

Hearing with Health System CEOs

HEARING BEFORE THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

SECOND SESSION

APRIL 28, 2026

Serial No. 119-FC13

COMMITTEE ON WAYS AND MEANS

JASON SMITH, Missouri, *Chairman*

| | |
|----------------------------------|-----------------------------------|
| VERN BUCHANAN, Florida | RICHARD E. NEAL, Massachusetts |
| ADRIAN SMITH, Nebraska | LLOYD DOGGETT, Texas |
| MIKE KELLY, Pennsylvania | MIKE THOMPSON, California JOHN B. |
| DAVID SCHWEIKERT, Arizona | LARSON, Connecticut |
| DARIN LAHOOD, Illinois | DANNY DAVIS, Illinois LINDA |
| JODEY ARRINGTON, Texas | SANCHEZ, California |
| RON ESTES, Kansas | TERRI SEWELL, Alabama |
| LLOYD SMUCKER, Pennsylvania | SUZAN DELBENE, Washington |
| KEVIN HERN, Oklahoma | JUDY CHU, California |
| CAROL MILLER, West Virginia GREG | GWEN MOORE, Wisconsin |
| MURPHY, North Carolina | DON BEYER, Virginia |
| DAVID KUSTOFF, Tennessee | DWIGHT EVANS, Pennsylvania |
| BRIAN FITZPATRICK, Pennsylvania | BRAD SCHNEIDER, Illinois |
| GREG STEUBE, Florida CLAUDIA | JIMMY PANETTA, California |
| TENNEY, New York | JIMMY GOMEZ, California |
| MICHELLE FISCHBACH, Minnesota | STEVEN HORSFORD, Nevada |
| BLAKE MOORE, Utah | STACEY PLASKET, Virginia |
| BETH VAN DUYN, Texas | TOM SUOZZI, New York |
| RANDY FEENSTRA, Iowa | |
| NICOLE MALLIOTAKIS, New York | |
| MIKE CAREY, Ohio | |
| RUDY YAKYM, Indiana | |
| MAX MILLER, Ohio | |
| AARON BEAN, Florida | |
| NATHANIEL MORAN, Texas | |

MATT MEYER, *Staff Director*

BRANDON CASEY, *Minority Chief Counsel*



United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
April 21, 2026
No. FC-13

CONTACT: 202-225-3625

Chairman Smith Announces Hearing with Health System CEOs

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a hearing on the impact of rising health care costs on patients and families by examining the role of health systems within the current state of health care affordability. The hearing will take place on **Tuesday, April 28, 2026, at 10:00 AM in 1100 Longworth House Office Building.**

Members of the public may view the hearing via live webcast available at <https://waysandmeans.house.gov>. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Tuesday, May 12, 2026**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials

submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at <http://www.waysandmeans.house.gov/>.

###

1 HEARING WITH HEALTH SYSTEM CEOS

2 Tuesday, April 28, 2026

3 House of Representatives,

4 Committee on Ways and Means,

5 Washington, D.C.

6

7

8

9 The committee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth
10 House Office Building, Hon. Jason Smith [chairman of the committee] presiding.

11

12 *Chairman Smith. The committee will come to order.

13 Good morning, and I would like to thank each of our witnesses for voluntarily
14 agreeing to appear before the committee this morning. Today's hearing is a continuation
15 of the committee's larger effort to get to the root causes of why health care is so
16 outrageously expensive for patients, and why so many Americans lack access to health
17 care.

18 CEOs representing some of the nation's largest hospitals are before us. But let me
19 be clear, the entire health care system -- hospitals, insurance companies, drug
20 manufacturers, pharmacy middlemen -- all bear responsibility for the high costs patients
21 face.

22 First, hospitals and, in particular, the doctors, nurses, and medical professionals
23 who work there, treat vulnerable, sick Americans and do it with some of the most advanced
24 medicine in the world. Our communities are better off with hospitals in them, but large
25 health systems have taken advantage of that reality.

26 The corporatization of American hospitals means that our local hospitals and
27 physicians have been replaced by mega-corporations that put quarterly earnings over
28 quality care, and grow larger simply for the sake of growing larger. Hospitals with more
29 than 100 beds have a higher profit margin than Delta Airlines, Target, or Disney. Let me
30 repeat that again: Hospitals with more than 100 beds have a higher profit margin than
31 Delta Airlines, Disney, and Target. It turns out charging an arm and a leg for health care
32 is more lucrative than the happiest place on Earth.

33 When CEOs of some of the largest health insurance companies came before this
34 committee earlier this year, they pointed the finger at hospitals as the culprit. This
35 committee isn't interested in hearing about how the high prices your businesses charge are
36 somehow someone else's fault. The blame game didn't work with insurers, and it won't

37 work today with us.

38 Simply put, hospitals are charging an insane amount for care. Hospital prices have
39 skyrocketed 300 percent in just over 2 decades, more than any other sector of our economy.
40 Not one sector was even close.

