevent a conflict of interest between corporate profits and patient care. However, corporate actors and private equity firms have exploited loopholes in these state laws, which have allowed them to acquire medical practices. Congress needs to close these loopholes so patients' health comes first.
- Stakeholders Supporting: AELP supports this policy idea, but the bill has not yet been circulated for support.

Exiting Bill: H.R. 9482, Health and Location Data Protection Act of 2026 (Rep. Mary Gay Scanlon)

- Status: Existing bill
- Description: This bill would ban data brokers from collecting, selling, or transferring location data and health data, including data entered into AI systems. The legislation would also empower the FTC, state attorneys general, and injured persons to sue to enforce the provisions of the law and provide the FTC $1 billion in funding over 10 years to carry out its work, including enforcement of this bill.
- Cosponsors: 9 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Data brokers gather and sell location, search history, and other personal data. This $300 billion industry is largely unregulated by the federal government, and data gathered by these brokers has been sold and used to circumvent the Fourth Amendment, out LGBTQ+ Americans, stalk and harass individuals, and track those seeking reproductive care. American's personal information should be protected, not exploited for profit.
- Stakeholders Supporting: National Partnership for Women & Families, All* Above All, the Guttmacher Institute, the National Network of Abortion Funds, and the National Council of Jewish Women.

First year:

Policy Idea: Limiting Total Health Care Costs

- Status: New idea with no legislative text
- Description: This bill would tie total health care costs for individuals and families to their income and institute an eight percent cap on costs across all public and private payors, including employer-based coverage.
- Cosponsors: N/A
- Expected Committees of Jurisdiction: Ways and Means; Energy and Commerce; Education and Workforce; Oversight and Government Reform

- Justification: Despite being the richest country in history, Americans are left paying some of the highest health care prices in the world. High deductibles, copays, and surprise out-of-network bills mean that having coverage no longer guarantees being able to afford care, with four-in-ten Americans holding medical debt—many of them insured. Existing protections are partial and leave the biggest gaps open: the Affordable Care Act's enhanced premium tax credits successfully instituted a maximum cap on monthly premiums for plans offered through the ACA marketplaces, which limited premium costs to no more than 8.5 percent of a household's income. This proposal would build upon that by capping total health care spending—premiums, deductibles, copays, and out-of-pocket costs combined—at 8 percent of household income, across all coverage, including employer-sponsored plans. According to a recent poll conducted by KFF, insured adults cited lowering out-of-pocket costs as the most important change they wanted from their health insurance.
- Stakeholders Supporting: Families USA.

IV: Expanding Access to Affordable, Preventive Care to Reduce Costs

First 100 hours:

Policy Idea: Eliminate Medical Debt

- Status: New idea with no existing legislative text
- Description: This bill would eliminate or substantially reduce the medical debt currently held by millions of Americans, and protect patients from the long-term financial consequences of seeking medically-necessary care.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Financial Services
- Justification: Medical debt is a leading factor in personal bankruptcies. One in five Americans is saddled with medical debt, totaling over $220 billion, including approximately 14 million adults who owe more than $1,000. Medical debt can follow patients long after they receive care, affecting household finances and access to credit. Americans should not be drowning in debt because they sought needed care, like cancer treatment or prenatal care, for themselves and their families. Congress should pursue a comprehensive strategy to address both existing medical debt and the practices that allow unaffordable medical bills to become debt in the first place.

Existing Bill: H.R. 3257, Bridge to Medicaid Act of 2025 (Rep. Terri Sewell)

- Status: Existing bill
- Description: This bill would provide affordable ACA Marketplace coverage to low-income individuals in states that have not expanded Medicaid, including people with incomes below 138 percent of the federal poverty level who would otherwise fall into the Medicaid coverage gap. For 2026 through 2028, it would substantially reduce their cost sharing, establish continuous enrollment opportunities, provide certain additional benefits, and expand premium tax credit eligibility, while also increasing federal Medicaid funding to encourage states to expand Medicaid.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The Affordable Care Act originally envisioned Medicaid expansion as the primary source of coverage for adults with incomes below 138 percent of the federal poverty level, but the Supreme Court's 2012 decision in *NFIB v. Sebelius* effectively made expansion optional for states. As a result, an estimated 1.4 million uninsured adults remain in the Medicaid coverage gap in states that have not expanded Medicaid, earning too much to qualify for their states' Medicaid programs but generally too little to qualify for ACA premium tax credits. This bill would provide these low-income adults with an affordable pathway to Marketplace coverage while offering states an enhanced 93 percent federal matching rate from 2026 through 2028 to encourage Medicaid expansion.
- Stakeholders Supporting: Families USA.

First 100 days:

Existing Bill: H.R. 9693, Patients First Act of 2026 (Reps. John Joyce and Kim Schrier)

- Status: Existing bill
- Description: This bill would comprehensively reform Medicare physician payment by tying annual physician fee updates to the Medicare Economic Index, establishing a hybrid primary care payment model, and reforming the Merit-based Incentive Payment

System (MIPS) into the Patient Outcome Improvement National Tabulation System (POINTS) with greater clinician involvement in quality measures. It would also modify alternative payment model participation requirements, add notice-and-comment requirements for certain Center for Medicare and Medicaid Innovation models, and update Medicare physician fee schedule budget-neutrality rules.

- Cosponsors: 39 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the Sustainable Growth Rate formula and established MIPS and incentives for alternative payment models, but physician practices continue to face rising operating costs, administrative burdens, and payment instability. These pressures are particularly significant for independent and primary care practices and can contribute to practice closures and consolidation, potentially reducing patient choice and access to care. This bill would modernize MACRA by tying physician reimbursement more closely to inflation, creating predictable monthly payments for primary care, streamlining quality measurement through clinician-led reforms, and improving incentives for value-based care, with the goal of strengthening independent practices and preserving Medicare beneficiaries' access to physician-led care.
- Stakeholders Supporting: American Medical Association, American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS), Primary Care Collaborative. Better Health Now, American College of Radiology, American Academy of Family Physicians, American Academy of Neurology, American College of Gastroenterology, American College of Physicians, American College of Radiology, American College of Rheumatology, American Medical Association, American Society of Anesthesiology, American Urological Association, America's Physician Groups, Association for Clinical Oncology, Medical Group Management Association, National Partnership for Women and Families, Society for Cardiovascular Angiography and Interventions, United States of Care.

Previously Introduced Bill: H.R. 711, Throw Away Junk Plans Act (Rep. Kathy Castor)

- Status: Previously introduced in the 118th Congress; proposed for reintroduction with additional provisions
- Description: This bill would eliminate the federal exemption for short-term, limited-duration insurance (STLDI), subjecting these plans to the ACA's individual-market consumer protections. The reintroduced bill would also add new provisions addressing fixed-indemnity plans and health care sharing ministries, strengthening federal standards for alternative coverage arrangements that can be marketed as substitutes for comprehensive health insurance.
- Previous Cosponsors: 0
- Expected Committee(s) of Jurisdiction: Energy and Commerce
- Justification: Short-term health plans, or "junk plans," are exempt from many ACA consumer protections and can exclude preexisting conditions, omit essential health benefits such as prescription drugs and maternity care, and impose annual or lifetime benefit limits. Individuals enrolled in "junk plans" may be subject to high out-of-pocket costs, high medical bills, and massive medical debt. These concerns have become more significant as rising Marketplace premiums have pushed some consumers toward cheaper alternative coverage; Marketplace enrollment declined about 20 percent from 2025, while some alternative arrangements have reported substantial enrollment growth. The Trump administration has also stopped enforcing the Biden administration's 2024 restrictions on

short-term plans, increasing the importance of establishing protections in federal statute rather than relying on administrative regulations. This bill would ensure short-term plans are subject to ACA standards and reduce the risk that consumers purchase coverage that leaves them exposed to substantial medical costs. The new provisions addressing fixed-indemnity plans and health care sharing ministries are particularly important because consumers increasingly use these arrangements as substitutes for comprehensive insurance even though they can provide limited benefits or, in the case of sharing ministries, are not legally obligated to pay members' medical bills.

Policy Idea: Strengthen oversight of Health Care Sharing Ministries (HCSMs)

- Status: New idea with no existing legislative text
- Description: This bill would strengthen federal consumer protections and oversight of health care sharing ministries (HCSMs), including standards preventing HCSMs and brokers from deceptively marketing their products as health insurance and clearer disclosure that payment of members' medical claims is not guaranteed.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: HCSMs, a form of "junk plans," can closely resemble traditional insurance in their marketing and structure but are not health insurance, do not guarantee payment of medical claims, and are not subject to Affordable Care Act protections such as required coverage of essential health benefits and protections for preexisting conditions. State regulators have reported consumers mistakenly believing they purchased insurance and have identified deceptive broker practices, while limited regulatory authority can make oversight difficult. Stronger federal standards would protect consumers from misleading coverage arrangements, particularly as higher Marketplace premiums may push more consumers toward lower-cost alternatives that provide substantially fewer protections.
- Stakeholders supporting: ACS CAN.

Forthcoming Legislation: Preserving Rules Ordered for The Entities Covered Through (PROTECT) 340B Act of 2026 (Rep. Doris Matsui)

- Status: Previously introduced in the 118th Congress; proposed for reintroduction with additional provisions
- Description: This bill would prohibit pharmacy benefit managers (PBMs) and health insurance plans from discriminating against health providers participating in the 340B drug pricing program, including pharmacies contracted with such providers to dispense 340B drugs. The bill also provides for a process to prevent duplicate 340B drug discounts to states under Medicaid. This bill would also would prevent the Trump administration's 340B Rebate Model pilot program from going into effect
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The 340B program allows certain health care facilities, including those that operate on thin margins like community health centers and safety net hospitals, to purchase medications from drug manufacturers at a discounted price. This allows providers to stretch their resources, invest in expanding care, and serve more patients. The 340B Rebate Model Pilot Program would require participating health care providers to pay the full wholesale drug price upfront and receive a rebate on the backend. This means that safety net providers will be required to float millions of dollars to pharmaceutical manufacturers while absorbing new administrative costs and the risk of rebate denials or delays. This essentially shifts the financial responsibility from

manufacturers to providers and would create significant cash flow issues that many safety net providers are unable to absorb. In addition, PBMs and other third -party payors currently have the power to unfairly discriminate against 340B safety net providers by excluding them from networks, interfering with patient choice of provider, imposing onerous reporting requirements, or simply refusing to contract with 340B safety net providers. This bill would prevent such actions.

- Stakeholders Supporting: This bill has not yet been circulated for support.

Policy Idea: Strengthen and Reform the Rural Health Transformation Fund

- Status**:** New idea with no existing legislative text
- Description: This legislation would increase and extend funding for the Rural Health Transformation Fund and reform how funds are distributed to ensure federal dollars reach the rural hospitals and communities with the greatest need. The bill would require CMS and states to prioritize rural hospitals at risk of closure, hospitals with negative operating margins, and facilities serving high shares of Medicaid and low-income patients. It would also establish transparency requirements so the public can see which providers receive funding and how those dollars are used.
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The RHTF provides just $50 billion over five years, while rural communities are estimated to lose $137 billion in federal Medicaid funding over ten years under Republicans' reconciliation law – meaning the fund offsets only about 37% of those losses. The program is also poorly targeted: half of its funding is distributed equally among states with approved applications, meaning a state with only a handful of rural hospitals can receive the same amount from that portion of the fund as a state with dozens. Meanwhile, 44% of rural hospitals operate with negative margins, yet the law does not require states to prioritize financially distressed hospitals or even ensure that all funding reaches rural communities. Strengthening the RHTF and tying funding to demonstrated rural need would help ensure federal resources reach the hospitals most at risk of reducing services or closing their doors.

Existing Bill: H.R. 8261, Chronic Care Management Improvement Act of 2026 (Reps. Suzan DelBene and Mike Kelly)

- Status: Existing bill, passed out of the House Ways and Means committee in the 116th Congress.
- Description: This bill would eliminate Medicare Part B cost sharing for chronic care management services beginning January 1, 2027, covering 100 percent of the Medicare-approved amount and exempting these services from the Part B deductible.
- Cosponsors: 9 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Medicare covers chronic care management (CCM) for beneficiaries with two or more chronic conditions expected to last at least 12 months, providing ongoing care coordination and monitoring outside regular office visits. However, beneficiaries generally remain responsible for the Part B deductible and 20 percent coinsurance, which can discourage use of these services; research found that nearly 75 percent of Medicare fee-for-service beneficiaries were potentially eligible for CCM from 2015–2019, yet only 3.4 percent used the benefit in 2019, with cost sharing identified as a potential barrier. This bill would eliminate those out-of-pocket costs, helping more beneficiaries with multiple chronic conditions access consistent care coordination and better manage their health.

