National Rural Health Association

January 22, 2026
Submitted via email: Annabelle.huffman@Mail.house.gov

House Energy & Commerce Committee
Attn. Editorial and Document Section
2123 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record – Health Subcommittee: *Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability*

Dear Chairman Griffith, Ranking Member DeGette, Chairman Guthrie, and Ranking Member Pallone:

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record for the sequential Energy & Commerce Health Subcommittee and Ways & Means Committee hearing examining health insurance affordability and insurer oversight.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Support for *Improving Seniors' Timely Access to Care Act*

NRHA strongly supports the *Improving Seniors' Timely Access to Care Act* (H.R. 3514/S. 1816) as a bipartisan, bicameral, and commonsense reform that would meaningfully improve Medicare Advantage (MA) prior authorization processes while preserving program integrity. Prior authorization remains one of the most frequently cited administrative barriers to timely, medically necessary care for rural Medicare beneficiaries and the providers who serve them. These barriers are particularly acute in rural areas, where workforce shortages, limited specialty access, and constrained administrative capacity already strain the delivery system. We commend Congress for the unprecedented, bipartisan alignment demonstrated in this joint hearing. The coordination between two key committees with jurisdiction over MA reflects Congress's critical role in overseeing insurer practices and asserting its authority to govern in the interest of beneficiaries and providers alike.

NRHA commends the Committees for using this sequential set of hearings to assert Congress's critical oversight role in MA and insurer practices. For rural communities, passage of the Seniors' Act would represent a concrete step toward ensuring that Medicare Advantage works as intended, delivering timely access to medically necessary care while reducing unnecessary administrative burden on providers already operating at the margins.

The *Seniors' Act* stands out as one of the most widely supported health care bills in this Congress and the last two Congresses. The legislation has garnered **65 Senate cosponsors and 244 House cosponsors**, reflecting broad bipartisan and bicameral consensus. Support within the House committees of jurisdiction is especially notable: **79 percent of the Energy & Commerce Health Subcommittee and 74 percent of the Ways & Means Health Subcommittee** are cosponsors, with more than **70 percent of each full committee** also signed on.

This level of alignment is rare and proves the shared recognition that prior authorization reform in MA is both necessary and achievable. The bill previously passed out of both the Energy & Commerce and Ways & Means Committees by **voice vote** in the 117th Congress and carries a **Congressional Budget Office score of zero**, with no changes to the bill text that would alter that determination. In short, the Seniors' Act is a commonsense reform that would improve beneficiary protections and administrative efficiency at no additional cost to taxpayers.

Rural Impact of Prior Authorization in Medicare Advantage.

Rural providers consistently report that prior authorization requirements by MA plans delay and disrupt care for beneficiaries and impose substantial administrative burden on small practices and hospitals with limited staffing. Unlike larger urban systems, rural providers often lack dedicated utilization management teams, making repeated documentation requests, manual submissions, appeals, and opaque denial processes especially disruptive. For rural seniors who are more likely to be older, have multiple chronic conditions, and face transportation challenges, delays in care can result in avoidable deterioration, emergency department use, or hospitalization.

Importantly, NRHA emphasizes that prior authorization is not confined to inappropriate utilization. Rural providers frequently report delays and denials for services that would otherwise be routinely covered under traditional Medicare, displaying the need for greater transparency, standardization, and accountability in MA utilization management. For example, many rural hospitals experience issues receiving authorization to discharge MA beneficiaries to post-acute care, particularly in the swing bed setting. This is problematic because hospitals must shoulder the additional costs of continuing to provide care for the beneficiary despite and beneficiaries are denied timely access to their needed post-acute level of care. When care is approved MA plans frequently steer rural beneficiaries to a particular provider type or facility, frequently outside of the local rural community. The biggest instance of this practice is plans steering beneficiaries to a skilled nursing facility (SNF) rather than a swing bed in a local rural facility. This is an issue for beneficiaries when swing bed care is in their community and near their support system, and the SNF is further away adding significant travel burden for the individual and their families. MA plans should send rural beneficiaries to the setting that best meets their needs, which includes keeping them close to home.

Other Rural Medicare Advantage Issues.

Approximately 48% of all rural beneficiaries are enrolled in an MA plan and current trends point to MA plans enrolling a majority of rural beneficiaries in the next year.[1] As MA enrollment continues to grow in rural communities, plan practices such as prior authorization, claims denials, and delayed payments increasingly undermine long-standing rural Medicare protections. Even when plans ultimately pay at rates comparable to Traditional Medicare, rural providers report that retroactive denials, repeated documentation requests, and prolonged payment timelines create substantial financial strain and divert scarce resources away from patient care. For rural seniors, who are more likely to have multiple chronic conditions and fewer alternative care options, these delays can result in avoidable deterioration in health status.

[1] Fred Ullrich & Keith Mueller, *Medicare Advantage Enrollment Update 2024*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Jan. 2025) https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf?utm_medium=email&utm_content=Image%3A+right+arrow&utm_source=d.pubhealth.rupri&utm_campaign=RUPRI+Center+Announcements&utm_id=1186247592.1388688166.

Payment parity.