41 Hospital consolidation and mergers that lead to ever-growing market power are
42 fueling the borderline extortionary prices hospitals charge patients. Today there are 4,500
43 hospitals, and 2,000 of them have undergone a merger since 2000. The result is that today
44 90 percent of hospital beds are part of the health system. The place and scale of the
45 mergers have led to market concentration. That puts patients at the mercy of hospital
46 empires. When hospitals have no competition, it is no wonder that the sky seems to be the
47 limit for prices.

48 A family in California was charged nearly \$300,000 to treat their toddler's snake
49 bite, \$300,000 for a toddler's snake bite. A man in Florida had an emergency CT scan that
50 the hospital billed for \$13,000. A follow-up scan at a different location cost him only 79
51 bucks. Another Alabama woman was sued for the full cost of her appendix procedure plus
52 interest, nearly \$37,000. After faithfully paying the bill every month for three years she
53 told her husband that the burden of the lawsuit was so great that she wished she had passed
54 away at the hospital, rather than deal with the lawsuit. Those stories illustrate how these
55 systems prey on patients, who have few options for care in their time of need.

56 Patients are not getting better for the higher prices, either. Study after study found
57 that hospital mergers are not generally associated with better health. In rural America
58 hospital mergers may sustain access in some communities, but I have seen firsthand how
59 profit-seeking health systems view struggling rural hospitals as nothing more than a
60 gateway to more patient referrals. It is no wonder rural Americans are sicker, have higher
61 rates of chronic disease, and die earlier as a result.

62 What is worse, a complex set of legal loopholes and open-ended taxpayer subsidies
63 manipulated by sophisticated hospitals have become a key part of a business model that
64 fuels ever-larger systems, eliminates competition, and drives higher prices. Urban hospital
65 chains double-dip and classify themselves as both urban for higher wage index
66 reimbursements and then reclassify as rural for another set of government benefits. That is
67 absurd.

68 One example that this committee has been focused on is the 10 percent of new
69 residency slots that Congress set aside in 2020 for rural hospitals. Of the 120 slots
70 allocated to rural hospitals, only 30 have actually gone to truly rural communities. In total,
71 urban hospitals have taken 97 percent of all new residency slots, far more than Congress
72 ever intended. It is unacceptable for large, wealthy urban hospitals to take what rightfully
73 belongs to truly rural communities when those communities already suffer from lack of
74 access to care.

75 Regardless of a hospital's geography, we have seen health systems leverage
76 payment differentials between hospital-owned clinics and independent physician offices
77 direct more money to their corporate coffers. The higher reimbursement for hospital-
78 owned clinics incentivizes consolidation and encourages hospitals to buy up more
79 independent practices. It is no wonder today half of the U.S. physicians are employed by
80 larger systems like hospitals.

81 Unsurprisingly, this business practice also raises costs for patients receiving the
82 exact same service. For example, an ultrasound costs \$164 when provided by a physician.
83 It costs \$339 at a hospital outpatient department. A biopsy costs about \$150 when
84 performed by a physician; it costs \$800 at a hospital outpatient department.

85 Congress, including this committee, has taken efforts to right the wrong and ensure
86 patients and taxpayers pay lower prices for the same service with the same quality. But

87 every time we try to advance these so-called site neutral policies, big hospitals, they fight
88 us. They fight us tooth and nail.

89 For-profit hospitals are legally required to put shareholders over patients, but so-
90 called non-profit hospitals rarely act much different. Tax-exempt hospitals deliver charity
91 care that is consistently worth less than the tax breaks that they receive. These non-profit
92 hospitals receive a \$28 billion tax break while only spending roughly 16 billion on charity
93 care a year. The difference fuels a spending spree totally unrelated to providing health
94 care like real estate investments, stadium-naming rights, green energy initiatives, and
95 political activism.

96 Large hospital systems also manipulate the 340B drug pricing program to keep
97 steep drug discounts for themselves instead of passing the savings to low-income patients.
98 There is little evidence that the \$290 billion in discounts given to hospitals under the 340B
99 program since Obamacare was reinvested in patients. Even worse, there is evidence that
100 hospital abuse of 340B actually directly led to increases in Obamacare premiums.

101 Today I expect we will hear how, from these hospital executives, their opinion on
102 how insurers and drug-makers contribute to the unaffordable cost of health care. But this
103 committee will be asking and expect answers to why hospital prices make up, by far, the
104 largest share of the insurance premium increases that grew three times faster than earnings.

105 This hearing is not the end of the road for our investigation into the unaffordable
106 cost of health care. The American people are fed up with outrageous prices that seem
107 artificially high. They are right. Hospital prices are unjustified. This committee will
108 continue to fight to lower health care costs for working families. The first step is to get
109 answers and expose the truth, and that is exactly why you are all here today.

110

111 *Chairman Smith. I am pleased to welcome the ranking member, Mr. Neal, for his
112 opening statement.

