Federation of American Hospitals

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STATEMENT
of the
Federation of American Hospitals
to the U.S. House Energy and Commerce Health Subcommittee hearing:
"Lowering Health Care Costs for All Americans:
An Examination of Health Insurance Affordability."
January 22, 2026

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Energy and Commerce Health Subcommittee hearing entitled, "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability." The FAH appreciates the opportunity to submit this statement for the record as Congress examines health care affordability, the influence of insurer practices on patient access to care, and the impacts they have shifting costs to patients and increasing costs throughout the health care system.

As the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the United States – accounting for approximately 20 percent of community hospitals nationally – the FAH appreciates the subcommittee's leadership in addressing patients' rising out-of-pocket health costs and the topic of health insurer accountability.

FAH hospitals provide lifesaving care around the clock to all patients, regardless of their ability to pay, and provide more uncompensated care than the national average. Yet their ability to deliver care is increasingly constrained by insurance industry practices that raise costs for patients, delay access to necessary services, and burden clinical teams with unnecessary administrative requirements.

Growth in Health Insurance Premiums and Out-of-Pocket Costs

One of the most significant drivers of financial pressure on American families is the rapid growth in health insurance premiums. Annual premiums for employer-sponsored family health coverage reached $26,993 in 2025, a six percent increase over 2024, and the average deductible for individual coverage has climbed to nearly $1,900.[1] This is what working families have to pay out of pocket before their insurance will even start to help.

[1] Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks | KFF

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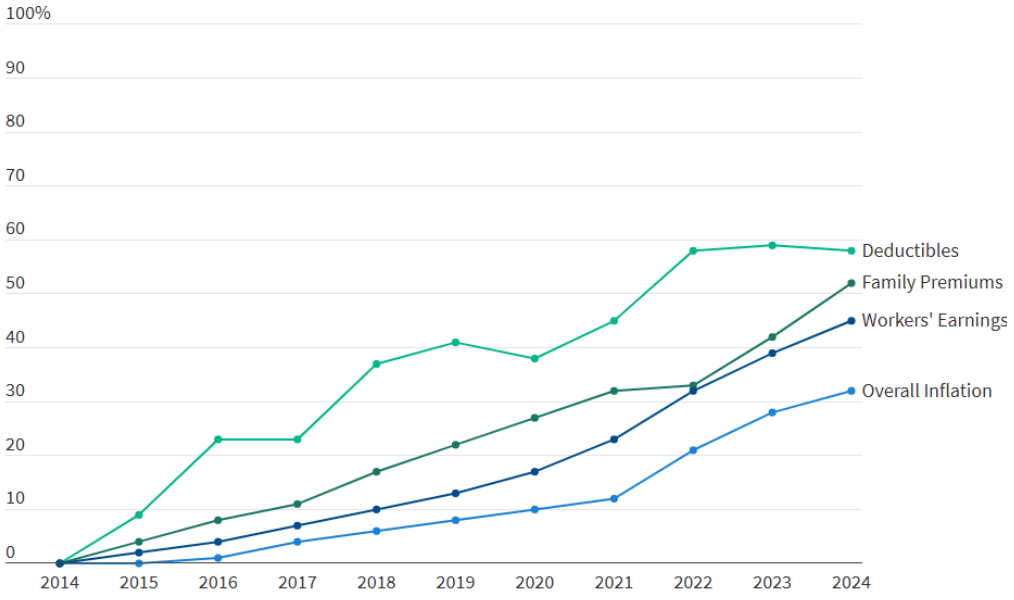
Consumers are shouldering a growing share of these rising costs not only through premiums but also through deductibles and other forms of cost sharing. According to the Kaiser Family Foundation's Employer-Sponsored Health Insurance analysis, the average worker contribution toward employer-based insurance has climbed to roughly $1,440 annually for single coverage and $6,850 for family coverage, and a larger share of workers are enrolled in plans with higher deductibles than in prior years.[2] This trend shows both the rising share of premiums paid by employees and the upward trajectory of deductibles that families must meet before insurance coverage begins. These costs cannot be dismissed as one-off increases. As deductibles grow, workers face higher out-of-pocket exposure at the very moment they are required to pay more just to maintain coverage, reducing disposable income and creating real affordability challenges for middle-class households. In fact, family premiums grew roughly 32% from 2019 through 2025, reflecting persistent upward pressure on household budgets in recent years.[3]

Cumulative Increases in Family Coverage Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2014-2024



Note: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

Source: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2014-2017. Bureau of Labor Statistic, Consumer Price Index, U.S. City Average of Annual Inflation, 2014-2024; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2014-2024 • Get the data • Download PNG

KFF

For individuals and families purchasing coverage on the Affordable Care Act marketplace, the financial strain can be even more acute. Analysts estimate the marketplace will lose 7.3 million enrollees due to premium spikes and the expiration of enhanced subsidies.[4] We must strengthen the individual market and lower costs for families – and that requires an extension of the enhanced premium tax credits and appropriate oversight to ensure coverage works for patients.