- Stakeholders Supporting: Alzheimer's Association, Alzheimer's Impact Movement and 39 other organizations sent a letter of support.

Existing Bill: H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025 (Reps. Richard Hudson and Scott Peters)

- Status: Existing bill. Congress has enacted several 1-year delays of the underlying PAMA cuts that the bill aims to permanently avert.
- Description: This bill would reform how Medicare sets payment rates for clinical diagnostic laboratory tests by using a large independent private-claims database for widely available tests and improving the accuracy and transparency of private-payor data used to calculate rates. It would also limit annual Medicare payment reductions for laboratory tests to 5 percent beginning in 2029, replacing the current 15 percent maximum reduction.
- Cosponsors: 115 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The Protecting Access to Medicare Act of 2014 (PAMA) established Medicare's market-based Clinical Laboratory Fee Schedule, using private-payor data reported by laboratories to set payment rates. Concerns have since emerged that the reporting system does not adequately represent the broader laboratory market and can produce substantial payment reductions. H.R. 5269 would update PAMA's methodology by using more representative claims data, improving payment transparency, and limiting future rate reductions to provide greater stability for laboratories and Medicare beneficiaries' access to diagnostic testing.
- Stakeholders Supporting: Alliance for Aging Research and more than 30 other organizations.

Existing Bill: H.R. 4752, Reducing Hereditary Cancer Act (Reps. Debbie Wasserman Schultz and Mariannette Miller-Meeks)

- Status: Existing bill
- Description: This bill would expand Medicare coverage for hereditary cancer genetic testing to individuals with a blood relative who has a hereditary cancer gene mutation or a personal or family history suggesting hereditary cancer risk. For individuals found to have a high-risk inherited mutation, it would also cover clinically recommended risk-reducing surgeries and more frequent cancer screenings, including mammograms, breast MRIs, colonoscopies, and prostate-specific antigen (PSA) testing.
- Cosponsors: 31 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Identifying inherited cancer mutations can allow patients to begin enhanced screening or preventive treatment before cancer develops, but current Medicare policy generally does not cover hereditary cancer genetic testing for individuals who have not already developed cancer, even when a family member has a known mutation. This leaves high-risk Medicare beneficiaries without coverage for testing that could identify their cancer risk early and inform preventive care. This bill would close that gap by covering evidence-based genetic testing and, for beneficiaries who test positive, the screenings and preventive surgeries recommended to reduce their risk of developing cancer.
- Stakeholders Supporting: National Comprehensive Cancer Network and 100+ other organizations sent a letter of support.

Existing Bill: H.R. 3947, Easy Enrollment in Health Care Act (Rep. Ami Bera)

- Status: Existing bill
- Description: This bill would streamline enrollment in Medicaid, CHIP, and ACA Marketplace coverage by allowing uninsured individuals to use information from their federal income tax returns to determine eligibility and enroll in health coverage. Beginning no later than 2028, consenting taxpayers and household members who qualify could be automatically enrolled in available zero-premium coverage, while the bill would also simplify eligibility determinations by allowing programs to use information already collected through programs such as SNAP and TANF.
- Cosponsors: 0 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Millions of Americans remain uninsured even though they already qualify for free or subsidized health coverage, in part because of complicated enrollment requirements and administrative barriers. An estimated 14.1 million uninsured Americans in 2024 were eligible for Medicaid or subsidized Marketplace coverage, representing more than half of the uninsured population. By allowing people to determine their eligibility while filing their taxes and automatically enroll in zero-premium coverage with their consent, this bill would reduce unnecessary paperwork and help connect eligible uninsured Americans with affordable health coverage they already qualify to receive.
- Stakeholders Supporting: Maryland Healthcare for All Coalition, American Heart Association, First Focus Campaign for Children, Families USA.

Existing Bill: H.R. 1428, Poverty Line Act of 2025 (Reps. Kevin Mullin and Brian Fitzpatrick)

- Status: Existing bill. Introduced for the first time in 2023 (118th Congress).
- Description: This bill would modernize the federal poverty line by calculating it based on current household expenses, including food, housing, child care, health care, transportation, clothing, telephone, and internet costs, while accounting for differences in cost of living across states and counties. It would update the measure at least annually and prohibit any state or county's poverty line from falling below its current inflation-adjusted level.
- Cosponsors: 15 (119th Congress)
- Committees of Jurisdiction: Education and Workforce; Oversight and Government Reform
- Justification: The cost of basic necessities has changed dramatically since the federal poverty line was created, but the measure still does not account for major expenses like health care. Households in the bottom fifth of incomes devote an average of 33.9% of their income to health care, more than twice the share for the highest-income households By incorporating these real-world expenses into the poverty measure, this bill would more accurately identify families struggling to afford basic needs and help ensure that people who need assistance can access it.
- Stakeholders Supporting: United Way Worldwide, Children's Defense Fund, Feeding Texas, Florida Impact to End Hunger.

Existing Bill: H.R. 5557, Mental Health Services for Students Act of 2025 (Reps. Andrea Salinas and Brian Fitzpatrick)

- Status: Existing bill, which passed the House in the 117th Congress as part of the Restoring Hope for Mental Health and Well-Being Act.

- Description: This bill would provide grants to schools and community partners to expand comprehensive, trauma-informed mental health services for children and adolescents, including screening for trauma, mental health disorders, and suicide risk. It would authorize $300 million annually for FY2027 and FY2028 and support partnerships between schools, mental health providers, health care professionals, families, and other community organizations.
- Cosponsors: 67 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: America continues to face a youth mental health crisis. In 2023, 40 percent of high school students reported persistent feelings of sadness or hopelessness, 20 percent seriously considered suicide, and nearly 10 percent attempted suicide. Schools are uniquely positioned to identify struggling students and connect them with care before problems escalate. This bill would expand access to school-based mental health services, strengthen partnerships with community providers, and help schools identify and respond to trauma, mental health disorders, and suicide risk.
- Stakeholders Supporting: National Council for Mental Wellbeing, National Alliance on Mental Illness, NACBHDD, American Psychological Association, American Foundation for Suicide Prevention, National Association of Social Workers, American Association of Child & Adolescent Psychiatry.

Existing Bill: H.R. 9847, Improving Coordination and Access to Resources Equitably (CARE) for Youth Act (Reps. Neal Dunn and Troy Carter)

- Status: Existing bill
- Description: This bill would require state Medicaid programs to cover otherwise eligible primary care and mental health or substance use disorder services when they are provided to a beneficiary on the same day at the same physician's office, Federally Qualified Health Center, rural health clinic, or other outpatient facility. The requirement would also apply to services delivered through telehealth.
- Cosponsors: 2 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Same-day billing restrictions in some state Medicaid programs can prevent providers from receiving reimbursement for physical and behavioral health services delivered at the same site on the same day, requiring patients to schedule multiple appointments and creating barriers to coordinated care. These restrictions can be particularly burdensome for children and families facing transportation, work, or other barriers to attending multiple appointments; as of September 2026, Medicaid covers over 35 million children. At least 37 states and D.C. already allow same-day billing, and this bill would establish this protection nationwide, improving access to integrated primary and behavioral health care for Medicaid beneficiaries.
- Stakeholders Supporting: Blue Cross Blue Shield, American Psychiatric Association, American Psychological Association, NAMI.

Existing Bill: H.R. 7118, Genomic Answers for Children's Health Act of 2026 (Reps. Scott Peters and Gus Bilirakis)

- Status: Existing bill
- Description: This bill would clarify that Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit covers whole genome and whole exome sequencing for children suspected of having a genetic disorder, rare disease, developmental disability, congenital anomaly, or other condition of unknown origin. It

would allow sequencing to be used as a first-tier diagnostic test in inpatient or outpatient settings, require separate Medicaid payment for the testing, and direct HHS to conduct outreach and assess barriers to access.

- Cosponsors: 24 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Children with rare or undiagnosed conditions can undergo lengthy diagnostic testing before the underlying cause of their illness is identified, delaying appropriate treatment and increasing health care costs. A 2024 multicenter study found that rapid whole genome sequencing produced a molecular diagnosis in 59 percent of critically ill children, with 80 percent of diagnosed patients experiencing changes in clinical management. Although Medicaid's EPSDT benefit requires states to cover medically necessary diagnostic services for children, whole genome and whole exome sequencing are not explicitly identified in federal Medicaid law, contributing to inconsistent state coverage, prior authorization requirements, and reimbursement barriers. This bill would clarify that genomic sequencing is a covered EPSDT service and require separate reimbursement, helping children with suspected genetic or rare diseases receive earlier diagnoses and more targeted care.
- Stakeholders Supporting: Rady Children's Health, ACLA, Avery's Hope, Jackson Laboratory, MI Rare Alliance.

Existing Bill: H.R. 8867, Planning for Long-term Aging Needs (PLAN) Act of 2026 (Reps. Thomas Suozzi and Aaron Bean)

- Status: Existing Bill
- Description: This bill would direct the Department of Health and Human Services to establish a nationwide public education initiative to help Americans plan for their future long-term care needs. The initiative would provide information and planning tools on long-term care risks, costs, financing, caregiving, home- and community-based services, and institutional care through media campaigns, online resources, and partnerships with state and local governments and community organizations.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Education and Workforce; Energy and Commerce
- Justification: Nearly 70 percent of Americans turning 65 are expected to need some form of long-term care, yet many families are not adequately prepared for these costs. Only 28 percent of adults ages 50–64 have set aside money for future long-term care, while significant confusion remains about coverage—23 percent of adults incorrectly believe Medicare would pay for long-term nursing home care. The PLAN Act would build on the National Clearinghouse for Long-Term Care Information, created under the Deficit Reduction Act of 2005, to give Americans accessible and objective information so they can better understand their options and plan for long-term care before they need it.
- Stakeholder Supporting: AARP, NCOA, LeadingAge, American College of Physicians, BPC, ACLI, Genworth, Nationwide, Northwestern Mutual, New York Life, Finseca, NAIFA, Empire State Association of Assisted Living.

Existing Bill: H.R. 9432, LIFT the BAR Act (Rep. Pramila Jayapal)

- Status: Existing bill. This bill was first introduced in the 117th Congress, but has never advanced to floor vote in either the House or Senate.
- Description: This bill would eliminate the arbitrary five-year waiting period lawfully present immigrants must undergo before receiving access to healthcare, social services, and certain housing assistance programs. The bill also responds to additional restrictions

from H.R. 1, which would render certain lawfully present immigrants ineligible for services in perpetuity.
- Cosponsors: 101 (119th Congress)
- Committee(s) of Jurisdiction: Ways & Means, Agriculture, Education & Workforce, Energy & Commerce, Judiciary.
- Justification: The five year waiting period for lawfully present immigrants is a harmful barrier to services, raising fear and confusion among immigrant communities and creating a chilling effect that reduces participation in essential social safety net services.
- Stakeholders Supporting: Center for Law and Social Policy, National Immigration Law Center, Protecting Immigrant Families Coalition.

First year:

Existing Bill: H.R. 1096, Helping Out Patients for Emotional (HOPE) and Mental Wellbeing Act (Rep. Andrea Salinas)
- Status: Existing bill
- Description: This bill would require Medicare, Medicare Advantage, and Medicaid to cover an individual's first three primary care visits each year without cost sharing, beginning in 2026. Primary care visits would include nonspecialty medical care, outpatient mental and behavioral health services, and care coordination for the prevention, diagnosis, treatment, or management of physical, mental, or behavioral health conditions.
- Cosponsors: 8 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Primary care can help prevent disease, manage chronic conditions, and identify physical and behavioral health problems before they become more serious, but out-of-pocket costs can discourage patients from seeking routine care. Medicare Part B generally requires beneficiaries to pay 20 percent coinsurance after meeting the annual deductible for physician and other outpatient services, while Medicaid cost-sharing requirements vary by state and beneficiary. Although certain preventive services are already exempt from Medicare cost sharing, routine primary care visits generally are not. This bill would eliminate cost sharing for the first three primary care visits each year under Medicare and Medicaid, reducing financial barriers to routine physical and behavioral health care.
- Stakeholders Supporting: Bridgeway Recovery Services, National Alliance on Mental Illness, New Narrative, O4AD.

