



Federation of American Hospitals
Response to the Senate Finance Committee RFI on Health Coverage Reform
October 2, 2026

As the national representative of more than 1,000 tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Senate Finance Committee regarding the Request for Information on *Health Coverage That Works for Everyone*. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural communities across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and can provide a wide range of inpatient, ambulatory, post-acute, and emergency services. FAH members account for approximately 20 percent of community hospitals nationally. We appreciate the Committee's leadership in working to address patients' rising out-of-pocket health costs.

I. Executive Summary

Taxpaying hospitals provide lifesaving care around the clock to patients in communities across the country, regardless of their ability to pay. FAH members also provide substantially more charity care than hospitals nationally, spending \$4.71 on charity care for every \$100 in total expenses, nearly twice the national average of \$2.48.¹ FAH believes affordable, reliable health insurance is a fundamental pillar of access to health care. Meaningful coverage helps patients obtain the right care at the right time, while providing the stability necessary for hospitals and health systems to sustain access to care in the communities they serve.

As the Committee considers policies to strengthen health care coverage, we urge you to build on what works across private insurance, Medicare, and Medicaid to expand access to affordable coverage and ensure patients can access care when they need it. Recent changes to the coverage landscape, including the expiration of the enhanced premium tax credits (EPTCs) and forthcoming reductions in Medicaid enrollment, underscore the importance of policies that preserve access to affordable coverage while addressing barriers that can prevent patients from receiving necessary care. Consumers are already feeling the impact with ACA Marketplace insurers proposing a median 15 percent premium increase for 2027, on top of a 20 percent median increase in 2026.²

Although this RFI focuses primarily on private insurance markets, FAH also urges the Committee to consider the significant implications of recent changes to Medicaid financing and eligibility as part of its broader work to protect coverage and access to care. Changes enacted in H.R. 1 to Medicaid provider taxes and state-directed payments will constrain states' ability to finance their Medicaid programs and put pressure on states to reduce provider payments, services, or coverage. New work requirements and other eligibility changes could further disrupt coverage for Medicaid beneficiaries. FAH encourages the Committee to mitigate these impacts through legislation and implementation guidance that preserve state flexibility and support stable Medicaid coverage and access to care.

Against this backdrop, FAH offers the following comments and recommendations in response to the Committee's request for information. Our comments address all three sections of the RFI. For ease of reference, we have identified below the RFI section(s) to which each comment most directly relates. We urge the Committee to adopt policies that promote:

- Health insurance affordability and coverage stability, including policies to maintain and strengthen affordable Marketplace plans and mitigate the effects of coverage losses (Section 1);
- Structural reform of the Medical Loss Ratio (MLR) framework, including greater transparency into how premium dollars are used and stronger accountability for vertically integrated insurers (Section 3.II/3.III);
- Reform of inappropriate prior authorization and utilization management practices, particularly in Medicare Advantage, that contribute to excessive claims delays, downcoding, denials, and administrative burdens that interfere with timely patient care (Section 2.II/2.III); and,
- Strengthened access to care in rural and post-acute settings, including addressing Medicare Advantage practices that can create barriers to care and recognizing the unique challenges facing providers serving these communities (Section 2.I/2.II).

¹ Analysis of Medicare Cost Report Data FY 2024

² McGough, M., Ortaliza, J., Ferguson, A., et al. (2026, July 8). How much and why ACA marketplace premiums are going up in 2027. Peterson-KFF Health System Tracker. <https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/>

FAH appreciates the opportunity to provide the Committee with the perspective of hospitals and health systems on these issues. We look forward to working with the Committee on practical policies that strengthen affordability, improve patients' ability to access and use their health insurance, and support the delivery of high-quality care.

II. Ensure Affordable Premiums and Meaningful Cost-Sharing Protection

Extend the Enhanced Premium Tax Credits (EPTCs) (Section 1.III)

The most immediate and direct step Congress can take to improve the affordability and stability of individual-market coverage is to restore enhanced premium tax credits (EPTCs). FAH has consistently supported extending the credits because they have helped millions of Americans afford Marketplace plans and strengthened the individual health insurance market. We encourage the Committee to make restoration of the EPTCs a central, near-term priority.