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[2] Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks | KFF

[3] Employer-Sponsored Health Insurance 101 | KFF

[4] Putting the Extraordinary Increase in ACA Premiums in 2026 in Perspective | The Commonwealth Fund

As policymakers focus on lowering health care costs, it is critically important to understand the impact of rising insurance premiums and growing patient out-of-pocket costs, which have far outpaced inflation.[5] Voters consistently report that insurers and pharmaceutical companies—not hospitals—are primarily responsible for rising health care costs.[6] This perception reflects the real-world experience of patients and providers who face higher premiums and deductibles each year while insurers impose new administrative hurdles that get between patients and their clinicians.

Health Insurer Administrative Burdens Raise Costs - Medicare Advantage and Prior Authorization Abuses

The insurer-driven administrative burden placed on both patients and providers has skyrocketed in recent years. Nearly 50 million prior authorization requests were submitted in Medicare Advantage (MA) in 2023, a sharp increase from previous years, and denial rates continue to rise. Many of these denials involve services that fully meet Medicare coverage criteria, contributing to care delays and creating a significant administrative burden for hospitals.[7] Private payers routinely deny claims at high rates as well; nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized.[8] More than half of these denials are eventually overturned, but only after multiple rounds of costly appeals, frustrating patients and providers alike because they divert time and resources away from direct patient care.

Medicare Advantage plans, in particular, have adopted practices that delay and deny seniors' care, impose burdensome prior authorization requirements, and limit access to essential health care services. Despite federal requirements that MA coverage must match the standards of Traditional Medicare so that all seniors receive the care they've earned after a lifetime of hard work, MA plans routinely fall short. Many plans rely on non-transparent proprietary decision tools and algorithms that conflict with Medicare coverage policies and often lead to inappropriate denials or premature discharge determinations without necessary clinical oversight. Studies consistently show that MA plans underperform compared to Traditional Medicare across multiple quality measures, including patient experience, mortality rates, racial and ethnic disparities, and readmission rates. Furthermore, MA plans frequently reclassify medically necessary inpatient stays as "observation" care, undermining seniors' access to benefits they would receive under Traditional Medicare. At the same time, the federal government continues to overpay MA plans by tens of billions of dollars each year—funds that often do not translate into improved care for seniors.

Congress can address these issues by simplifying administrative barriers and ensuring MA patients receive the same benefits as those in Traditional Medicare. The FAH supports bipartisan legislation, including the *Improving Seniors' Timely Access to Care Act* (S. 1816 / H.R. 3514), which would reform prior authorization and strengthen reporting requirements, reducing unnecessary burden and complexity. Additionally, there is a lack of consistent standards defining a "clean claim" or timelines for MA reimbursement to in-network providers. MA plans frequently update claim submission requirements, impose excessive documentation

[5] How much do people with employer plans spend out-of-pocket on cost-sharing? | Peterson-KFF
[6] Understanding voter attitudes towards hospitals and health care | FAH
[7] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023 | KFF
[8] Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims | Premier, Inc.

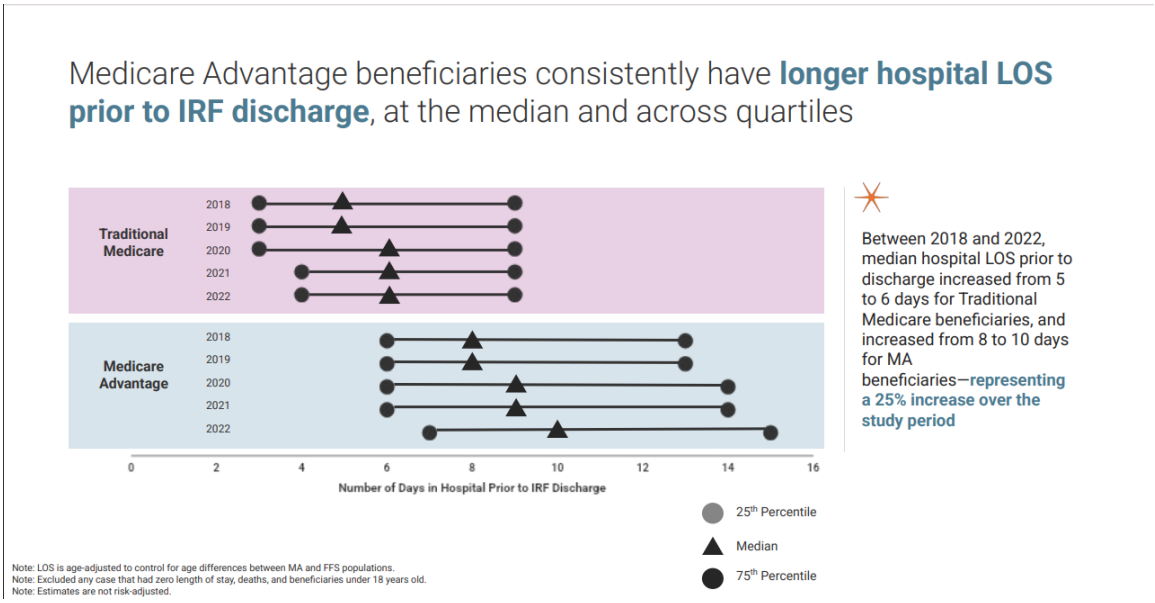
requests, and initially deny technically clean claims, creating administrative burdens, delayed payments, and unnecessary costs. Passing the *Medicare Advantage (MA) Prompt Pay Act* (H.R. 5454 / S. 2879) would help maintain MA participation, particularly in rural areas, protect seniors' access to care, and ensure providers are fairly compensated.