Existing Bill: H.R. 5509, Safe Step Act (Reps. Rick Allen and Lucy McBath)
- Status: Existing bill
- Description: This bill would require employer-sponsored group health plans regulated under the Employee Retirement Income Security Act (ERISA) that use prescription drug step therapy to establish a clear and transparent process for patients or prescribers to request exceptions. Exceptions would be available when required treatments have already failed, are contraindicated or likely to cause harm, could delay effective treatment and worsen a condition, interfere with daily functioning, or when a patient is already stable on the prescribed medication. Plans would generally have 72 hours to respond, or 24 hours for urgent requests, and an approved exception would remain in effect for at least one year.
- Cosponsors: 155 (119th Congress)

- Committees of Jurisdiction: Education and Workforce
- Justification: Step therapy, or "fail first," allows health plans to require patients to try preferred medications before covering the treatment prescribed by their provider, which can delay access to effective care. Although dozens of states have enacted step therapy protections, state insurance laws generally cannot regulate self-funded employer health plans governed by ERISA, leaving a significant gap in protections for workers with employer-sponsored coverage. Research has also found that step therapy protocols can be more restrictive than clinical guidelines and can delay or disrupt appropriate treatment. This bill would establish a federal exceptions process for ERISA-regulated plans, allowing patients to bypass step therapy when medically appropriate while preserving insurers' ability to use step therapy in other circumstances.
- Stakeholders Supporting: National Psoriasis Foundation, Crohn's & Colitis Foundation.

Existing Bill: H.R. 3907, Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act of 2025 (Rep. Kathy Castor)

- Status: Existing bill
- Description: This bill would strengthen the Affordable Care Act's Navigator program by requiring federally facilitated Marketplaces to fund at least one community and consumer-focused nonprofit in each state, expand assistance with Medicaid and CHIP, and require Navigators to maintain an in-state physical presence for in-person assistance. It would also provide $100 million annually beginning in FY2026 for Navigator grants in federally facilitated Marketplaces.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Navigators provide free, year-round assistance to help consumers, particularly those in underserved communities, understand their coverage options and enroll in ACA Marketplace, Medicaid, and CHIP coverage. In February 2025, CMS cut annual federal Navigator funding from approximately $100 million to $10 million, a 90 percent reduction that could significantly reduce the availability of enrollment assistance. This bill would restore stable funding at $100 million annually while strengthening requirements for in-person assistance, community-based organizations, and public education to ensure consumers can access the help they need to obtain and maintain health coverage.
- Stakeholders Supporting: American Cancer Society Cancer Action Network, Community Catalyst.

Existing Bill: H.R. 6455, Health Insurance Premium Fairness Act of 2025 (Rep. Mike Levin)

- Status: Existing bill
- Description: This bill would modify the Affordable Care Act's premium tax credit to account for Medicare premiums paid by members of the same household, including premiums for Medicare Parts A, B, C, and D and Medigap coverage. This would increase premium tax credits for eligible households in which some family members are enrolled in Medicare while others remain enrolled in an ACA Marketplace plan.
- Cosponsors: 3 (119th Congress)
- Committees of Jurisdiction: Ways and Means
- Justification: Under the ACA, premium tax credits limit how much eligible households are expected to contribute toward Marketplace coverage based on household income. However, when one spouse becomes eligible for Medicare while another remains on an

ACA plan, the formula does not account for the Medicare premiums the household must also pay, potentially increasing the family's total health insurance costs by thousands of dollars per year. This bill would close this gap by counting Medicare premiums toward a household's required contribution, helping mixed Medicare-Marketplace households afford their health coverage.

- Stakeholders Supporting: Protect Our Care, Alliance for Retired Americans, National Committee to Preserve Social Security & Medicare, Social Security Works, Justice in Aging, Center for Medicare Advocacy, and Third Way.

Existing Bill: H.R. 9831, Medicaid Dental Benefit Act of 2026 (Rep. Nanette Diaz Barragán)

- Status: Existing bill
- Description: This bill would require state Medicaid programs to cover comprehensive dental and oral health services for adults beginning in 2027, including preventive and restorative care, dentures, implants, treatment for oral disease and pain, and emergency dental care. It would provide states with 100 percent federal funding for newly required services for three years, establish national oral health quality measures, and support outreach to connect Medicaid beneficiaries with dental care.
- Cosponsors: 21 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Unlike dental coverage for children, adult dental services are optional under Medicaid, leaving coverage dependent on where a beneficiary lives and allowing states to limit or eliminate benefits. Poor oral health can contribute to pain, difficulty eating and working, and preventable emergency department visits, while low-income adults face particularly significant barriers to obtaining dental care. This bill would establish comprehensive adult dental care as a mandatory Medicaid benefit nationwide while providing 100% federal financing for newly required services for the first three years, helping states expand access without immediately assuming the additional cost.
- Stakeholders Supporting: American Dental Association and 14 other organizations support.

Existing Bill: H.R. 9833, Ensuring Kids Have Access to Medically Necessary Dental Care Act (Rep. Nanette Diaz Barragán)

- Status: Existing bill
- Description: This bill would prohibit state CHIP programs from imposing annual or lifetime dollar limits on dental benefits for eligible children and, in states providing CHIP pregnancy-related assistance, eligible pregnant women. It would also require states to provide dental-only supplemental, or "wraparound," CHIP coverage for eligible children who have other health insurance that does not include adequate dental coverage.
- Cosponsors: 14 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Although CHIP is required to provide dental coverage for children, states have flexibility in designing their benefits, and some programs can impose dollar limits that leave families responsible for medically necessary care once those limits are reached. Access to dental care also remains a challenge: in the 2023 Medicaid and CHIP Child Core Set reporting cycle, the median state reported that only about 45 percent of enrolled children received a comprehensive or periodic oral evaluation. Untreated dental problems can cause pain and infection and interfere with a child's overall health and development. This bill would prohibit state CHIP programs from imposing annual or lifetime dollar

limits on dental benefits for eligible children and, in states providing CHIP pregnancy-related assistance, eligible pregnant women.
- Stakeholders Supporting: American Dental Association and 15 other organizations support.

Existing Bill: H.R. 8201, Expanding Community Access to Health Services Act (Rep. Susie Lee)

- Status: Existing bill, which passed unanimously out of the House Energy and Commerce Subcommittee on Health in the 119th Congress as a part of the Lower Costs, More Transparency Act (H.R. 9393).
- Description: This bill would require federally funded community health centers to provide behavioral and mental health and substance use disorder services as part of their required primary health services. It would provide $700 million annually from FY2027 through FY2031 to help health centers provide these services.
- Cosponsors: 2 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Community health centers serve more than 32 million patients nationwide, many of whom live in rural and medically underserved communities and face barriers to accessing behavioral health care. Mental health and substance use disorder services are currently considered optional additional services under Section 330 of the Public Health Service Act rather than required primary health services. This bill would make behavioral health care a required service at community health centers and provide dedicated federal funding to expand access, helping patients receive mental and physical health care through the same trusted community providers.
- Stakeholders Supporting: American Medical Association.

Policy Idea: Double Funding for Community Health Centers

- Status: No existing legislative text
- Description: This bill would double funding for community health centers.
- Expected Committee(s) of Jurisdiction: Energy and Commerce
- Justification: More than 50 million Americans rely on community health centers (CHCs), or one in seven people, yet CHCs account for only one percent of total U.S. health care spending. CHCs serve constituents in nearly every Congressional district in the country and are a proven model for expanding access and reducing strain on the broader health system, saving our healthcare system billions of dollars annually by reducing costly emergency room and specialty care. While community health centers have received consistent federal funding year over year, when adjusting for inflation, CHC funding has actually decreased by 27 percent since 2015, despite an increase in the number of patients served. Now, due to the passage of H.R. 1, CHCs are estimated to see as many as 4.2 million new uninsured patients by 2034, bringing the total number of uninsured seeking care at CHCs to 10 million. Taken together, this underscores the urgent need to dramatically increase funding for CHCs so they can continue to provide high-quality, affordable, and accessible care to tens of millions of Americans.
- Stakeholders Supporting: National Association for Community Health Centers.

Existing Bill: H.R. 2082, Well-Being Insurance for Seniors to be at Home Act (WISH) Act (Reps. Thomas Suozzi and John Moolenaar)

- Status: Existing bill

- Description: This bill would establish a new federal long-term care insurance benefit through Social Security for retirement-age individuals who develop a serious, continuing functional disability. Benefits would begin after a waiting period—starting at 12 months for lower-income individuals and increasing for higher earners—and would be based on the national median cost of six hours per day of paid personal assistance. The bill would also establish a Federal Long-Term Care Insurance Trust Fund and provide education to help Americans plan for future long-term care needs.
- Cosponsors: 5 (119th Congress)
- Committees of Jurisdiction: Ways and Means
- Justification: More than half of Americans entering old age are expected to need long-term services and supports (LTSS), at an average cost of approximately $298,000 per person, with more than half of those costs paid out of pocket. Meanwhile, only about 11 percent of American adults have private LTSS coverage, forcing many middle-income families to exhaust their savings before becoming eligible for Medicaid. This bill would create federal insurance against especially prolonged and financially catastrophic long-term care needs, helping seniors remain in their communities, protecting families from severe financial burdens, supporting the direct-care workforce, and reducing reliance on Medicaid.
- Stakeholders Supporting: National Council on Aging, LeadingAge, American College of Physicians, American Geriatrics Society, Genworth Financial, National Association of Insurance and Financial Advisors.

V: Strengthening Women's, Maternal, and Reproductive Health

First 100 hours:

Existing Bill: H.R. 999, Right to Contraception Act (Rep. Lizzie Fletcher)

- Status: Existing bill. Received 203 signatures on a discharge petition in the 119th Congress. This bill also passed the House in the 117th Congress.
- Description: This bill would create a federal right for people to obtain contraceptives, and establish a right for health care providers to provide contraceptives and information related to contraception. It would also allow the Department of Justice, providers, and patients to go to court to enforce these rights.
- Cosponsors: 210 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce
- Justification: In the post-Roe landscape, there is real confusion over whether states can restrict some forms of contraception. Seven states allow pharmacists to refuse to fill birth control prescriptions based on their personal beliefs. Twenty-four states restrict minors' ability to obtain contraception without parental consent. In Texas, Title X-funded clinics cannot provide confidential birth control to minors without parental consent. This bill guarantees the right to obtain and use contraception, protects providers' right to offer it, and lets both the Department of Justice and individuals sue to enforce it. Contraception has overwhelming public support, making this one of the clearest cases where Democrats are aligned with the vast majority of Americans.
- Stakeholders Supporting: The American College of Obstetricians and Gynecologists and 24+ organizations.

