Federation of American Hospitals

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STATEMENT
of the
Federation of American Hospitals
to the
United States House Committee on Energy and Commerce Subcommittee on Health Hearing:
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."
March 18, 2026

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the United States House Energy and Commerce Subcommittee on Health hearing entitled, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape." FAH appreciates the opportunity to submit this statement as the Subcommittee continues examining health care affordability.

As the national representative of more than 1,000 tax-paying community hospitals and health systems – accounting for nearly 20 percent of U.S. community hospitals – FAH welcomes Congress's focus on affordability and is deeply committed to ensuring that every patient can access high-quality, affordable care. For more than 60 years, FAH members have shown up to meet the demand for quality, affordable patient care across the country in both urban and rural communities. In fact, tax-paying hospitals disproportionately serve underserved and vulnerable communities, often as the only safety net hospital.[1] Our members contribute state and local taxes that help fund essential public services such as schools, law enforcement, emergency services and local infrastructure, while also sustaining some of the largest and most stable sources of employment in our communities.

For our hospitals, affordability is not an abstract policy debate – it is a daily reality experienced by patients who arrive needing care while navigating increasingly complex insurance coverage and rising out-of-pocket costs. Hospitals serve every patient who walks through their doors regardless of their insurance status or their ability to pay. They see firsthand how benefit design, administrative barriers and other factors can affect whether patients are able to obtain timely care and manage the financial impact of that care. FAH members are committed to operating efficiently, increasing transparency and ensuring that patients and policymakers have clear information about out-of-pocket costs. As Congress considers policies to improve affordability, it is critical that reforms address the real drivers of patients' financial burdens and ensure that coverage facilitates access to care when patients need it most.

The Role of Tax-Paying Hospitals

FAH member hospitals have made significant investments in price transparency tools to promote access to affordable care, increase competition, and allow consumers to shop for care and make informed decisions. We continue to work to provide data and insights on input costs to help inform federal policymaking. At the local level, our hospitals provide patients with financial counselors to explore payment options, financial assistance, or coverage enrollment before and after services are provided. Having witnessed affordability challenges play out in our hospitals every day, we firmly believe that any discussion on affordability and transparency is not complete without taking a hard look at where costs are increasing most for patients – rising premiums, deductibles and other out-of-pocket expenses. We encourage Congress and the Administration to ensure that patients have the tools they need to better understand their cost sharing obligations.

Medical Loss Ratio (MLR) Oversight and Patient Affordability

The way patients experience health care affordability is most closely tied to whether the premiums they pay are actually used to support patient care. Congress established the medical loss ratio (MLR) to ensure that most premium dollars – generally 80–85 percent – are directed toward medical services rather than administrative costs or profits. Consumers reasonably expect that the premiums they pay will translate into meaningful access to hospitals, physicians, and other essential services.

However, vertical integration of insurers, providers and related entities has created ways for plans to technically comply with MLR standards while shifting premium revenue within affiliated corporate structures. Insurers that own provider entities, pharmacy benefit managers, and other subsidiaries inflate reported medical spending by directing care to their affiliates – often paying higher rates – while retaining the funds within the same corporate family.[2] This intra-corporate spending enables plans to delay and deny care provided by unaffiliated hospitals and clinicians without risking noncompliance with MLR requirements.

Under the current regulatory framework, the opaque nature of these internal transfers makes it more difficult for regulators and consumers to determine whether an insurer's reported medical spending reflects genuine investment in patient care. In fact, MedPAC has observed that traditional measures of health plan financial performance may not fully capture insurer profitability when plans are part of larger integrated organizations that include providers and other health care businesses.[3] To improve transparency and reinforce the accountability objectives of the MLR framework, CMS should consider several targeted policy improvements:

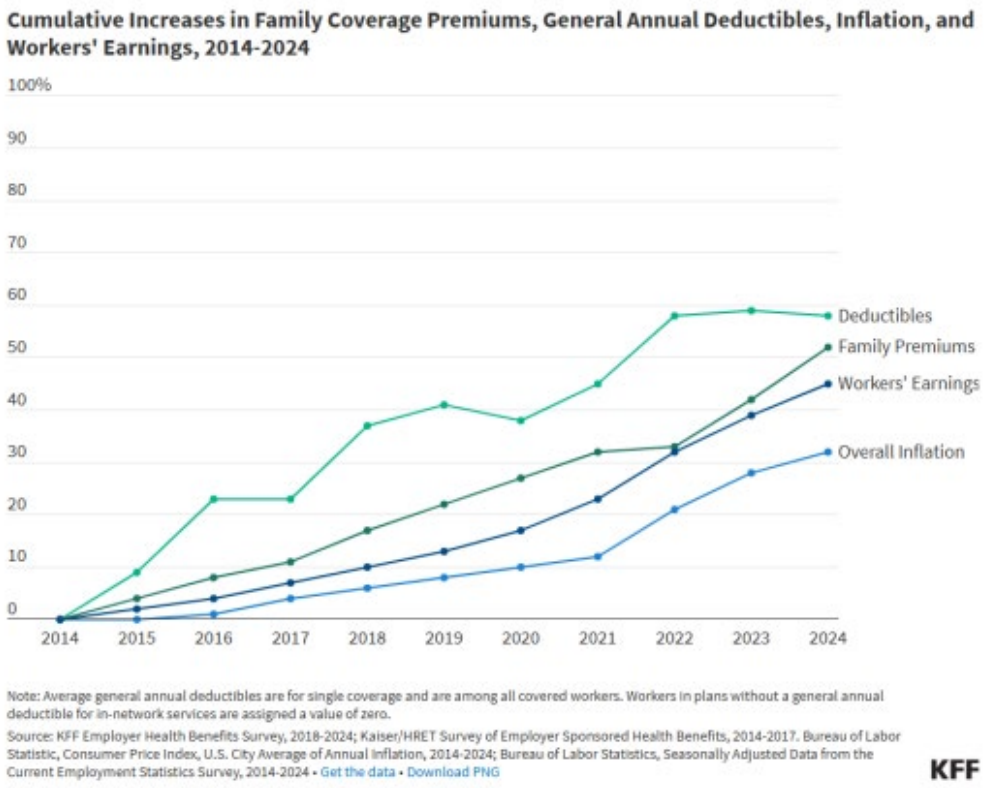
- **Require issuers to separately report payments counted as medical spending that are made to affiliated entities**, including provider organizations, pharmacy benefit managers, utilization management vendors and other subsidiaries.
- **Require issuers to disclose corporate relationships** between the insurer and entities receiving payments reported as medical claims so that regulators can evaluate the extent of vertically integrated spending.
- **Strengthen reporting requirements for quality improvement activities** to ensure that administrative functions performed by affiliated entities are not recharacterized as medical spending.
- **Expand public reporting of MLR data** to distinguish direct medical claims payments from other forms of reported medical spending, including quality improvement activities and payments to affiliated entities.
- **Incorporate review of vertically integrated payment arrangements into MLR audits and program integrity activities** to ensure that reported medical spending reflects genuine patient care rather than internal financial transfers.

Analysts and policymakers agree that gaming MLR requirements through vertical integration weakens the consumer protections Congress intended to provide, contributes to high premiums for consumers, and creates an uneven competitive landscape for providers.[4] Improving transparency and oversight of MLR reporting would help ensure that premium dollars are used to support patient care, strengthen accountability in vertically integrated insurance markets and better protect patients from rising premiums and reduced access to care.

Benefit Design and Patient Out-of-Pocket Cost Growth

Affordability challenges are compounded by insurer network design and benefit structures. Insurers have steadily increased cost-sharing obligations and continue to design coverage in ways that limit access to care and put significant financial pressure on American families. One of the most visible drivers of these pressures is the rapid growth in out-of-pocket costs.

Consumers are shouldering a growing share of costs and face ever-increasing out-of-pocket exposure before coverage kicks in. A recent study found the average deductible for individual coverage has grown more than 50 percent since 2013, now approaching $1,900.[5] When deductibles and coinsurance obligations reach several thousand dollars, many patients effectively face the full cost of care until those thresholds are met. Research shows that higher cost sharing reduces utilization of both discretionary and necessary medical services, meaning many families with insurance coverage delay or forgo care because of cost.[6]



Further, nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized.[7] More than half of these denials are eventually overturned, but only after multiple rounds of costly appeals,[8] frustrating patients and providers alike because they divert time and resources away from direct patient care. These practices create substantial barriers to accessing covered services and expose patients to unexpected costs.