NRHA members have voiced that payment-related challenges with MA plans have negatively impacted their patients, staff, and facilities. Reimbursement challenges are heightened for providers with special rural designations and payment systems, like critical access hospitals (CAHs) and rural health clinics (RHCs) because of their unique payment rates. However, CAHs and RHCs are not alone in struggling with reimbursement. NRHA members representing various facility types have raised concerns over payment timeliness, audits, negotiating power, and payment denials.

As the proportion of MA beneficiaries compared to Traditional Medicare beneficiaries continues to grow, rural providers that are reimbursed on a unique payment system to ensure viability are increasingly at risk. Growing MA enrollment in rural areas is diluting the original purpose of these rural designations and threatening the role they play to support rural providers. CAHs are paid 101% of reasonable costs and RHCs are paid their specific all-inclusive rate (AIR) through Traditional Medicare. Yet MA plans frequently do not adhere to these Traditional Medicare payment rates and in turn CAHs and RHCs receive unsustainable reimbursement from the plans. To remedy this persistent issue, **NRHA calls on the Committee to support and pass H.R. 4559, the *Prompt and Fair Pay Act*.**

NRHA members have also consistently reported that MA plans are not paying rural providers Traditional Medicare rates when there is no network contract in place. Regulations on MA payment state that services furnished by 1861(u) providers (which include hospitals, CAHs, and skilled nursing facilities [SNFs]) without a contract with an MA plan must accept as payment in full the amount that it could collect if the beneficiary were enrolled in Traditional Medicare.[2] Further, sub-regulatory guidance on MA payment to out-of-network providers states that MA plans are generally required to pay at least Traditional Medicare rates for Medicare covered services.[3] NRHA asks Congress urge CMS to enforce these standards with MA plans.

Timeliness and denials of payment.

Other common payment issues facing rural providers relate to timeliness and denials of claims. Even when a rural provider receives payment equivalent to their Traditional Medicare rate, getting timely payments is difficult. For example, when a provider bills for a service, a plan may deny the claim after the beneficiary received the service despite previously receiving prior authorization which is used to determine medical necessity. NRHA members note that this happens most often for inpatient stays. In other cases, MA plans delay payment or make the process of getting paid the correct amount so time consuming and burdensome that rural providers do not have adequate staff, time, or resources to address every payment issue or to pursue timely and accurate payment. In extreme circumstances, NRHA members have noted up to $800,000 in delayed or denied payments. For rural hospitals that operate with thin or negative margins delayed payments are a critical cash flow issue. **Almost of rural hospitals operate on negative margins and cannot absorb this level of untimely payments.**[4] Furthermore, administrators are frustrated with untimely payments because it is difficult to operate and plan without predictable payments for a growing number of their patients. **Again, NRHA urges the Committee to support timeliness standards for MA plans through H.R. 4559 and H.R. 5454/S. 2879, the *Medicare Advantage Prompt Pay Act*.**

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[2] 42 C.F.R. § 422.214(b) (2023).
[3] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf
[4] Michael Topchik, et al., *2025 rural health state of the state,* Chartis (2025), 2, https://www.chartis.com/insights/2025-rural-health-state-state.

Network adequacy.

Some MA plans carve rural providers out of plan networks and are able to do so because of current network adequacy time and distance standards set in regulation.[5] In certain cases, plans have dropped existing contracts with rural providers. Ultimately, this stifles rural beneficiary access to care. To target this practice, **MA plans should be required to offer all rural safety net providers contracts to provide acute care and outpatient services, psychiatric services, swing bed services, and rural health clinic services with no carveouts. NRHA asks that the Committee support future legislation to this effect.**

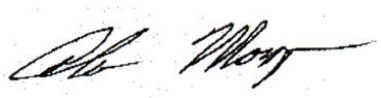
Addressing Healthcare Affordability.

Access to health care coverage is foundational to the stability of the rural health care system, shaping both the financial viability of providers and the well-being of the communities they serve. One solution to making healthcare more affordable for the 2.8 million rural enrollees in Affordable Care Act Marketplace plans is reviving the enhanced premium tax credits (ePTCs) that expired at the end of 2025. These subsidies have been in place since 2021 and have allowed rural residents to access affordable healthcare coverage. Almost 80 percent of rural enrollees were in a zero-premium plan prior to the expiration of the ePTCs and saved an average of $890 per year on coverage.[6] Projections from prior to the expiration estimated that rural residents would experience a 107 percent increase in premiums compared to 89 percent for urban residents.[7]

NRHA urges the Committee to support a clean extension of ePTCs to lower healthcare costs for rural residents. NRHA supports **H.R. 247/S. 46, the *Health Care Affordability Act* and any bipartisan efforts to enact a clean extension of ePTCs.**

These targeted policies would protect, sustain, and improve health care delivery for rural patients. NRHA calls on Congress and the Administration to prioritize rural health and ensure rural communities have the same accessible, quality health care as their urban counterparts. For additional information, please contact Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

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[5] 42 C.F.R. § 422.116.
[6] Cristina Lilley & Whitney Zahnd, *Role of enhanced premium tax credits in rural America*, NATIONAL RURAL HEALTH ASSOCIATION (Aug. 2025) https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/nrha-policy-paper-enhanced-premium-tax-credits-final.pdf.
[7] *Id.*