Existing Bill: H.R. 7973, Momnibus Act (Rep. Lauren Underwood)

- Status: Existing bill; All reconciliation-eligible provisions passed the House in the 117th Congress as part of the Build Back Better Act.
- Description: A package of 14 individual bills geared toward ending preventable maternal death in America by ending maternal health disparities, growing and diversifying the perinatal health workforce, expanding access to maternal mental health and substance use care, lowering health care costs, investing in technological solutions, closing research gaps, improving data collection, and providing direct federal funding for local community-based organizations that improve maternal health outcomes.
- Cosponsors: 213 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Education and Workforce; Veterans' Affairs; Natural Resources; Judiciary
- Justification: The United States has the highest maternal mortality rate of any high-income country. Since the pandemic, this crisis has only worsened. However, more than 80 percent of America's maternal deaths are preventable. The Momnibus is a comprehensive package designed to address adverse maternal health outcomes, from the perinatal workforce and maternal mental health to the social and environmental conditions that shape outcomes, with particular attention to the Black mothers at highest risk.
- Stakeholders Supporting: More than 330 organizations, including A Better Balance, ACA Consumer Advocacy, American Academy of Family Physicians, American Academy of Nursing, and many more organizations

Existing Bill: H.R. 6303, CARE for Moms Act (Rep. Robin Kelly)

- Status: Existing bill; Provisions from this bill were signed into law in the 117th Congress, and the provision to require continuous eligibility for Medicaid and CHIP for postpartum women was included in the Build Back Better Act, which passed the House in the 116th Congress.
- Description: This bill would reduce preventable maternal deaths and racial disparities. It funds state perinatal quality collaboratives, creates Regional Centers of Excellence to address implicit bias in maternal care, expands and diversifies the doula workforce, addresses oral health, requires state Medicaid and CHIP programs to provide 12 months of continuous eligibility to postpartum women, and pilots rural obstetric mobile health units to reach maternity care deserts.
- Cosponsors: 11 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Education and Workforce; Ways and Means
- Justification: Access to maternal care remains out of reach for many women, and unequal for many more. This bill funds rural obstetric mobile health units to bring prenatal and postpartum care into the one in three U.S. counties that have no birthing facility or obstetric provider, and it establishes Regional Centers of Excellence to confront the implicit bias behind the racial gap in maternal outcomes. The bill strengthens the frontline of maternal care by growing and diversifying the doula workforce and supports state perinatal quality collaboratives that spread proven clinical protocols hospital to hospital.
- Stakeholders Supporting: National Partnership for Women & Families

First 100 days:

Existing Bill: H.R. 3762, Supporting Healthy Moms and Babies Act (Rep. Jared Golden)

- Status: Existing bill
- Description: This bill eliminates out-of-pocket costs for prenatal and postnatal care by prohibiting private insurance carriers from imposing cost sharing.
- Cosponsors: 29 (119th)
- Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means; Education and Workforce
- Justification: While Medicaid enrollees do not pay for maternity care, women and families who receive health insurance through their employers may pay thousands of dollars to have a baby. The United States ranks amongst the most expensive countries in which to give birth, averaging a total of $20,000 per birth, with out-of-pocket expenses averaging nearly $3,000 for patients with insurance. As a result, childbirth is associated with an increased likelihood of new medical debt, and current debt and anticipated medical costs are linked to worse mental health and higher levels of stress and depression. This legislation would ensure that individuals can focus on growing their families and taking care of their new babies, without worrying about debt or forgoing needed care.
- Stakeholders Supporting: American College of Obstetricians and Gynecologists and 8 other organizations.

Existing Bill: H.R. 7227, Mental Health and Making Access More Affordable (MAMA) Act of 2026 (Rep. Gwen Moore)

- Status: Existing bill

- Description: This bill would require commercial, FEHB, and state and local government insurance plans that offer services related to mental health and substance abuse to offer such services, including telehealth, with no cost sharing from the onset of prenatal care through one-year postpartum. This bill would also provide continuity of care protections and ensure that individuals do not lose coverage or access to care when plan networks change during the prenatal or postpartum periods.
- Cosponsors: 25 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Education and Workforce; Ways and Means; Oversight and Government Reform
- Justification: Maternal mental health is a crisis within a crisis. Maternal mental health conditions impact at least one in five new moms and are now considered the leading cause of pregnancy-related deaths. However, the burden of untreated and undiagnosed maternal mental health conditions is felt most by people of color and low-income communities. Those living in poverty suffer from postpartum depression at double the rate of those who do not live in poverty. Nearly 40 percent of new mothers of color have postpartum depression, almost twice the rate of white mothers. Improving access to maternal mental health care is central to addressing the nation's maternal mortality crisis.
- Stakeholders Supporting: March of Dimes and 17 other organizations.

Existing Bill: H.R. 3942, Keeping Obstetrics Local Act (Rep. Suzanne Bonamici)

- Status: Existing bill
- Description: The bill would increase Medicaid payment rates for labor and delivery services for eligible rural and high-need urban hospitals, provide "standby" payments to cover the costs of staffing and maintaining an obstetrics unit at low-volume hospitals, create low-volume payment adjustments for labor and delivery services at hospitals with low birth volumes, and require all states to provide postpartum coverage for women in Medicaid for 12 months.
- Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Currently, one in three U.S. counties are considered maternity care deserts, with no birthing hospital, birth center, or obstetric clinician, forcing pregnant women to drive hours to give birth. In addition, more than half of U.S. counties lack a hospital with labor and delivery services, and the problem is only accelerating as rural hospitals close. The cause is largely financial—Medicaid pays for a majority of rural births but reimburses labor and delivery below cost, and low-volume hospitals cannot sustain a unit on so few deliveries per year. This bill raises Medicaid payment rates for labor and delivery at eligible rural and high-need hospitals and provides payments to cover the fixed cost of keeping these units staffed even when birth volume is low.
- Stakeholders Supporting: American College of Nurse-Midwives, America's Essential Hospitals, Catholic Health Association, Community Catalyst, Families USA, Hospital Association of Oregon, March of Dimes, National Partnership for Women & Families, National Rural Health Association, the Oregon Perinatal Collaborative, American College of Obstetricians and Gynecologists.

Existing Bill: H.R. 2762, Expanding Access to Family Planning Act (Rep. Sharice Davids)

- Status: Existing bill
- Description: This bill would guarantee stable, annual funding for Title X and protect providers who provide Title X services from discrimination.
- Cosponsors: 14 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce

- Justification: Title X is the country's only federal program dedicated to family planning and preventative care, including birth control, cancer screening, and STI testing. For more than fifty years, it has served people regardless of income and has reached roughly four million patients a year. The Trump administration's attacks on the Title X program have impacted 879 health clinics and could result in 834,000 patients losing access to care. This impact is disproportionately felt by low-income and rural communities and communities of color. This bill establishes a dedicated Title X fund with mandatory funding of $512 million per year, plus $50 million a year for clinic construction and renovation, thus preserving access to critical family planning services for millions of Americans.
- Stakeholders Supporting: Guttmacher Institute and 8 other organizations.

Existing Bill: H.R. 7417, the Women's Heart Health Expansion Act (Rep. Joyce Beatty)

- Status: Existing bill
- Description: This bill would reauthorize and expand access to the CDC's Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program. This bill would help more women receive screenings, lifestyle support, and early interventions to reduce heart disease and stroke risk.
- Cosponsors: 29 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce
- Justification: Cardiovascular disease is responsible for one in three deaths among women, making it the leading cause of death among women in the U.S. Despite this, many women remain underdiagnosed and undertreated. Black women are particularly underserved, with cardiovascular disease impacting more than half of all Black women. The CDC's WISEWOMAN Program has provided free screenings, risk assessments, and lifestyle intervention services to low-income, uninsured, and underinsured women for over 30 years. However, the program currently only operates in a limited number of states and Tribal organizations, restricting access for women at highest risk of heart disease. This bill would expand eligibility, allow more community-based providers to participate in the program, and authorize $250 million over five years to increase screenings, education, and early intervention. Expanding access to screenings and early interventions saves lives, and no woman should lose their life because existing interventions were inaccessible.
- Stakeholders Supporting: American Heart Association, Women's Heart Alliance, The Association of Black Cardiologists, The Adult Congenital Heart Association, WomenHeart, the American College of Cardiology, and Heart Valve Voice-US.

Existing Bill: H.R. 8729, No-Cost Breast Examinations in Medicaid Act of 2026 (Rep. Greg Landsman)

- Status: Existing bill
- Description: This bill would require Medicaid to cover diagnostic and supplemental breast examinations without cost sharing, including medically necessary diagnostic mammography, breast MRI, and breast ultrasound used to investigate abnormalities or screen individuals at elevated risk. It would also make U.S. Preventive Services Task Force-recommended screening mammography a mandatory Medicaid benefit, with the changes taking effect one year after enactment.
- Cosponsors: 1
- Committees of Jurisdiction: Energy and Commerce

- Justification: Early detection of breast cancer can improve treatment options and outcomes, but current federal protections for no-cost breast cancer screening do not uniformly extend to diagnostic and supplemental imaging needed after an abnormal mammogram or for individuals at elevated risk. Medicaid cost sharing and coverage rules also vary by state, meaning beneficiaries can face different financial barriers depending on where they live. This bill would establish a nationwide Medicaid requirement for no-cost diagnostic and supplemental breast examinations and make recommended screening mammography a mandatory benefit, helping ensure that cost does not prevent beneficiaries from completing medically necessary follow-up or high-risk screening.
- Stakeholders Supporting Susan G. Komen.

Existing Bill: H.R. 9090, Advancing Menopause Care and Mid-Life Women's Health Act (Rep. Yvette Clarke)

- Status: Existing bill
- Description: A bill that boosts federal research on menopause and would—for the first time—coordinate the federal government's existing programs related to menopause and mid-life women's health. The bill would better address menopause and mid-life women's health issues by strengthening and expanding federal research, health care workforce training, awareness and education efforts, and public health promotion and prevention activities.
- Cosponsors: 7 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Seventy-five million women are in perimenopause, menopause, or post-menopause right now in the U.S. Despite the fact that half the population in the U.S. will eventually experience menopause, menopause research has long been underinvested in and overlooked. To date, there are few federally-funded clinical trials on menopause and menopausal hormone therapy and very little menopause education for doctors—only 30 percent of U.S. OB-GYN residency programs offer a formal menopause curriculum, and 80 percent of OB-GYN residents admit to being ill-prepared to discuss menopause. This bill expands long overdue investments in federal research into menopause and evidence-based approaches to better support patients through the menopausal transition.
- Stakeholders Supporting: American College of Obstetricians and Gynecologists and 7 other organizations.

First year:

Existing Bill: H.R. 9941, Right to IVF Act (Rep. Lori Trahan)

- Status: Existing bill
- Description: This bill would create a federal statutory right for health care providers to provide IVF and intrauterine insemination (IUI) care, and corresponding right for their patients to receive that care, free from medically unnecessary restrictions. The bill would also require insurance coverage for IVF and IUI under Medicare and Medicaid; in the ACA marketplace; and for veterans, servicemembers and federal employees.
- Cosponsors: 125 (119th Congress)
- Committee(s) of Jurisdiction: Energy and Commerce; Veterans' Affairs; Armed Services; Education and Workforce; Ways and Means; Oversight and Government Reform.
- Justification: IVF is broadly popular and access is increasingly precarious. Attacks on IVF have proliferated since the overturning of Roe v. Wade, and include policy proposals that would grant embryos legal rights, disregard best medical practices, stigmatize IVF,

jeopardize patients' rights, and discriminate against LGBTQ+ families and single and unmarried people. This bill would provide a nationwide statutory right to provide and receive IVF, IUI, and other assisted reproductive technology, preempting more restrictive state laws. The bill would require coverage across every major insurer so families are not priced out of treatment that routinely costs tens of thousands of dollars per cycle. No one should be denied the chance to build a family simply because fertility care is unaffordable.

- Stakeholders Supporting: American Society for Reproductive Medicine and 6 other organizations.

VI: Investing in the Health Care Workforce and Care Workers

First 100 hours:

Existing Bill: H.R. 4731, Resident Physician Shortage Reduction Act of 2025 (Reps. Terri Sewell and Brian Fitzpatrick)

- Status: Existing bill. Since 2021, Congress has added 1,200 additional GME slots in the Consolidated Appropriations Act of 2021 (1,000) and 2023 (200) since residency caps were established in 1996.
- Description: This bill would expand Medicare-supported graduate medical education by adding 14,000 residency positions, with 2,000 new positions distributed annually from FY2026 through FY2032. It would prioritize portions of these positions for rural and physician-shortage areas and other qualifying hospitals, while also requiring a federal study on strategies to increase diversity in the health professional workforce.
- Cosponsors: 131 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: The United States is facing a growing physician shortage, with projections estimating a shortage of more than 141,000 physicians by 2038 as the population grows and ages and more physicians approach retirement. These shortages are particularly concerning in rural and medically underserved communities, where patients already face greater barriers to accessing timely care. H.R. 4731 would help address this shortage by adding 14,000 Medicare-supported residency positions over seven years, including dedicated positions for rural hospitals and hospitals serving health professional shortage areas. Congress should invest in training more physicians to ensure that Americans, regardless of where they live, have access to the doctors and health care they need.
- Stakeholders Supporting: Association of American Medical Colleges and American Medical Association.

Existing Bill: H.R. 3415, Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2025 (Rep. Janice Schakowsky)

- Status: Existing bill
- Description: This bill would establish federal minimum registered nurse-to-patient staffing ratios for hospitals, with specific ratios based on the type of hospital unit and level of care. It would also require hospitals to develop staffing plans based on patient needs, prohibit mandatory overtime to meet the required ratios, and provide protections for nurses who report unsafe staffing or refuse assignments that could jeopardize patient safety.
- Cosponsors: 49 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Nurses are essential to providing safe, high-quality hospital care, but inadequate staffing can leave nurses responsible for more patients than they can safely manage. Research has found that each additional patient added to a nurse's workload was associated with a 7 percent increase in the odds of patient death within 30 days, while higher workloads were also associated with greater nurse burnout and job dissatisfaction. This bill would establish minimum nurse-to-patient ratios to protect patients from unsafe staffing levels while improving working conditions and helping hospitals retain experienced nurses at the bedside.