The need for action is clear following the expiration of the EPTCs at the end of 2025. Analysis of CMS data shows that effectuated Marketplace enrollment fell 12 percent in 2026, while average premium payments increased 58 percent.³ These changes are already affecting patients. FAH members report that fewer patients with ACA Marketplace coverage are seeking care at their hospitals, while more patients are delaying care or receiving care without insurance as coverage becomes less affordable, contributing to higher uncompensated care. These trends are consistent with national estimate that recently enacted Medicaid changes and the expiration of EPTCs will increase the number of uninsured patients and lead to \$283 billion in additional uncompensated care between 2025 and 2034, including \$85 billion for hospitals.⁴ These experiences reflect the broader impact projected from EPTC expiration. The Urban Institute estimates that expiration of the enhanced credits will result in 4.8 million more uninsured people in 2026 and \$2.2 billion in additional uncompensated care costs for hospitals, with particularly significant effects in rural communities and states that have not expanded Medicaid.⁵

Restoring the EPTCs would help millions of Americans maintain affordable coverage, reduce the number of uninsured patients, and mitigate the growing uncompensated-care burden facing hospitals.

Comprehensively Define Affordability (Section 1.I)

Affordable coverage means more than an affordable premium. Patients must be able to use their health insurance to access medical care without facing excessive deductibles, cost-sharing or other financial barriers. The expiration of the EPTCs illustrates this challenge, with average Marketplace deductibles increasing 37 percent in 2026.⁶ More consumers also shifted to bronze plans, which generally offer lower premiums but higher deductibles.

FAH encourages the Committee to take a comprehensive approach to affordability that considers not only the cost of coverage, but also the barriers that can make coverage difficult for patients to use. This includes premiums, out-of-pocket costs, administrative burdens, insurer practices, and benefit design. The Committee should pursue reforms that address these cost and access barriers across the health care system and ensure accountability for all stakeholders that influence patients' ability to afford and access care.

Restore Strong Out-of-Pocket Protections (Section 1.II)

FAH strongly supports robust out-of-pocket protections, including enforcement of statutory Maximum Out-of-Pocket (MOOP) limits, to protect patients from excessive cost-sharing. Coverage is not meaningful if patients cannot afford to use their health insurance when they need care. Without strong MOOP protections, plans can structure cost-sharing in ways that leave patients facing substantial financial obligations even when they have insurance.

³ Anderson, M., Yi Chin, C., & Cohen, M. (2026). Emerging 2026 ACA data: Enrollment drops 12% as relative risk rises 6.3%. Wakely. <https://www.wakely.com/blog/emerging-2026-aca-data-enrollment-drops-12-as-relative-risk-rises-6-3/>

⁴ Blavin, F., & Simpson, M. (2025a, June 12). State-Level Estimates of Health Care Spending and Uncompensated Care Changes under the Reconciliation Bill and Expiration of Enhanced Subsidies. Urban Institute. <https://www.urban.org/research/publication/state-level-estimates-health-care-spending-and-uncompensated-care-changes>

⁵ Blavin, F., & Simpson, M. (2025, September 25). Changes in health care spending and uncompensated care under enhanced tax credit expiration for marketplace coverage. Urban Institute. <https://www.urban.org/research/publication/changes-health-care-spending-and-uncompensated-care-under-enhanced-tax-credit>

⁶ KFF. (2026, May 19). The average marketplace deductible grew by about \$1,000 per person in 2026, with more enrollees shifting to higher-deductible plans as enhanced tax credits expired. KFF. <https://www.kff.org/affordable-care-act/the-average-marketplace-deductible-grew-by-about-1000-per-person-in-2026-with-more-enrollees-shifting-to-higher-deductible-plans-as-enhanced-tax-credits-expired/>

FAH opposed CMS's recently finalized policy allowing certain individual market bronze plans to impose out-of-pocket limits above the standard annual maximum beginning in 2027, with similar changes for catastrophic plans beginning in 2028. For patients, this will mean significantly higher costs before reaching the point at which their coverage provides full protection from additional cost sharing, increasing the risk of delayed or forgone care because they cannot afford it. We encourage the Committee to limit or reverse this expansion of out-of-pocket exposure and strengthen statutory protections that ensure Marketplace coverage provides meaningful financial protection for patients.

Preserve Essential Health Benefits (EHB) Coverage (Section 1.I)

FAH encourages the Committee to maintain a strong federal floor for the ACA's EHBs while preserving states' flexibility to expand coverage. EHBs are foundational to ensuring patients have access to comprehensive, medically necessary care, while also protecting enrollees from annual and lifetime dollar limits and allowing eligible consumers to use cost-sharing subsidies for covered services. Narrowing the scope of EHBs could shift costs to patients, increase underinsurance, and create barriers to timely care. FAH also supports preserving states' authority to require services that fall within the 10 statutory EHB categories and ensuring those services retain EHB status and the associated consumer protections, including protections against annual and lifetime dollar limits and excessive cost-sharing.

