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**STATEMENT
of the
Federation of American Hospitals to the
United States House Committee on Ways and Means:
“Full Committee Hearing with Health System CEOs”
April 28, 2026**

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the United States House Ways and Means Committee hearing entitled, “Full Committee Hearing with Health System CEOs.” FAH appreciates the opportunity to submit this statement as the Committee 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.ⁱ 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 an increasingly complex coverage landscape. Well before federal mandates required it, our facilities prioritized consumer accountability and patient financial support and have invested in price estimator tools to help patients estimate their out-of-pocket costs. Hospitals serve every patient who walks through their doors regardless of their insurance status or their ability to pay. We meet patients where they are—working one-on-one to navigate costs, offering flexible payment options, providing discounts and financial assistance, and absorbing substantial uncompensated care to ensure access is never denied. As Congress considers policies to improve affordability, we believe accountability and transparency must be applied equitably, across the full health care landscape.

Meaningful Coverage is Critical to Patient Affordability

Meaningful coverage is critical to patient affordability and access to care. When patients have reliable, affordable coverage, they are more likely to seek care earlier, manage chronic conditions, and avoid costly, emergency-driven treatment. Coverage shapes how and when patients interact with the healthcare system—and when it is unstable, unaffordable, or unavailable, patients often delay care, arriving at our hospitals sicker and in need of more complex and expensive interventions.

Strong, stable coverage through programs like Medicaid, Medicare, and the individual market is essential to lowering costs for patients and improving outcomes. However, chronic underpayment from public programs—including Medicare and Medicaid—creates significant financial pressure for hospitals, as reimbursement often fails to cover the full cost of care. Today, approximately 56 percent of hospital costs are tied to service lines where payment is below the cost of delivering care,ⁱⁱ including behavioral health, obstetrics, infectious disease, and burn and wound care. Medicaid reimbursement rates are also typically lower than both Medicare and the cost of providing care, creating a persistent structural gap for hospitals that serve a high share of Medicaid patients.

At the same time, coverage design in both public and private markets is contributing to growing affordability challenges for patients. Insurers have steadily increased cost-sharing requirements and structured benefits in ways that shift more

costs onto patients before coverage fully applies. As a result, patients face increasing out-of-pocket exposure and financial pressure at the point of care. Research shows that higher cost sharing reduces utilization of both discretionary and necessary medical services, meaning many families with insurance coverage still delay or forgo care because of cost.ⁱⁱⁱ These dynamics underscore the importance of strengthening coverage stability and affordability to ensure patients can access care when they need it.

FAH Hospitals are Leading the Charge to Develop Private Sector Workforce Solutions That Bolster Patient Access

Hospitals face significant cost pressures that are largely driven by external market forces and regulatory requirements outside of their control. Foremost among these is the need to maintain a fully staffed, 24/7 care environment that is ready for anything, from routine care to disasters and large-scale emergencies. This constant state of readiness carries substantial and unavoidable costs, particularly as hospitals work to recruit, retain, and support a highly skilled workforce. Labor accounts for roughly 60 percent of total hospital expenses, making it the single largest driver of hospital spending,^{iv} and those costs continue to rise, with hospital labor expenses increasing by approximately 5 percent year-over-year as of December 2025.^v

These challenges are especially acute in rural communities, where workforce shortages are more pronounced and resources are more limited. Although 20 percent of the U.S. population lives in rural areas, only about 10 percent of physicians practice in those communities, contributing to disparities in access to care, ultimately resulting in longer wait times, reduced service complexity, and limited available health care resources.^{vi} Rural hospitals must work harder to recruit clinicians, sustain training programs, and maintain essential services, often with fewer resources and thinner margins.

Because of this, FAH member hospitals are leading the way in private sector solutions across the country to address health care workforce challenges and have made substantial investments to recruit, train, and upskill employees. Investments in nursing education include HCA Healthcare's Galen College of Nursing, which is the nation's largest sponsor of graduate medical education with more than 5,800 residents and fellows in 385 accredited programs of various specialties at 85 teaching hospitals in 16 states. Our hospitals are also making significant investments to expand the pipeline for skilled nurses. HCA's Galen College of Nursing is now one of the largest nursing school networks in the United States, with 25 campuses in 12 states and more than 19,600 students.^{vii} These efforts represent system-level investments to expand seat capacity, reduce financial barriers, and accelerate practice-ready graduates in regions facing persistent nursing shortages.