- Stakeholders Supporting: National Nurses United, California Nurses Association/National Nurses Organizing Committee, Alliance for Retired Americans, AFT, SEIU Healthcare, AFSCME.

First 100 days:

Existing Bill: H.R. 3885, Community Training, Education, and Access for Medical Students (TEAMS) Act of 2025 (Reps. Carol Miller and Marc Veasey)

- Status: Existing bill
- Description: This bill would establish a federal grant program to expand community-based clinical training opportunities for medical students in rural areas and medically underserved communities. Grants of one to five years would support partnerships between medical schools and rural health clinics, federally qualified health centers, or other health care facilities in underserved communities, with the goal of encouraging sustainable physician practice in high-need areas.
- Cosponsors: 33 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Rural and medically underserved communities continue to face persistent physician shortages and difficulty recruiting and retaining doctors. Existing HRSA programs support rural medical education, but the Medical Student Education Program is limited to eligible public medical schools in states with the greatest projected primary care shortages, while other federal programs focus primarily on residency training. Research has shown the potential impact of earlier training in underserved area. For example, graduates of one U.S. medical education program were more likely to practice in a rural area and to care for medically underserved populations than other graduates. This bill would expand community-based clinical rotations through partnerships between medical schools and rural or underserved health facilities, helping strengthen the pipeline of physicians who may ultimately practice in high-need communities.
- Stakeholders Supporting: American Association of Colleges of Osteopathic Medicine, the West Virginia School of Osteopathic Medicine, the Association of American Medical Colleges, and the National Rural Health Association.

Existing Bill: H.R. 6137, Recognizing the Role of Direct Support Professionals Act (Reps. Brian Fitzpatrick and Joseph Morelle)

- Status: Existing bill; In the 118th Congress, this bill passed out of the House Committee on Education and the Workforce and passed the Senate by unanimous consent. In the 119th Congress, it passed out of the Senate Committee on Homeland Security and Governmental Affairs.
- Description: This bill would require the OMB to consider establishing a separate Standard Occupational Classification (SOC) code for direct support professionals (DSPs) as a health care support occupation during the next revision of the federal classification system. If OMB declines to establish the code, it would be required to report to Congress and explain its decision.
- Cosponsors: 38 (119th Congress)
- Committees of Jurisdiction: Education and Workforce
- Justification: Direct support professionals provide essential daily care that allows people with intellectual and developmental disabilities to live and participate in their communities, but the federal SOC system does not currently recognize DSPs as a distinct occupation, instead grouping much of this workforce with other occupations such as

home health and personal care aides. The DSP workforce also faces significant recruitment and retention challenges, with a national turnover ratio of 39 percent according to 2023 National Core Indicators data. Establishing a distinct occupational code would allow federal and state governments to more accurately track DSP employment, wages, shortages, and turnover, providing better data to develop policies addressing persistent workforce shortages.
- Stakeholders Supporting: American Network of Community Options and Resources.

Existing Bill: H.R. 8109, Save Struggling Hospitals Act (Reps. Terri Sewell and David Kustoff)

- Status: Existing bill
- Description: This bill would codify the Medicare low-wage index hospital policy, increasing Medicare reimbursement for hospitals with area wage indexes below the 25th percentile. A qualifying hospital's wage index would be increased by half the difference between its otherwise applicable wage index and the 25th-percentile wage index, while maintaining budget neutrality and protections against significant payment reductions for other hospitals.
- Cosponsors: 5 (119th Congress)
- Committees of Jurisdiction: Ways and Means
- Justification: Medicare's area wage index can disadvantage rural and inner-city hospitals in lower-wage areas, where lower reimbursement limits hospitals' ability to offer competitive wages and can further depress future Medicare payments. These pressures come as nearly one-third of rural hospitals are reportedly at risk of closure. CMS established the low-wage index hospital policy in 2019 to provide relief to hospitals in the lowest quartile, but a 2024 court ruling found that CMS lacked statutory authority for the policy, leading CMS to terminate it and creating potential repayment risks for affected hospitals. This bill would provide a permanent statutory solution by codifying the policy, stabilizing reimbursement and helping financially vulnerable hospitals maintain their workforce and access to care.
- Stakeholders Supporting: American Medical Association, American Economic Liberties Project, National Rural Health Association, National Association of Rural Health Clinics, Alabama Hospital Association, Arkansas Hospital Association, Georgia Hospital Association, and 25 other organizations.

Existing Bill: H.R. 8540, HCBS Access Act (Rep. Debbie Dingell)

- Status: Existing bill; The Better Care Better Jobs Act, which passed the House as part of the Build Back Better Act in the 117th Congress, informed the development of this bill.
- Description: This bill would make HCBS a mandatory Medicaid benefit, expand eligibility, and provide states with 100 percent federal Medicaid funding for HCBS if they take steps to expand access, support family caregivers, and strengthen the direct care workforce. It would also invest in workforce recruitment and training, make the Money Follows the Person program and spousal-impoverishment protections permanent, and eliminate Medicaid estate recovery requirements.
- Cosponsors: 14 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Education and Workforce; Oversight and Government Reform; Ways and Means
- Justification: Medicaid is the nation's primary payer for long-term care, but most HCBS remain optional benefits that states can limit through waiver programs, leaving more than 600,000 people on waiting or interest lists in 2025. The Supreme Court's 1999 decision in

Olmstead v. L.C., interpreting the Americans with Disabilities Act, established that unjustified institutionalization of people with disabilities constitutes discrimination and affirmed their right to receive services in integrated community settings when appropriate. This bill would build on that principle by making HCBS a mandatory Medicaid benefit, reducing waiting lists, and strengthening the workforce needed to allow older adults and people with disabilities to receive care in their homes and communities.

- Stakeholders Supporting: ASFCME, Justice in Aging, the National Health Law Program, SEIU, Little Lobbyists, Partnership for Inclusive Disaster Strategies, Partnership for Inclusive Disaster Strategies, ANCOR, ADAPT, and PHI.

Existing Bill: H.R.___, Workforce Mobility Act of 2026 (Reps. Scott Peters and Thomas Kean)

- Status: Existing bill to be introduced
- Description: This bill would ban the use of noncompete agreements, except in necessary and limited circumstances such as the dissolution of a partnership or the sale of a business. In addition, the bill requires employers to notify their employees of the limitation on noncompete agreements.
- Cosponsors: N/A
- Committees of Jurisdiction:
- Justification: Noncompete agreements are employment provisions that prohibit individuals from joining a competing firm or starting a new venture in the same field after leaving their employer. These agreements currently cover an estimated 20 percent of all U.S. workers, both highly-skilled and low-wage workers alike. Noncompete agreements are inherently predatory, preventing workers from taking a better job, becoming independently employed, and negotiating better pay and benefits. They also suppress market competition and innovation by preventing the entry or expansion of competing firms. While the overuse of noncompete agreements impacts sectors across the U.S. economy, employers in the health care sector are some of the worst offenders. It is estimated that up to 45 percent of physicians were subject to such agreements in 2023. Noncompete agreements also impact patients. The FTC found that noncompete agreements result in increased health care costs for consumers and a ban on their use would reduce health care costs by up to $194 billion over 10 years. This bill would allow health care workers to find career opportunities that support their professional goals and community needs, and address the rising costs of health care.
- Stakeholders Supporting: AFL-CIO, American Academy of Emergency Medicine, American Academy of Family Physicians, American College of Emergency Physicians, American Compass, Center for American Entrepreneurship, Economic Innovation Group, Engine, Insights Association, National Employment Law Project, Niskanen Center, Open Markets Institute, R Street Institute, Small Business Majority, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, Steam Logistics, Teamsters, Third Way, Transport Workers Union, Veeva Systems, United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry, Y Combinator, the Bull Moose Project, SAG-AFTRA, and United Steel Workers.

Existing Bill: H.R. 8100, Safe Staffing Saves Lives Act (Rep. Lloyd Doggett)

- Status: Existing bill
- Description: This bill would establish minimum staffing requirements for Medicare- and Medicaid-certified nursing homes, requiring at least 4.1 hours of nursing care per resident per day and a registered nurse onsite 24 hours a day, seven days a week beginning in

2029. It would also strengthen enforcement against facilities that fail to meet the standards and require residents and their families to be notified when a facility is out of compliance.

- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: Nursing home residents are often older adults with complex medical needs who depend on nursing staff for medications, mobility, hygiene, and other essential care, making adequate staffing critical to their health and safety. Higher staffing levels are associated with better resident outcomes, and nursing homes providing roughly 4.5 to 4.8 hours of nursing care per resident per day performed better on measures including feeding assistance, incontinence care, exercise, and repositioning. This bill would establish enforceable minimum staffing standards to ensure nursing home residents receive adequate daily care and have access to a registered nurse around the clock. Nursing home residents and their families deserve confidence that facilities receiving Medicare and Medicaid dollars have enough qualified staff to provide safe, high-quality care.
- Stakeholders Supporting: AARP, AFL-CIO, SEIU, AFSCME, National Consumer Voice, Justice in Aging, Public Citizen.

First year:

Existing Bill: H.R.9140, MEDIC Careers Act of 2026 (Reps. Maxine Dexter and Abraham Hamadeh)

- Status: Existing bill; A provision from this bill passed the House in the FY2027 NDAA in the 119th Congress.
- Description: This bill directs the Secretaries of Defense and Homeland Security to develop recommendations for helping military medics transition into civilian healthcare jobs as certified nurse aids, LPNs, and medical assistants. It requires them to identify barriers in translating military medical credentials into civilian ones (credential standardization, bridge programs, SkillBridge access, Transition Assistance Program information) and to report recommendations and an implementation plan to Congress within 180 days.
- Cosponsors: 3 (119th Congress)
- Committees of Jurisdiction: Armed Services
- Justification: Despite the health care workforce shortage, military medics routinely find their military credentials do not translate to civilian licenses, forcing them to start over despite already having the training and experience. The bill targets that directly by building the credential recognition pathways and bridge programs that would move trained medics into civilian health jobs that badly need filling.
- Stakeholders Supporting: 50strong and HonorHealth have endorsed the Senate companion.

Existing Bill: H.R. 6672, Mental Health Professionals Workforce Shortage Loan Repayment Act of 2025 (Reps. Andrea Salinas and Brian Fitzpatrick)

- Status: Existing bill
- Description: This bill would establish a Health Resources and Services Administration (HRSA) loan repayment program for mental health professionals who agree to work full-time in designated mental health professional shortage areas for up to six years. The program would repay up to $250,000 in eligible student loans for professionals including

psychiatrists, psychologists, psychiatric nurses, social workers, counselors, and marriage and family therapists.

- Cosponsors: 6 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: The United States faces significant shortages of mental health professionals, leaving many communities without adequate access to care. More than 152 million Americans live in federally designated mental health professional shortage areas, where only about 27 percent of the need for providers is being met. HRSA also projects shortages by 2038 of 100,000 mental health counselors and 44,000 psychiatrists, even before fully accounting for unmet demand. This bill would help address these shortages by reducing educational debt for mental health professionals who commit to practicing in communities where their services are needed most.
- Stakeholders Supporting: National Alliance on Mental Illness, National Council for Mental Wellbeing, American Psychological Association, American Psychiatric Association, American Counseling Association, American Foundation for Suicide Prevention, Children's Hospital Association, and others.

Existing Bill: H.R. 5052, Train More Nurses Act (Reps. Zachary Nunn and Susie Lee)

- Status: Existing bill; The Senate companion passed by unanimous consent in the 118th Congress.
- Description: This bill would require the Departments of Health and Human Services and Labor to review existing federal grant programs that support the nursing workforce and recommend changes to strengthen the nursing pipeline. The review would focus on increasing nursing faculty, particularly in underserved areas, creating pathways for experienced nurses to become faculty, and helping licensed practical nurses become registered nurses.
- Cosponsors: 110 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Education and Workforce
- Justification: Nursing schools face persistent faculty shortages that limit their ability to train enough nurses to meet growing health care needs. In 2025, U.S. nursing schools turned away more than 92,000 qualified applications, with shortages of faculty, clinical sites, preceptors, and classroom space among the primary barriers. At the same time, the Health Resources and Services Administration (HRSA) projects a nationwide shortage of nearly 109,000 registered nurses by 2038, with greater shortages in nonmetropolitan areas. This bill would identify ways to better use existing federal grant programs to expand nursing faculty and create stronger pathways into the nursing workforce.
- Stakeholders Supporting: Clive Behavioral Health, Iowa Health Care Association.