Ensure Marketplace Plans Provide Meaningful Access to Care (Section 1.I)

FAH remains concerned about the certification of non-network QHPs, which CMS finalized beginning in 2027 for State Exchanges and 2028 for Federally-facilitated Exchanges (FFE's). Without contracted provider networks, patients may face uncertainty about whether their plan's payment will be sufficient to cover the care they need, potentially exposing them to significant and unpredictable out-of-pocket costs. FAH urges Congress to strengthen network adequacy standards and oversight to ensure that Marketplace coverage provides patients with meaningful access to care and adequate financial protection.

Support Broad, Stable Marketplace Enrollment (Section 1.I)

FAH supports policies that promote broad, stable Marketplace enrollment by making coverage affordable and ensuring that eligible consumers can enroll and maintain coverage without unnecessary barriers. This includes maintaining policies that support affordability and addressing administrative barriers that can cause eligible consumers to lose coverage or forgo enrollment. Program integrity remains an important component of a stable Marketplace, and FAH supports targeted enforcement against agents, brokers, and web-brokers that engage in improper or unauthorized enrollment practices. These targeted efforts can protect consumers and the integrity of the Marketplace while preserving access for eligible individuals.

III. Strengthen MLR Oversight and Transparency (Section 3.III)

The Medical Loss Ratio (MLR) framework was designed to ensure that most premium dollars are used to provide clinical services and improve health outcomes, rather than administrative costs and profits. As the insurance market has become increasingly vertically integrated, however, insurers make payments to affiliated providers, pharmacy benefit managers, utilization management companies, and other related entities within the same corporate structure that are reported as medical spending. These arrangements can make it difficult for regulators and consumers to determine whether reported medical spending reflects genuine investment in patient care. FAH encourages the Committee to strengthen MLR transparency and oversight, so patients and policymakers can better understand how premium dollars are being used and whether they are translating into value and access to care.

Increase Transparency into Vertically Integrated Insurers (Section 3.II/3.III)

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 under the same corporate family.⁷ Under the current regulatory framework, the lack of transparency surrounding these intra-corporate transfers makes it difficult for both regulators and consumers to determine whether reported medical spending reflects a true investment in patient care.

⁷ Arnold, D. R., & Fulton, B. D. (2025). UnitedHealthcare pays Optum providers more than non-Optum providers. *Health Affairs*, 44(11), 1395–1403. <https://doi.org/10.1377/hlthaff.2025.00155>



FAH encourages Congress to strengthen transparency and oversight of these arrangements. Congress should require issuers to disclose corporate relationships between insurers and entities receiving payments reported as medical claims and separately report payments to affiliated entities, including payments that may not reflect competitive market rates. Congress should also direct appropriate federal oversight agencies to incorporate review of vertically integrated payment arrangements into MLR audits and program integrity activities, giving regulators and policymakers greater visibility into how premium dollars are being used.

Ensure Quality Improvement Spending Reflects Genuine Investments in Patient Care (Section 3.III)

Quality improvement activities are a category of spending, separate from direct claims payments for medical services, that insurers may count toward their medical spending totals under MLR rules. These activities are intended to improve health outcomes rather than pay for a specific medical service. Current rules permit certain expenses of affiliated entities and vendors to qualify as quality improvement activities when they meet specific criteria, creating a greater need for transparency to ensure that reported quality improvement spending accurately reflects activities that improve patient care. FAH urges Congress to strengthen reporting standards to ensure issuers clearly demonstrate that quality improvement spending, particularly spending paid to related parties, reflects genuine improvement activities that benefit patients.

Strengthen Program Integrity and Oversight (Section 3.III)

Public reporting of MLR data should be expanded to draw a clearer line between direct medical claims payments and other spending categories currently counted toward the medical spending total. FAH encourages Congress to strengthen reporting requirements and oversight in this area to improve transparency and support program integrity, by giving regulators better tools to detect reporting practices that inflate MLR figures without a corresponding benefit to enrollees. This should include incorporating vertically integrated payment arrangements into MLR audits and program integrity activities, ensuring that audits specifically examine whether these internal payment structures reflect fair market value and genuine healthcare spending rather than mechanisms to inflate reported figures.