These insurer practices contribute substantially to rising system costs. Repeated denials, appeals, diversion of clinical staff time, prolonged inpatient stays, and delayed transitions to post-acute care increase overall spending, raise costs for hospitals and the Medicare program, and undermine the patient experience.

Seniors' Access to Post-Acute Care

Access to post-acute care represents another major concern. Seniors recovering from serious illness or injury depend on timely access to skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals to ensure safe recovery and prevent rehospitalization. Unfortunately, MA plans increasingly deny or delay authorization for these services, often at rates significantly higher than their overall authorization denial rates.[9] These delays force patients to remain in hospital beds longer than medically necessary, slowing recovery, reducing capacity for incoming patients, and increasing costs across the health care system.

In fact, between 2018 and 2022, median hospital length of stay prior to discharge increased from 5 to 6 days for Traditional Medicare beneficiaries, and increased from 8 to 10 days for MA beneficiaries—representing a 25% increase over the study period for inpatient rehab facility discharge.[10]



Some insurers have implemented automated review systems to reduce spending on post-acute care, tying financial incentives to higher denial rates and placing algorithms between clinicians and patients. These practices place seniors at risk and undermine appropriate clinical decision-making. To protect access to

[9] Analysis of hospital discharges to PAC settings among Medicare beneficiaries | NORC
[10] Analysis of hospital discharges to PAC settings among Medicare beneficiaries | NORC

the full range of post-acute services, FAH urges Congress to direct CMS to establish meaningful network adequacy standards for inpatient rehabilitation facilities and ensure MA plans comply with the Two Midnight- Rule and other Medicare coverage requirements.

Health Insurance Industry Consolidation

Consolidation within the insurance industry—both horizontal consolidation among insurers and vertical integration with physician practices and other components of the delivery system—has profoundly affected patient choice, competition, and access to care. In many states, the three largest insurers control more than 80 percent of the insurance market,[11] and some insurance companies employ or control as many as 10 percent of all physicians nationwide.[12] This concentration of power enables insurers to dictate which providers patients may see, what services those providers may deliver, how much they are paid, and the administrative hurdles they must overcome. Further, insurers that have vertically integrated with provider entities can inflate reported medical spending by directing care to their own high-priced affiliates, effectively weakening Medical Loss Ratio (MLR) requirements and contributing to higher health care costs without delivering additional patient benefit.[13]

Patients enrolled in Medicare Advantage (MA) often have access to only a fraction of the physicians available to Traditional Medicare beneficiaries, and approximately one-third of MA enrollees are in narrow-network plans that significantly restrict provider choice. At the same time, insurer provider directories are frequently inaccurate or outdated—so-called “ghost networks”—leaving patients unable to identify in-network physicians or secure timely appointments. Together, these practices severely limit patient choice and undermine meaningful network adequacy.

Insurer acquisitions and consolidation have created markets in which only a few dominant insurers wield disproportionate leverage over hospitals while imposing substantial administrative requirements that drive up costs and divert resources away from patient care. These trends have had significant negative implications for patient access, affordability, and the sustainability of community-based providers.

Hospital Transparency Versus the Insurer Black Box

Our members have made substantial investments in transparency to comply with federal price transparency requirements, but hospitals are only part of the equation. Complex cost-sharing structures, opaque benefit designs, inaccurate or incomplete network directories, and burdensome prior authorization requirements make it extremely difficult for hospitals to provide accurate cost estimates. As a result, patients frequently encounter unexpected financial exposure, not because of hospital pricing, but because of insurance design. Patients often cannot determine what their insurance covers, which providers are truly in-network, or how much they will owe until after receiving care, making meaningful comparison shopping impossible.

[11] Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022 | GAO
[12] HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation | GAO
[13] How Insurers That Own Providers Can Game The Medical Loss Ratio Rules | Health Affairs

Additional transparency mandates on hospitals alone will not solve this problem; real transparency requires insurers to provide accurate, complete, and timely information about coverage, networks, and cost-sharing. Without insurer accountability, patients will continue to face uncertainty and may delay or avoid needed care due to concerns about affordability.

Conclusion

The FAH urges Congress to hold insurers accountable for practices that inflate costs and restrict access to care for patients. Policymakers should address these excessive and inappropriate behaviors by insurers that lead to growing costs to the health care system and to the individual consumer. FAH member hospitals remain committed to providing patients with the high-quality care they deserve, but meaningful reform requires insurers to meet the same standards of accountability, transparency, and patient-centeredness that hospitals meet every day.

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FAH appreciates the Committees' leadership and attention to these critical health insurance coverage issues and welcomes the opportunity to continue working together to improve health care access, affordability, and quality for all patients.