Existing Bill: H.R. 8541, Long-Term Care Workforce Support Act (Rep. Debbie Dingell)

- Status: Existing bill; The Better Care Better Jobs Act, which passed the House as part of the Build Back Better Act in the 117th Congress, informed the development of this bill.
- Description: This bill would strengthen the long-term care workforce by increasing federal Medicaid funding for long-term care services and directing states to use those resources to improve direct care worker compensation, benefits, training, recruitment, and retention. It would also invest in workforce training and career advancement, establish workplace and labor protections, and develop a national strategy to improve compensation for direct care professionals.
- Cosponsors: 12 (119th Congress)

- Committees of Jurisdiction: Energy and Commerce; Education and Workforce; Ways and Means; Judiciary; House Administration; Oversight and Government Reform
- Justification: As the U.S. population ages, demand for long-term care is growing while low wages, high turnover, and workforce shortages make it increasingly difficult for older adults and people with disabilities to access the care they need. The direct care workforce currently includes approximately 5.4 million workers, but an estimated 9.7 million direct care job openings will need to be filled between 2024 and 2034, while median annual earnings for these workers remain below $26,000. This bill would address these challenges by investing in higher compensation, better benefits and working conditions, workforce training, and career advancement to help recruit and retain the direct care professionals needed to meet growing demand.
- Stakeholders Supporting: PHI.

Existing Bill: H.R. 8629, Developing the Community Health Workforce Act of 2026 (Reps. Raul Ruiz and Gus Bilirakis)

- Status: Existing bill, introduced in the 119th Congress.
- Description: This bill would strengthen the workforce at Federally Qualified Health Centers (FQHCs) and rural health clinics by prioritizing them for National Health Service Corps placements, establishing an FQHC loan repayment program, and supporting recruitment, training, apprenticeships, and behavioral health workforce development. It would also expand partnerships between FQHCs, hospitals, and colleges for health professions and residency training and expand Medicare and Medicaid coverage of certain behavioral health and case management services provided through FQHCs.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Community health centers served more than 32.7 million patients in 2025, including more than 25 million people who were uninsured or covered by Medicare or Medicaid, but persistent workforce shortages can limit access to care in rural and underserved communities. Existing federal programs such as the National Health Service Corps help place clinicians in shortage areas, but FQHCs compete with other eligible sites for these providers, and existing workforce programs do not comprehensively address health centers' recruitment, training, retention, and career-pipeline needs. This bill would give FQHCs and rural health clinics priority for Corps placements while expanding loan repayment, apprenticeships, training partnerships, behavioral health workforce programs, and residency opportunities to build a more sustainable community health workforce.
- Stakeholders Supporting: Advocates for Community Health, the National Association of Community Health Centers, and Health Center Partners of Southern California.

VII: Reclaiming MAHA and Protecting American Families

First 100 hours:

Existing Bill: H.R. 7601, No Immunity for Glyphosate Act (Reps. Thomas Massie and Chellie Pingree)

- Status: Existing bill, which builds upon an amendment to the 119th Congress' Farm Bill to strip provisions aimed at protecting pesticide manufacturers. The amendment was successful in the House with 280 members voting in support.
- Description: This bill would bar the use of federal funds to implement Trump's Executive Order titled "Promoting the National Defense by Ensuring an Adequate Supply of Elemental Phosphorus and Glyphosate-based Herbicides", which directs federal agencies to support domestic glyphosate production and has been read as a broader effort to shield pesticide manufacturers from liability when their products harm the health of Americans. By blocking implementation, the bill preserves plaintiff's ability to bring state-law claims against manufacturers like Bayer/Monsanto for harms associated with glyphosate exposure.
- Cosponsors: 12 (119th Congress)
- Committees of Jurisdiction: Judiciary
- Justification: Glyphosate is the most widely used herbicide in the country and Bayer/Monsanto faces tens of thousands of lawsuits from plaintiffs who developed cancer after exposure. The industry has sought federal protection from liability, first through preemption language in the Farm Bill and, when that failed, through executive action. This bill blocks President Trump's executive order by cutting off the funds to implement the order, preserving the right of people whose health has been harmed by the product to have their day in court. Preventing corporate immunity for a company selling a product marketed as safe is one of the few issues uniting the left and the populist right, and it is a coalition Democrats should be building rather than ceding.
- Stakeholders Supporting: Farm Action Fund.

Existing Bill: H.R. 7867, Infant Formula Safety Modernization Act of 2026 (Rep. Rosa DeLauro)

- Status: Existing bill
- Description: This bill would require pathogen testing of both infant formula manufacturing facilities and finished product, mandate that manufacturers notify FDA of any positive test within one business day, and require FDA to notify Congress of positive results in finished formula of any "Official Action Indicated" inspection finding.
- Cosponsors: 38 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce.
- Justification: The infant formula supply has faced two safety crises in four years. In 2022, Abbott Nutrition's Sturgis facility shut down after Cronobacter contamination, triggering a nationwide shortage. In 2025-2026, Clostridium botulinum contamination of ByHeart formula sickened at least 51 infants across 19 states. Under current rules, a manufacturer can discover contamination and say nothing so long as the product has not shipped, and FDA has no obligation to tell Congress when it finds serious violations at a formula plant. This bill closes both gaps and adds Clostridium botulinum to the required testing list.
- Stakeholders Supporting: American Academy of Pediatrics (AAP), Consumer Federation of America, Environmental Working Group, Center for Science in the Public Interest, and STOP Foodborne Illness.

Existing Bill: H.R. 8429, Baby Food Safety Act of 2026 (Rep. Raja Krishnamoorthi)

- Status: Existing bill
- Description: A bill that directs the FDA to set enforceable limits on lead, cadmium, mercury, and arsenic in baby food and in fruit and vegetable purees and juices, and makes any product exceeding those limits legally altered. Manufacturers must test finished products quarterly under written sampling plans at accredited labs, keep the records for FDA inspection, and the FDA gains authority to demand those records remotely in lieu of an on-site visit. It also expands the FDA's mandatory recall authority to cover baby food adulterated under the new limits.
- Cosponsors: 10 (119th Congress)
- Expected Committees of Jurisdiction: Energy and Commerce
- Justification: Independent testing has repeatedly found heavy metals including lead, arsenic, cadmium, and mercury in baby food. A 2021 congressional investigation led by Rep. Krishnamoorthi found heavy metals present at levels far above what any agency permits for other products. This bill requires testing, sets numerical limits, and makes exceeding those limits a violation, allowing the FDA to order a mandatory recall rather than relying on a company to pull contaminated products voluntarily. Heavy metals are linked to irreversible harm in neurological development. Setting binding federal limits protects every family regardless of which state they live in or which brand they can afford.
- Stakeholders Supporting: Unleaded Kids, Environmental Working Group, Consumer Reports.

First 100 days:

Existing Bill: H.R. 4958, Grocery Reform And Safety Act (GRAS Act) (Rep. Frank Pallone)

- Status: Existing bill
- Description: A bill that ends the "Generally Recognized As Safe" self-certification system by striking the GRAS exemption from the statutory definition of "food additive," making GRAS substances subject to FDA review. Manufacturers must notify FDA before any new use with supporting safety data and may not market the substance unless the FDA affirmatively declines to object within 180 days. FDA must object where the data is insufficient or supplied by an expert with an apparent conflict of interest. Notices and data are posted publicly for comment. The bill also requires FDA to reassess at least 10 existing substances or classes every three years.
- Cosponsors: 5 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: The GRAS loophole is the largest gap in U.S. food safety law. The category was originally created in 1958 for common ingredients like vinegar and salt, but industry has turned it into a self-certification system: a company decides its own novel additive is safe, hires its own experts to say so, puts it in the food supply, and never tells the FDA. The FDA cannot say how many chemicals are in American food, with the common estimates around 1,000 entering with no review at all. On August 10, 2026, the FDA proposed a rule requiring notification before new GRAS substances enter the food supply. However, the rule does not establish pre-market approval, and Congress would still have to amend the FFDCA to give FDA the authority. Companies could still sell before notifying FDA, enforcement is unclear, and manufacturers would still hire their

own experts to attest to safety. This bill closes those three gaps by striking the GRAS exemption, barring the substance from market until the FDA affirmatively declines to object, lets the FDA reject data from conflicted experts, and requires ongoing reassessment of what is already on shelves.
- Stakeholders Supporting: Environmental Working Group, Consumer Reports, Rutgers University.

Existing Bill: H.R. 7906, Fueling Optimal Outcomes through Diet (FOOD) for Health Act (Reps. Robin Kelly and Jennifer Kiggans)
- Status: Existing bill
- Description: This bill would establish a U.S. Department of Agriculture pilot grant program to support community-based Food is Medicine programs that partner with health care providers to address diet-related diseases. Grants could support medically tailored groceries and meals, produce prescriptions, cooking and nutrition education, emergency feeding operations, and transportation, with $20 million authorized for fiscal years 2027 through 2031.
- Cosponsors: 8
- Committees of Jurisdiction: Agriculture; Energy and Commerce
- Justification: Diet-related diseases such as diabetes, obesity, hypertension, cardiovascular disease, and malnutrition contribute substantially to poor health outcomes, while food insecurity and limited access to nutritious foods can make these conditions more difficult to prevent and manage. Food is Medicine programs integrate nutrition interventions with health care by providing services such as medically tailored meals, groceries, and produce prescriptions to individuals with or at risk of diet-related diseases. This bill would expand access to these interventions while requiring the federal government to evaluate their effects on patient outcomes and health care system costs, helping build evidence for their broader use.
- Supporting Stakeholders: Dion's Chicago Dream and Cosmic Crate, Greater Chicago Food Depository, Academy of Nutrition and Dietetics, Think Regeneration, Feeding America, and FoodSmart.

Existing Bill: H.R. 8390, National Food as Medicine Program Act of 2026 (Rep. Raul Ruiz)
- Status: Existing bill
- Description: A bill to provide federal grants to states to plan, implement, expand, or evaluate programs that integrate healthy food as a medical intervention to treat and prevent chronic diseases.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Agriculture
- Justification: This bill takes a comprehensive approach to addressing chronic conditions through interventions that integrate food as a key component of medical care.
- Stakeholders Supporting: Academy of Nutrition and Dietetics.

Existing Bill: H.R. 5439, Medically Tailored Home-Delivered Meals Program Pilot Act (Reps. James McGovern and Nicole Malliotakis)
- Status: Existing bill. During the 118th Congress, a provision for medically tailored meals for seniors was included in H.R. 8816, the American Medical Innovation and Investment Act, which passed out of Ways and Means unanimously in June 2024 and was reported to the full House in December 2024 but did not receive a floor vote.

- Description: This bill would establish a six-year Medicare pilot program in at least 40 hospitals to provide medically tailored home-delivered meals and medical nutrition therapy to certain high-risk beneficiaries with diet-impacted diseases following hospitalization. Participating beneficiaries would receive at least two medically tailored meals per day, without cost-sharing, with CMS evaluating effects on health outcomes, hospital readmissions, and Medicare Part A spending.
- Cosponsors: 31 (119th Congress)
- Committees of Jurisdiction: Ways and Means
- Justification: Patients with diet-related chronic conditions can face heightened risk of complications and hospital readmission when they lack access to appropriate nutrition after discharge. Although medically tailored meals are designed around an individual's medical needs, traditional Medicare does not generally provide a comprehensive medically tailored meal benefit. This bill would test whether integrating medically tailored meals and nutrition therapy into post-discharge Medicare care can improve clinical outcomes and reduce readmissions and Part A spending, while requiring CMS to compare participating beneficiaries with similar nonparticipants to evaluate the program's effectiveness. The Energy & Commerce committee staff are supportive of this bill.
- Stakeholders Supporting: The Food is Medicine Coalition (FIMC).