IV. Reform Prior Authorization and Utilization Management (Section 2.II/2.III).

Patients and providers continue to face significant barriers to timely access to medically necessary care as insurers increasingly rely on prior authorization, utilization management, claim denials, and repeated documentation requirements. These practices can delay treatment, prolong hospital stays, and require patients and providers to navigate costly and time-consuming appeals. FAH has seen particular concern post-acute care services, where delays in authorization can prevent patients from moving to the appropriate care setting.

Prior authorization reform is an important step toward addressing these barriers, and FAH supports efforts to shorten decision timeframes, require specific reasons for denials, improve transparency, and strengthen enforcement. However, prior authorization is only one component of broader utilization management and claims practices that can delay or deny care. Congress should therefore pursue a comprehensive approach that addresses inappropriate denials, excessive documentation requirements, appeals processes, and other insurer practices that create barriers to timely care, while strengthening accountability for plans that fail to meet their obligations to patients and providers.

Standardization and Electronic Processes (Section 2.II)

FAH supports standardizing prior authorization processes and improving information exchange among patients, providers, and payers. Electronic processes can reduce administrative burden, give providers more time to focus on patient care, and enable greater alignment with interoperability standards. To support effective electronic prior authorization, however, providers should have flexibility to use certified health information technology, electronic prescribing vendors, and other technology partners that support these workflows. FAH recommends a phased implementation approach to minimize operational risk and avoid duplicative work.

FAH encourages Congress to build on CMS's existing interoperability and prior authorization requirements by establishing consistent standards across payers and ensuring that electronic prior authorization systems reduce, rather than shift, administration burdens for providers and patients.

Timely Decisions (Section 2.II)

Prior authorization can also create delays that put patients at risk when they do not receive timely care, particularly in Medicare Advantage, where these requirements are common. These delays can cause patients to postpone or forego needed services and divert provider resources away from patient care. For patients transitioning from acute to post-acute care, delays or denials can prevent timely access to the appropriate level of care, including inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and other post-acute services. This can prolong hospital stays, disrupt recovery, and leave patients without the care they need to regain independence and return to their daily lives.

FAH encourages Congress to establish clear, timely standards for prior authorization decisions across payers and ensure that patients and providers receive timely, concurrent notice of determinations. FAH recommends shortening and standardizing, to the greatest extent possible, prior authorization timeframes and expanding reporting and disclosure requirements to provide greater insight into payers' use of prior authorization. FAH recommends that both providers and patients receive notification of determinations on the same business day whenever possible and no later than 24 hours after a determination is made on a request. FAH also supports meaningful consequences when payers fail to meet applicable prior authorization timeframes, including deemed authorization where appropriate.

CMS's 2024 final rule established 72-hour expedited and seven-day standard prior authorization decision timeframes for certain payers for non-drug items and services, but those requirements do not apply uniformly across payer types and exclude drug prior authorization.⁸ CMS's 2026 proposed rule would build on those requirements by extending prior authorization reforms to drugs and further aligning decision timeframes across federal health coverage programs, but those provisions have not yet been finalized. Congress should strengthen these efforts by establishing consistent protections that minimize delays in medically necessary care.

FAH has also advocated for legislation to reform prior authorization and strengthen reporting requirements to protect Medicare Advantage enrollees from delays in care and denials, including the *Improving Seniors' Timely Access to Care Act* and the *Medicare Advantage Improvement Act (MAIA)*. These bills would advance complementary reforms to streamline prior authorization and increase transparency and accountability. In particular, the *Medicare Advantage Improvement Act* would bolster network adequacy requirements for Medicare Advantage plans by requiring adequate access to IRFs and LTCHs while also strengthening requirements for timely payment of authorized services. These provisions would help ensure that Medicare Advantage enrollees can access the appropriate post-acute setting when they need it, and that providers can deliver that care without unnecessary administrative and payment barriers. FAH urges Congress to advance these provisions alongside broader Medicare Advantage prior authorization reforms.

Transparency and Reporting (Section 2.II/2.III)

As enrollment in Medicare Advantage grows, so must oversight to ensure plans meet their obligations under the Medicare statute and CMS regulations. Without transparency and accountability guardrails in place, harmful plan practices can evolve into threats to the long-term integrity of the program and the Medicare Trust Fund. FAH encourages Congress to strengthen reporting standards, so policymakers, regulators and patients can better understand how prior authorization is being used to identify patterns of excessive denials or delays.