These costs cannot be dismissed as aberrations. American workers are facing 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. As Congress focuses on lowering health care costs, it is critically important to understand the impact of benefit design, denial trends and growing patient out-of-pocket costs, which have far outpaced inflation. Voters consistently report that insurers and pharmaceutical companies are primarily responsible for rising health care costs[9] — a perception that reflects the real-world experience of patients and providers alike.

Hospitals as Cost Aggregators

Hospitals face significant cost pressures that are largely driven by external market forces and regulatory requirements outside of their control. As of December 2025, national year-over-year hospital costs per day were increasing at 5% for labor, 13% for supplies like personal protective equipment, and 13% for drugs — far outpacing economy-wide inflation of 2.4%.[10] Hospitals bear substantial fixed costs to maintain a fully staffed, 24/7 care environment that is ready for anything, from routine care to disasters and large-scale emergencies. They face unavoidable cost growth to recruit, retain, and support a highly skilled workforce, which accounts for roughly 60 percent of total hospital expenses—making labor the largest driver of hospital spending.[11] Even as FAH hospitals operate over 400 Graduate Medical Education (GME) programs, train over 5,000 residents and fellows, and operate state-of-the-art nursing education programs with over 17,000 students enrolled, we continue to face clinician shortages. Addressing these shortages requires competitive wages, flexible staffing models, and ongoing investments in training and professional development.

Administrative burdens further constrain our members' capacity to invest in their workforce and to expand access to patient care. In 2025, hospitals spent $43 billion trying to collect payments from insurers for care already delivered.[12]

Excessive prior authorization, claim delays and denials and repeated documentation requests continue to divert clinical resources away from direct patient care.[13] In fact, nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized. More than half of those denials are eventually overturned, but only after multiple rounds of costly appeals.[14] Many denials involve services that fully meet Medicare coverage criteria. These insurer practices create substantial administrative and payment friction, driving up costs without improving patient outcomes.[15]

These pressures are compounded by chronic underpayment from public programs, including Medicare and Medicaid, which often fail to cover the full cost of care. Currently, about 56% of hospital costs are tied to service lines where reimbursement is less than the cost of delivering care, including behavioral health, obstetrics, infectious disease, and burns and wounds.[16] Medicaid reimbursement rates are typically lower than both Medicare and the cost of providing care, which creates a persistent gap for hospitals serving a high share of Medicaid patients. According to the nonpartisan Congressional Budget Office, federal funding for Medicaid is expected to decline by approximately $990 billion over the next decade,[17] in large part due to newly enacted limits on provider taxes and state-directed payment programs. Reducing states' ability to use provider taxes will end up shifting costs to providers, exacerbating recent trends related to reductions in service lines and hospital closures.

Not all providers operate under the same obligations to serve patients, maintain emergency capacity, or absorb uncompensated care and those differences have real implications for affordability and access. Unlike full-service community hospitals, physician-owned hospitals are not structured to serve the full spectrum of patient needs. Extensive findings from the Medicare Payment Advisory Commission (MedPAC),[18] Government Accountability Office (GAO),[19] and Centers for Medicare and Medicaid Services (CMS)[20] show that these facilities systematically treat healthier, better-insured patients while avoiding Medicaid and more clinically complex cases. Rather than fueling a competitive market for care, physician-owned hospitals shift the burden of caring for sicker, uninsured, and underinsured patients onto full-service community hospitals, destabilizing local health care systems and undermining the financial viability of hospitals that must maintain emergency services, standby capacity, and comprehensive care for all patients. Weakening or repealing these protections would drive up health care spending,[21] exacerbate conflict-of-interest concerns, and further erode the stability of the full-service community hospitals that serve as the backbone of America's health care system.

Conclusion

There is no replacement for a full-service hospital in a community, and there is no replacement for the people who make that hospital work. FAH member hospitals remain committed to delivering high-quality, accessible and affordable care in the communities we serve. Every day, our hospitals treat patients regardless of their insurance status or ability to pay, invest in the workforce and infrastructure needed to maintain a 24/7 care environment and work to help patients better understand their health care costs.

Improving affordability for patients requires ensuring that the consumer protections Congress established are working as intended. FAH appreciates the Subcommittee's attention to these issues and stands ready to work with Congress to ensure that the premiums Americans pay translate into meaningful access to care.

We look forward to working with the Subcommittee on reforms that lower costs for families, reduce administrative burden, and protect access to full-service hospital care in every community we serve. Together we can deliver a more affordable system that keeps patients at the center.

Endnotes

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