Existing Bill: H.R. 7267, Produce Prescriptions for Veterans Act (Reps. Chellie Pingree and Vern Buchanan)

- Status: Existing bill
- Description: This bill would authorize the Department of Veterans Affairs to provide produce prescriptions as a covered medical service for veterans with diet-related chronic conditions who are also food insecure. Produce prescriptions could include vouchers or debit cards for purchasing fruits and vegetables to help improve veterans' chronic health conditions.
- Cosponsors: 1 (119th Congress)
- Committees of Jurisdiction: Veterans' Affairs
- Justification: Food insecurity can make it more difficult for veterans to manage diet-related chronic conditions by limiting consistent access to nutritious foods. Produce prescription programs seek to address both challenges by integrating access to fruits and vegetables into health care for patients with nutrition-related conditions. This bill would explicitly authorize the VA to provide these services as part of veterans' medical care, expanding access to nutrition-based interventions for veterans who are both food insecure and managing chronic disease.
- Supporting Stakeholders: National Produce Prescription Collaborative.

Existing Bill: H.R. 9474, Local Foods for Healthy Schools Act of 2026 (Rep. Kristen McDonald-Rivet)

- Status: Existing bill
- Description: This bill would create a USDA Local Foods for Healthy School Program providing $200 million per year in mandatory funding through noncompetitive cooperative agreements with state agencies, which would either purchase minimally processed foods from producers within the state or a 400-mile radius and distribute them to schools, or pass the funds to school food authorities to buy directly.
- Cosponsors: 3 (119th Congress)
- Committees of Jurisdiction: Agriculture

- Justification: The bill aims to get fresher, less-processed food into school cafeterias, with the money going to the farmers who grow it. The bill defines local foods as minimally processed so the money can only buy whole, cut, fresh, frozen, canned, or dried products. Funding is noncompetitive and formula-based rather than grant driven, so smaller and rural districts are not disadvantaged.
- Stakeholders Supporting: Bendle Public Schools, School Nutrition Association President, President of Michigan Farmers Union.

Existing Bill: H.R. 8928, Scratch Cooked Meals for Students Act (Rep. Jahana Hayes)

- Status: Existing bill
- Description: This bill would establish a USDA pilot program awarding two-year competitive grants to school food authorities to expand scratch cooking, defined as preparing food from unprocessed or minimally processed ingredients. Grants could fund equipment, staff training, labor costs, and culinary education, with priority to districts serving the most low-income students, operating their own food service, and whose employees are unionized.
- Cosponsors: 10 (119th Congress)
- Committees of Jurisdiction: Education and Workforce
- Justification: Nutrition standards govern what schools serve but not how it is made, and most cafeterias lack the equipment, staffing, and training to cook from whole ingredients. This bill funds the capacity that makes real cooking possible and directs it first to the districts with high need, self-operated food services, and unionized workers.
- Stakeholders Supporting: Chef Ann Foundation, Food Research & Action Center (FRAC), National Education Association (NEA), School Nutrition Association (SNA), and School Nutrition Association of Connecticut, and ScratchWork.

Existing Bill: H.R. 8370, Dietary Supplement Listing Act of 2026 (Rep. Maxine Dexter)

- Status: Existing bill
- Description: This bill requires manufacturers of dietary supplements to list their products with the FDA for the first time, submitting product name, ingredients and amounts, the label, health claims, and manufacturer information. The FDA would compile this into a publicly searchable database, so that the agency and the public would know what supplements are on the market and what's in them. This does not give the FDA authority to approve supplements before sale.
- Cosponsors: 0 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Americans spend roughly $60 billion a year on supplements, but the industry operates almost entirely in the dark. Under current law, manufacturers do not have to tell the FDA their products exist or are being sold, so the agency has no complete list of supplements sold in America, no way to find every product when one is recalled, and no visibility into ingredients concealed inside proprietary blends. This bill closes that information gap with a mandatory listing requirement and a public database, so regulators can act quickly when a supplement is found to be dangerous and consumers can see what they are taking.
- Stakeholders Supporting: Council of Responsible Nutrition, Consumer Federation of America, United States Pharmacopeia, United States Public Interest Research Group, and Ritual.

Existing Bill: H.R. 2339, Children's Health Protection Act of 2025 (Rep. Jerry Nadler)

- Status: Existing bill
- Description: This bill requires the EPA to permanently maintain its Office of Children's Health Protection and the Children's Health Protection Advisory Committee, and directs the office to identify environmental health risks that disproportionately affect infants, children, and adolescents; coordinate federal research and community programs; and guide safe chemicals management. The bill makes the advisory committee permanent and authorizes roughly $13.2 million a year through 2030.
- Cosponsors: 20 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Children are uniquely vulnerable to environmental hazards, with exposures during development causing lifelong harm.The EPA's Office of Children's Health Protection exists to make sure the agency's rules and research account for that vulnerability, but as an office created by executive order rather than statute, it can be weakened or eliminated by any administration. In his first term, Trump attempted to eliminate this office, but rolled back this decision after public outcry. During his second term, the Office of Children's Health was moved into the new Office of Applied Sciences and Environmental Solutions. Notably, Project 2025 called for eliminating the office. This bill makes both the office and its advisory committee permanent.
- Stakeholders Supporting: Asthma and Allergy Foundation of America, American Lung Association, Physicians for Social Responsibility, OneGreenThing, Alliance of Nurses for Healthy Environments.

First year:

Existing Bill: H.R. 5085, Protect America's Children from Toxic Pesticides Act (Rep. James McGovern)

- Status: Existing bill
- Description: A bill to ban the highly toxic pesticide paraquat, organophosphates, and neonicotinoids; suspend the use of pesticides already banned in the European Union or Canada until they have been reviewed; close the conditional-registration and emergency-exemption loopholes, require disclosure of "inert" ingredients; and increase farmworker and public protections.
- Cosponsors: 22 (118th Congress)
- Committees of Jurisdiction: Agriculture
- Justification: The way the U.S. regulates pesticides is broken, and children and farmworkers pay the price. Once the EPA approves a pesticide, it can stay on the market for decades even as the science turns against it because the agency relies on conditional registrations for nearly 65 percent of pesticides and uses emergency exemptions and indefinite review delays to keep them in use without a full safety assessment. The result is that the U.S. still permits 72 pesticides that have been banned or phased out in the European Union. This bill bans three of the most dangerous pesticides, automatically suspends any pesticide already banned in the EU or Canada pending EPA review, closes the regulatory loopholes, requires disclosure of "inert" ingredients that can make up 99 percent of a product, and strengthens protections for the farmworkers who are exposed first and worst. A pesticide too dangerous for the rest of the developed world should not be sprayed on American food.

- Stakeholders Supporting: Earthjustice, Environmental Working Group, Farmworker Justice, Natural Resources Defense Council, United Farm Workers, and 16 other organizations.

Existing Bill: H.R. 9231, No Toxic Chemicals in Food Packaging Act of 2026 (Rep. Jan Schakowsky)

- Status: Existing bill
- Description: This bill would ban some of the most dangerous toxic chemicals from food packaging and food processing materials. The bill targets chemicals that have been linked to cancer, reproductive harm, and other serious health risks.
- Cosponsors: 13 (119th Congress)
- Committees of Jurisdiction: Energy & Commerce
- Justification: Thousands of synthetic chemicals make up the materials that come in contact with our food. Chemicals from these materials can migrate into food and then into our body, with many being linked to cancer, hormone disruption, and other serious health risks. Over 200 chemicals on the FDA-approved list of food contact materials have been identified as hazardous, and another 530 would qualify for official hazard classification based on data. This bill would keep cancer-causing toxins like PFAS and asbestos out of food packaging and processing materials. The bill regulates by class rather than one compound at a time so manufacturers cannot swap a banned chemical for a similar unregulated one. Chemicals known to cause cancer should not be permitted in materials that touch our food.
- Stakeholders Supporting: Breast Cancer Prevention Partners and 12 other organizations.

Policy Idea: Banning Harmful Additives in School Meals

- Status: No existing legislative text
- Description: This bill would prohibit schools participating in federal meal programs from serving foods containing a defined list of synthetic additives linked to harm in children, beginning with the synthetic dyes Red 40, Yellow 5, Yellow 6, Blue 1, Blue 2, and Green 3, with the authority for USDA or FDA to add substances as evidence warrants.
- Expected Committee(s) of Jurisdiction: Education and Workforce; Energy and Commerce
- Justification: For millions of low-income students, school meals are their main source of daily nutrition. Yet, federal programs still allow synthetic dyes that a growing body of evidence links to neurobehavioral harm in children. A two-year California state assessment found 64 percent of clinical trials showed a link between synthetic food dyes and hyperactivity, inattentiveness, and restlessness in children. The FDA's safe intake levels are based on studies 40-60 years old and do not reflect current science or adequately protect children's health. These same dyes have been banned or restricted in the European Union, where safer alternatives now exist with natural colorings. States including California, Virginia, Utah, and West Virginia have already moved to bar these dyes from school meals, but a federal school-meal standard would make this protection universal.
- Stakeholders Supporting: Environmental Working Group.

Existing Bill: H.R. 6294, Childhood Diabetes Reduction Act of 2025 (Reps. Donald Beyer and Michael Lawler)

- Status: Existing bill. The Senate companion, S. 5026, was reported out of HELP in the 119th Congress.

- Description: This bill would require prominent front-of-package health warning labels on sugar-sweetened beverages, foods containing non-sugar sweeteners, ultra-processed foods, and foods high in nutrients of concern such as added sugar, saturated fat, or sodium. It would also prohibit advertising these foods to children, expand federal nutrition research, and establish a national nutrition and physical activity education campaign.
- Cosponsors: 2 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce
- Justification: Poor diet is a major risk factor for obesity, type 2 diabetes, cardiovascular disease, and other chronic conditions, with dietary habits established during childhood potentially affecting health throughout adulthood. Current federal nutrition labeling provides consumers with nutritional information but does not require the front-of-package health warnings established by this bill, while federal restrictions on marketing unhealthy foods specifically to children remain limited. This bill would strengthen consumer information and protections for children through warning labels and advertising restrictions while investing in additional research and public education aimed at preventing diet-related chronic disease.
- Supporting Stakeholders: UNC Global Food Research Program.

VIII: Increasing Access to Affordable Innovations and Breakthroughs

First 100 days:

Existing Bill: H.R. 3521, Clinical Trial Modernization Act (Reps. Raul Ruiz and August Pfluger)

- Status: Existing bill
- Description: This bill would expand access to clinical trials for underrepresented populations by funding community-based education, outreach, recruitment, and investigator training and by reducing financial and geographic barriers to participation. It would allow sponsors to cover participants' travel, transportation, meals, necessary digital health technologies, and certain cost sharing obligations without violating specified federal fraud and abuse laws, and would exclude up to $2,000 in clinical trial payments from participants' taxable income each year.
- Cosponsors: 8 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Clinical trial participants often do not reflect the populations most affected by the diseases being studied, limiting how well researchers can evaluate treatments across different populations. Financial and logistical barriers are a significant factor: a 2025 HHS study found that 64 percent of surveyed oncology clinical trial participants experienced financial stress, with greater burdens among those who traveled farther or more frequently. Federal law already requires diversity action plans for certain late-stage drug and device trials, but those requirements do not eliminate costs that can prevent patients from participating. This bill would complement those requirements by reducing financial barriers, expanding community-based recruitment, and providing clearer legal protections for sponsors that help participants with trial-related expenses, making clinical trials more accessible and representative.
- Stakeholders Supporting: Nearly 200 patient advocacy, public health, and health care professional organizations sent a support letter for the Senate version.

Existing Bill: H.R. 1750, Health Equity and Rare Disease (HEARD) Act of 2025 (Rep. Marilyn Strickland)

- Status: Existing bill
- Description: This bill would expand federal research and public health efforts addressing rare diseases that disproportionately affect minority populations by directing the NIH to coordinate research, develop a comprehensive federal plan, improve data collection, and support early detection and treatment. It would also establish grants for health professional training, mentoring, scholarships and loan repayment for providers serving rare disease populations, support Tribal research, and require reviews of clinical trial diversity and Medicare barriers to rare disease care.
- Cosponsors: 5 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means; Natural Resources
- Justification: More than 30 million Americans are estimated to have one of over 10,000 rare diseases, yet effective treatments are available for only about 5 percent of rare diseases. The Orphan Drug Act of 1983 created federal incentives that significantly expanded rare disease drug development, but gaps remain in research, diagnosis, and treatment, particularly for underserved populations. This bill would build on existing federal rare disease efforts by coordinating research focused on minority populations,

improving data collection and clinical trial representation, and strengthening the health care workforce trained to diagnose and treat rare diseases.