Taken together, these investments strengthen the clinician pipeline, improve access to timely care in underserved rural communities, and help reduce system-wide costs by addressing workforce shortages that drive delays and inefficiencies.

The Need for Administrative Simplification to Address Cost and Access to Coverage Issues

Administrative burdens are a significant and growing challenge that directly affect both rising costs and patient care in our hospitals. Clinicians and staff spend more time navigating paperwork and less time delivering care due to unnecessary administrative complexity. Reducing these burdens and better aligning requirements across the system would improve efficiency, lower costs, and ensure patients receive timely, appropriate care.

Even when patients have insurance coverage, complex requirements—particularly in Medicare Advantage—such as prior authorization, network restrictions, and payment disputes can delay or limit access to needed services. In Medicare Advantage, excessive prior authorization requirements function as a barrier to care restricting access to covered services, even for clinically appropriate treatment. These same processes also create substantial administrative burden for hospitals and clinicians, requiring repeated documentation, reviews, and appeals that divert scarce clinical resources away from direct patient care. Excessive prior authorization, claim delays and denials, and repeated documentation requests continue to drive administrative and payment friction and increase costs without improving patient outcomes.^{viii}

In 2025, hospitals spent \$43 billion trying to collect payments from insurers for care already delivered.^{ix} Nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized.^x More than half of these denials are eventually overturned, but only after multiple rounds of costly appeals,^{xi} frustrating patients and providers alike and diverting time and resources away from direct patient care. These practices create substantial barriers to accessing covered services, increase administrative workload, and expose patients to delays and unexpected financial burden—ultimately adding to system-wide costs and undermining timely access to care.

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.^{xii}

Under the current regulatory framework, the opaque nature of these intra-corporate transfers makes it more difficult for regulators and consumers to determine whether an insurer's reported medical spending reflects genuine investment in patient care. This practice contributes to higher premiums for consumers and creates an uneven competitive landscape for providers. 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.

Effective oversight of the MLR standard requires greater insurer transparency in how premium dollars are allocated across complex corporate structures. Hospitals have led in advancing transparency by publishing patient-friendly price estimator tools that allow individuals to view expected out-of-pocket costs based on their insurance coverage, procedure, and location of care. Hospitals also provide comprehensive machine-readable files of prices and furnish good faith estimates that outline anticipated charges in advance of care. Similar commitments to clarity and accountability should apply across all segments of the health care system, including health plans.

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 Committee's attention to these issues and stands ready to work with Congress to ensure Americans have meaningful access to affordable care. We look forward to working with the Committee 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

ⁱ Cronin, C. E., Franz, B., Choyke, K., Rodriguez, V., & Gran, B. K. (June 2021). For-profit hospitals have a unique opportunity to serve as anchor institutions in the U.S. *Preventive Medicine Reports*, 22. <https://doi.org/10.1016/j.pmedr.2021.101372>

ⁱⁱ AHA. (September 2024). Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Impacting Patient Care. <https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-AreImpacting-Patient-Care.pdf>

ⁱⁱⁱ Brot-Goldberg, Z. C., Chandra, A., Handel, B. R., & Kolstad, J. T. (October 2015). What Does a Deductible Do?, National Bureau of Economic Research. https://www.nber.org/system/files/working_papers/w21632/w21632.pdf

^{iv} AHA. (March 2026). Costs of Caring. <https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf>

^v Kaufman Hall. (December 2025). National Hospital Flash Report. https://www.kaufmanhall.com/sites/default/files/2026-02/KH-NHFR_Report_December2025_Metrics.pdf

^{vi} Arredondo, Touchett, Khan, Vinventi, Watts, (June 2023) Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review, *PubMed*, [Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative](https://pubmed.ncbi.nlm.nih.gov/41111111/)

[Review - PubMed](#)

^{vii} United States House of Representatives Committee on Ways and Means Full Committee Hearing with Health System CEOs, Testimony of Samuel N. Hazen Chief Executive Officer, HCA Healthcare. <https://waysandmeans.house.gov/wp-content/uploads/2026/04/Hazen-HCA-Testimony-1.pdf>

^{viii} AHA. (September 2024). Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Impacting Patient Care. <https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-AreImpacting-Patient-Care.pdf>

^{ix} AHA. (March 2026). Costs of Caring. <https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf>

^x Premier. (March 21, 2024). Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. <https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims>

^{xi} *Ibid.*

^{xii} Arnold, D. R. & Fulton, B. D. (November 2025). UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers. Health Affairs, 44(11). <https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00155>