FAH has urged CMS to require reporting on prior authorization measures for each category of items and services, including inpatient and outpatient hospital services, inpatient rehabilitation services, and long-term acute care services as well as at the individual plan level. More detailed reporting would reveal, for example, whether the payer denies prior authorization requests for high-intensity and time-critical items and services, including post-acute care services, at disproportionately higher rates. Such reporting is needed to appropriately hold payers accountable for excessive denials and delays in responding to prior authorization requests.

Delays or denials of authorization for IRF and LTCH services can impede timely hospital discharges and prevent patients from transitioning to the level of care most appropriate for their clinical needs. CMS now requires certain payers to publicly report specified prior authorization metrics annually,⁹ but current requirements do not provide the full level of service-specific and payer-level detail FAH has advocated. More specifically, the data are generally aggregated across

⁸ Centers for Medicare and Medicaid Services. (2024a). CMS interoperability and prior authorization final rule (CMS-0057-F) | CMS. CMS.Gov. <https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f>

⁹ Centers for Medicare and Medicaid Services. (2024b). Prior authorization API. CMS.Gov. <https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/frequently-asked-questions/prior-authorization-api>

medical items and services, making it difficult to determine how denial rates differ for hospital, post-acute, or other specific services.¹⁰

Denial Communications (Section 2.II/2.III)

When prior authorization is denied, patients and providers need clear, actionable information about the reason for the denial and how to appeal the decision. Effective communication is particularly important for patients who may not understand their appeal rights or have the time or ability to navigate a complex appeals process. Recent data underscores the need to strengthen these protections. In 2024, only 11.5 percent of denied Medicare Advantage prior authorization requests were appealed, yet 80.7 percent of those appeals were partially or fully overturned.¹¹ This suggests that many patients may not be pursuing an available avenue to obtain care that is ultimately determined to be appropriate. Navigating the appeals process has also proved challenging for patients, with nearly eight in 10 insured adults who experienced a denied claim reported difficulty understanding some aspect of their health insurance.¹² Congress should ensure that patients and providers receive timely, understandable explanations of adverse determinations, clear information about their appeal rights, and straightforward instructions on how to initiate an appeal.

Separately, FAH members continue to report concerns with the substance of certain utilization management decisions. These include inappropriate downcoding that effectively denies the treatment course recommended by the treating provider, as well as instances in which Medicare Advantage plans do not follow applicable Medicare coverage criteria when making authorization decisions for medically necessary services. These practices can prevent patients from receiving the level or type of care their treating providers determine is medically necessary, particularly when patients are transitioning from acute to post-acute care. Congress should strengthen oversight and accountability for utilization management practices to ensure that coverage decisions are consistent with applicable Medicare requirements and do not create unnecessary barriers to medically necessary care.

Under its 2024 Interoperability and Prior Authorization final rule, CMS requires payers to provide health care providers with a specific reason for denying a prior authorization request for non-drug items and services. In its 2026 Interoperability Standards and Prior Authorization for Drugs Proposed Rule, CMS proposed extending this requirement to prior authorization requests for drugs, regardless of how the request is submitted or the decision is communicated. While FAH supported CMS's proposal as an important step towards clearer communication, more structured and narrative information should be required. Providers need information that is not only understandable, but also sufficiently specific and standardized to identify what must be addressed to resubmit or appeal the request. Without structured data, providers must rely on manual review, payer-specific interpretations, and inconsistent follow-up workflows that do not support scalable operations. FAH recommended that each denial should include a structured denial code, a plain-language explanation, any specific missing document or unmet criterion, the applicable coverage policy or medical necessity requirement, the appeal or resubmission pathway, and whether alternative therapies or services would meet coverage criteria. FAH encourages Congress to build on these efforts by establishing clear and consistent requirements for denial communications that give providers and patients the information they need to understand the basis for a denial, determine their options, and pursue appropriate next steps.

Gold Carding (Section 2.II)

A potential solution that prevents prior authorization from delaying necessary care is gold carding. Under the current framework, Medicare Advantage plans routinely use prior authorization policies, procedures, and protocols to delay and limit care for patients and place significant burden on providers. Due to unclear and constantly changing requirements, 95 percent of physicians report that prior authorization delays patients' access to necessary care.¹³ FAH endorsed the *GOLD Card Act of 2023*, a bipartisan House proposal allowing providers that have prior authorization approval rates of over 90 percent to bypass the prior authorization process entirely. FAH encourages Congress to establish a gold carding