- Stakeholders Supporting: Rare Disease Diversity Coalition (RDDC), Undiagnosed Diseases Network Foundation (UDNF), GLO Preemies, American Muslim Health Professional, Ehlers-Danlos Society, and the Nisqually Indian Tribe.

Existing Bill: S. 2665, Drug Shortage Prevention Act of 2025 (Sens. Amy Klobuchar and Susan Collins)

- Status: Existing bill with no House companion; key provisions passed out of the HELP Committee in the 118th Congress as part of the Pandemic and All-Hazards Preparedness and Response Act (S. 2333), but the legislation did not advance to the Senate floor.
- Description: This bill would strengthen FDA drug-shortage prevention requirements by requiring manufacturers of critical drugs to notify the agency of manufacturing or active pharmaceutical ingredient disruptions, increased demand, export restrictions, and other circumstances likely to cause a meaningful supply shortfall. It would also require twice-yearly reporting on drug supply chains, including suppliers of active pharmaceutical ingredients and other manufacturing materials.
- Cosponsors: 5 (119th Congress)
- Committees of Jurisdiction: Health, Education, Labor, and Pensions
- Justification: Drug shortages can disrupt access to lifesaving and medically necessary treatments, particularly when manufacturing problems, increased demand, or supply-chain vulnerabilities reduce available supply. Current law requires manufacturers to notify FDA of certain discontinuations and manufacturing interruptions, but this bill would broaden these requirements to cover increased demand, export restrictions, active pharmaceutical ingredient disruptions, and other emerging risks. It would also give FDA greater visibility into pharmaceutical supply chains through more frequent supplier reporting, helping the agency identify vulnerabilities and respond to potential shortages earlier.
- Supporting Stakeholders: American Hospital Association, American Society of Anesthesiologists.

Existing Bill: H.R. 3164, Ensuring Community Access to Pharmacist Services Act (Reps. Schneider and Adrian Smith)

- Status: Existing bill, passed out of House Ways and Means in the 119th Congress and renamed "Main Street Pharmacy Act."
- Description: This bill would establish Medicare Part B coverage and payment for certain pharmacist-provided testing and treatment services for COVID-19, influenza, respiratory syncytial virus (RSV), and strep throat, as well as services addressing needs during a declared public health emergency. Covered services would have to be within the pharmacist's scope of practice under state law, including applicable supervision or collaboration requirements.
- Cosponsors: 140 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Pharmacists can provide testing and treatment for common infectious diseases under many state laws, but Medicare generally does not recognize pharmacists as Part B practitioners, limiting their ability to receive direct reimbursement for these services. This gap became particularly apparent during the COVID-19 public health emergency, when federal authorities temporarily expanded pharmacists' ability to provide testing, vaccination, and treatment services. This bill would establish permanent

Medicare coverage for specified pharmacist services, expanding access to timely testing and treatment while maintaining state scope-of-practice requirements.

- Stakeholders Supporting: Future of Pharmacy Care Coalition, including the American Pharmacists Association, American Society of Health-System Pharmacists, Abbott, AmerisourceBergen, Cardinal Health, CVS Health, Good Neighbor Pharmacy, Health Mart, Kroger, McKesson, Medicine Shoppe, the National Association of Chain Drug Stores, Walgreens, and Walmart.

Existing Bill: H.R. 6423, Help Ensure Lower Patient (HELP) Copays Act (Reps. Thomas Kean and Nanette Diaz Barragán)

- Status: Existing bill
- Description: This bill would require group and individual health plans to count financial assistance paid by or on behalf of an enrollee, including assistance from nonprofit organizations and prescription drug manufacturers, toward the enrollee's deductible, copayments, coinsurance, and out-of-pocket maximum. It would apply these protections to specialty drugs and drugs subject to utilization management while preserving plans' ability to use tools such as prior authorization and step therapy.
- Cosponsors: 62 (119th Congress)
- Committees of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Many patients with chronic or complex conditions rely on manufacturer or nonprofit copay assistance to afford high-cost medications, but copay accumulator programs can prevent this assistance from counting toward their deductibles and out-of-pocket maximums. Federal policy has remained uncertain: a 2020 HHS rule allowed insurers to exclude certain manufacturer assistance from cost-sharing calculations, but a federal court vacated that rule in 2023 in *HIV and Hepatitis Policy Institute v. HHS*. Congress has previously considered bipartisan legislation to address this issue, including the HELP Copays Act in the 118th Congress. This bill would establish a clear federal standard requiring financial assistance to count toward patients' cost-sharing obligations, protecting patients from unexpected out-of-pocket costs.
- Stakeholders Supporting: All Copays Count Coalition.

Existing Bill: H.R. 6214, Kidney Care Access Protection Act (Reps. Carol Miller and Terri Sewell)

- Status: Existing bill, discussed in Ways & Means Health Subcommittee hearing on March 18, 2026.
- Description: This bill would expand Medicare access to kidney disease prevention and treatment by improving payment for innovative end-stage renal disease (ESRD) drugs, biologics, devices, and supplies; adjusting dialysis payments to account for forecasting errors; and extending certain innovation payments to Medicare Advantage beneficiaries. It would also add chronic kidney disease screening to the Medicare Annual Wellness Visit and expand access to Medicare's kidney disease education benefit.
- Cosponsors: 14 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: Medicare's ESRD payment system can create barriers to adoption of new kidney therapies when temporary add-on payments expire and innovative treatments are incorporated into the bundled dialysis payment, while inaccurate cost forecasts can place additional financial pressure on dialysis providers. This bill would improve reimbursement for innovative kidney treatments and correct significant forecasting errors while also strengthening prevention and patient education by incorporating kidney

disease screening into Medicare wellness visits and expanding eligibility and providers for kidney disease education. Together, these changes would support earlier detection and treatment of kidney disease while improving access to innovative care for patients who progress to ESRD.
- Stakeholders Supporting: Dialysis Patient Citizens, American Kidney Fund, and Kidney Care Partners.

Policy Idea: Allow Medicare and Medicaid to participate in subscription-based payment models for high per-patient cost drugs
- Status: New idea with no existing legislative text
- Description: This bill would expand the use of subscription-based payment models for high-cost prescription drugs, allowing public payers, like Medicare and Medicaid, to negotiate fixed or capped payments with manufacturers in exchange for broad access to treatment for eligible patients.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: High per-patient costs can make it difficult for public health programs to expand access to effective but expensive treatments. Subscription models pioneered for hepatitis C treatment in Louisiana and Washington instead provide manufacturers with predictable payments while enabling states to treat more Medicaid beneficiaries and incarcerated individuals without paying separately for each additional prescription. Expanding these models could improve treatment access while giving public payers greater predictability over drug spending.

Policy Idea: Expand Medicare beneficiary access to Medicare Prescription Payment Plan (M3P)
- Status: New idea with no existing legislative text
- Description: This bill would expand beneficiary outreach and simplify enrollment in the Medicare Prescription Payment Plan (M3P), including by developing real-time enrollment options that allow beneficiaries to opt into the program at the pharmacy when filling a prescription.
- Cosponsors: N/A
- Expected Committee(s) of Jurisdiction: Energy and Commerce; Ways and Means
- Justification: Established by the Inflation Reduction Act, M3P allows Medicare Part D beneficiaries to spread out-of-pocket prescription drug costs across monthly payments rather than paying the full amount at the pharmacy. CMS already requires plans to conduct outreach to beneficiaries likely to benefit and process enrollment within 24 hours, but has not implemented real-time pharmacy enrollment. Strengthening beneficiary outreach and simplifying enrollment, including at the point of sale, could increase use of the program and help beneficiaries with high upfront drug costs better manage their expenses.

First year:

Drug Patent Reform Package to include:
- **Existing Bill: H.R. 8908, Stop GAMES Act (Reps. Eric Sorenson and Stephanie Bice)**
- **Existing Bill: H.R. 3269, ETHIC Act (Reps. Lloyd Doggett and Jodey Arrington)**

- **Existing Bill: S. 1096, Preserve Access to Affordable Generics and Biosimilars Act (Sens. Amy Klobuchar andChuck Grassley); and**
- **Existing Bill: S. 1040, Drug Competition Enhancement Act (Sens. John Cornyn and Richard Blumenthal)**
- Status: All four bills are existing bills. The bills listed below have had the following activity:
    - H.R. 8908, Stop GAMES Act passed out of the House Energy and Commerce Committee in the 119th Congress as part of the Lower Costs, More Transparency Act of 2026.
    - S. 1096, Preserve Access to Affordable Generics and Biosimilars Act passed out of the Senate Judiciary Committee in the 119th Congress.
    - S. 1040, Drug Competition Enhancement Act passed out of the Senate Judiciary Committee in the 119th Congress.
- Description: This package would address several ways in which pharmaceutical companies abuse the drug patenting system in order to limit competition and increase their profits. The Stop GAMES Act would prevent brand-name pharmaceutical companies from abusing the FDA citizen petition process to delay approval of lower-cost generic and biosimilar applications. By curbing delay tactics that exploit regulatory processes, the legislation would help ensure patients and plan sponsors can benefit from competition as soon as lower-cost alternatives are ready for approval. The ETHIC Act would tackle patent thickets, which occur when brand-name companies secure as many patents as possible on a blockbuster drug to artificially prolong monopoly periods awarded by the patent system and deter competitors. Specifically, it would curb patent thickets by limiting the number of patents a pharmaceutical manufacturer could assert during litigation to one per patent family. The Preserve Access to Affordable Generics and Biosimilars Act would ban pay-for-delay agreements, which occur when brand-name drug companies pay a potential competitor to delay selling a generic version of a drug, therefore keeping it off the market in order for the brand-name drug to maintain its monopoly for longer. The Drug Competition Enhancement Act would ban "product hopping," which occurs when a brand-name drug company games the patent and regulatory systems by switching patients to a "newer" version of a drug at the time an older version is losing its monopoly and about to face competition. Usually, the "new" version involves only a small change that is not a true clinical improvement.
- Cosponsors: H.R. 8908 - 1 (119th Congress); H.R. 3269 - 9 (119th Congress), S. 1096 - 8 (119th Congress), S. 1040 - 3 (119th Congress)
- Committee(s) of Jurisdiction: H.R. 8908 - Energy and Commerce; H.R. 3269 - Judiciary, S. 1096 - Judiciary; S. 1040 - Judiciary
- Justification: This suite of bills would lower drug prices and ensure better access by enabling greater competition in the pharmaceutical drug market. Due to the anticompetitive practices of Big Pharma, U.S. prescription drugs are nearly three times higher than in other countries and, despite paying the highest prices in the world, Americans often face shortages of life-saving generic drugs, despite no unpredictable increase in demand. A recent poll found that 85 percent of Democrats and 75 percent of Republicans support Congressional efforts to rein in abuse of the patent system.
- Stakeholders Supporting: AARP, Patients for Affordable Drugs Now.

Existing Bill: H.R. 5343, Ensuring Patient Access to Critical Breakthrough Products Act (Reps. Blake Moore and Suzan DelBene)

- Status: Existing bill; In the 118th Congress, it passed out of the House Ways and Means and House Energy and Commerce committees. In the 119th Congress, it passed out of the House Ways and Means Committee.
- Description: This bill would provide Medicare beneficiaries with four years of transitional coverage for certain FDA-designated breakthrough medical devices that meet specified clinical and safety criteria. It would also require the CMS to make timely coverage determinations before the transitional period ends, helping prevent gaps in access to qualifying breakthrough technologies.
- Cosponsors: 65 (119th Congress)
- Committees of Jurisdiction: Ways and Means; Energy and Commerce
- Justification: FDA's Breakthrough Devices Program expedites the development and review of medical devices that provide more effective treatment or diagnosis for life-threatening or irreversibly debilitating conditions, but FDA authorization does not automatically result in Medicare coverage. This can create a gap between when an innovative device reaches the market and when Medicare beneficiaries can access it through coverage. This bill would address this gap by providing four years of transitional Medicare coverage for qualifying breakthrough devices while preserving patient-safety protections and requiring CMS to reach a longer-term coverage decision before the transitional period expires.
- Stakeholders Supporting: More than 75 national organizations including the Medical Device Manufacturers Association (MDMA), AdvaMed, ALS Association, Blinded Veterans Association, Christopher & Dana Reeve Foundation, Epilepsy Foundation, Muscular Dystrophy Association, National Disability Rights Network, Spina Bifida Association, Team Gleason, United Spinal Association, Sepsis Alliance, and the Partnership to Advance Cardiovascular Health.