¹⁰ Long, M., Biniak, J. F., Lo, J., et al. (2026, August 13). Prior authorization metrics provide new insights into insurer practices, but gaps remain. KFF. <https://www.kff.org/patient-consumer-protections/prior-authorization-metrics-provide-new-insights-into-insurer-practices-but-gaps-remain/>

¹¹ Fuglesten Biniak, J., Sroczynski, N., & Freed, M. (2026, January 28). Medicare advantage insurers made nearly 53 million prior authorization determinations in 2024 | KFF. KFF. <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/>

¹² Pollitz, K., Pestaina, K., Lopes, L., et al. (2023, September 29). Consumer survey highlights problems with denied health insurance claims. KFF. <https://www.kff.org/affordable-care-act/consumer-survey-highlights-problems-with-denied-health-insurance-claims/>

¹³ American Medical Association. (2026, May 13). AMA survey: Prior authorization reform pledge falls short with physicians. American Medical Association. <https://www.ama-assn.org/press-center/ama-press-releases/ama-survey-prior-authorization-reform-pledge-falls-short-physicians>

pathway that allows providers with demonstrated high approval rates to bypass unnecessary prior authorization requirements.

V. Protect Post-Acute and Rural Access to Care (Section 2.I/2.II).

Post-Acute Network Adequacy (Section 2.I)

Network adequacy standards for post-acute providers such as Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs) are critical to ensuring timely access to medically necessary care. These facilities often serve as medically appropriate settings for patients who can be safely discharged from a hospital but are not yet able to return home. Too often, patients with brain injuries, spinal cord injuries, stroke victims, and others with complex, but common conditions face barriers to accessing these services because health plans do not contract adequately with post-acute providers. While federal network adequacy standards apply in certain coverage markets, post-acute providers are not consistently incorporated into these standards.

FAH has urged CMS to establish explicit network adequacy standards for IRFs and LTCHs and encourages Congress to strengthen network adequacy requirements and oversight across federally regulated health insurance markets, including Medicare Advantage and Marketplace coverage. Congress should also strengthen CMS oversight of sub-networks and ensure that network adequacy standards reflect actual patient access to providers and facilities, rather than relying solely on a plan's reported network. Patients should be able to access the providers and services their coverage is intended to provide when they need them.

Discharge Delays (Section 2.II)

When patients cannot access appropriate post-acute care, including because of delayed or denied authorization, delayed discharge can keep them in the hospital longer than medically necessary. These delays can also reduce payment to the post-acute provider without increasing the hospital's per-discharge payment. For Medicare Advantage enrollees, gaps in post-acute networks can contribute to longer hospital stays and limit access to higher-acuity post-acute settings. A recent study also found that patients enrolled in Medicare Advantage plans were more likely to experience longer hospital stays and were less likely to be discharged to certain higher-acuity post-acute settings than traditional Medicare beneficiaries.¹⁴ CMS should monitor how long Medicare Advantage enrollees wait for discharge to post-acute care and strengthen oversight of MA plans' post-acute networks. Congress should build on these efforts by requiring greater transparency into discharge delays and access to post-acute providers, including reporting on the time patients wait for authorization and placement. This information would help identify barriers to timely transitions and ensure patients can move to the appropriate level of care without unnecessary delays.

Rural Access (Section 2.I)

Coverage and network challenges are particularly significant for rural hospitals and providers serving medically underserved communities. Many rural markets operate with limited financial margins and have fewer opportunities to offset increases in uncompensated care. Narrow networks and high-deductible, limited-network plan designs can further limit patients' ability to access care in markets where provider capacity is already constrained. FAH encourages Congress to consider the unique challenges facing rural communities when strengthening network adequacy and insurer accountability requirements, including whether patients in rural areas can access medically necessary care within a reasonable time and distance.

VI. Conclusion

FAH commends the Committee's thoughtful approach to improving health care affordability, strengthening the value of health coverage, and protecting patients' access to medically necessary care. Across these issues, patients should have coverage that is affordable, provides meaningful financial protection, and allows timely access to the providers and services they need. FAH appreciates the opportunity to share the perspective of America's hospitals and health systems and looks forward to working with the Committee on these critical issues. If you have any questions or would like to discuss these recommendations further, please contact FAH's Christina McCauley, Vice President, Government Relations at cmccauley@fah.org.

¹⁴ Strengthen Healthcare. (2025, June). Analysis of hospital discharges to PAC settings among Medicare beneficiaries. <https://strengthenhealthcare.org/wp-content/uploads/2025/06/PAC-Analysis-Findings.pdf>