113 *Mr. Neal. Thank you, Mr. Chairman.

114 Rightfully feeling the heat of the public's anger, the majority is holding their third
115 hearing on health care in as many weeks, all to deflect blame and responsibility. Families
116 are not going to be fooled easily. This is about their tax bill. They know that right now it
117 is wildly unpopular, and anything that can distract from the tax bill should be part of this
118 conversation.

119 Last year in America the only real economic growth was in health care for obvious
120 and good reason. It is based on innovation that is taking place. A reminder to colleagues:
121 technology helps to drive the cost of health care. Let me give you an example. From
122 Springfield to Worcester, Baystate Medical Center, UMass Memorial, a 40-mile stretch --
123 and this morning the addition of Mercy Medical Center -- 40 miles, more than 30,000
124 people get up and go to work every day. Who wouldn't want the teaching hospitals that
125 we have across this country? And I am proud of the fact that we expanded GME slots in a
126 bipartisan manner recently.

127 We will continue on the Democratic side to defend Medicare and Medicaid and the
128 Affordable Care Act, an understanding that patients and families simply can't afford what is
129 being offered to them as they watch profits for big corporations soar. But trying to lower
130 the cost of health care -- or perhaps a better description would be to manage it -- is a
131 challenge now, largely because of their tax bill. Thirty-seven percent of marketplace
132 enrollees say they are cutting back on food and other necessities to afford health care
133 coverage. We need to listen to them.

134 I heard the argument that was offered just a couple of minutes ago. It has been my
135 honor to represent the Sisters of Providence in the Mercy Medical Center through my

136 lifetime. As I always point out, at seven years old I left my appendix there, as well. Their
137 achievements are remarkable. The Sisters of Providence, what they did for health care in
138 western Massachusetts, the Pioneer Valley, and indeed across America, is witness to the
139 advances we have made in health care.

140 Democrats know that they can be done, and we want further opportunities to make
141 sure that health care in America is expanded to all members of the American family.
142 Because of our fight, Medicare drug negotiations and cap -- we capped out of pocket, and
143 insulin costs, expanded senior benefits, we delivered years of record enrollment, and now
144 only 8.5 percent of the American people are without health insurance.

145 A statistic: every child in Massachusetts has health insurance; 97 percent of the
146 adults in Massachusetts have health insurance. Four former governors and the current
147 governor of Massachusetts, including Mitt Romney and Bill Weld, gathered but two weeks
148 ago to celebrate our achievement. And you know what? Republican and Democrat, they
149 all deserve credit for what they were willing to do when they had the opportunity. That is
150 how you deliver for families.

151 The President stamps his name on websites and hands out favors, but doesn't want
152 to acknowledge the reality of how hard it is to manage health care costs. With the health
153 care crisis, it is looming over millions of families.

154 The fervor and attention that we have heard everywhere seldom addresses some of
155 the root causes. Last year we warned for months that their trillion-dollar tax cut bill was
156 going to harm the American health care system. They refused to acknowledge the
157 questions that we raised. They ripped coverage from 15 million people and pushed
158 hundreds of hospitals to the brink, and then they complain about the problem after it is their
159 tax bill that is going to lead to these massive cuts.

160 Health care is not a Democratic or Republican issue, it is an American issue. Their

161 challenge based on rural health care is simple, and we want to help because many of us,
162 myself included, we have rural health care challenges as well. I helped to reopen a
163 hospital that was in desperate need of a rural -- because of its rural setting. And today that
164 hospital continues to deliver first-class health care.

165 All of this is based upon they set the fire and now they are calling the fire
166 department. There is no plan. I have been here for a long time. There has never been a
167 Republican agreement on health care, simply the critique of what we have tried to do in the
168 affirmative. They keep trying to convince people that it is about just the providers. It is
169 about many of their policies, as well. Families are paying more for everything because
170 they have decided to go along with these ill-considered proposals.

171 There is a different path, and Democrats believe in the power of legislating for a
172 fairer tomorrow. We stand up against those who try to cut taxes so that they can cut health
173 care. We need to be talking about real solutions that bring costs down for workers and
174 families, and that starts with reversing the harm of what they did in their tax bill, and you in
175 the room today are going to be asked questions because of their policies as it relates to the
176 tax bill.

177 We should have a conversation about the tax bill, and then we can get on to some of
178 the questions that perhaps are legitimately posed to all of you this morning.

179 *Mr. Neal. Thank you, Chairman.

180 *Chairman Smith. Thank you, Ranking Member Neal. I will now introduce our
181 witnesses.

182 Mr. Sam Hazen is the chief executive officer of the HCA Healthcare.

183 Mr. Wright Lassiter is president and chief executive officer of CommonSpirit
184 Health.

185 And we have Dr. Brian Donley as president and chief executive officer of New
186 York-Presbyterian.

187 And we have Dr. Michael Waldrum as chief executive officer of ECU Health.

188 We have Mr. Brad Woodhouse as president of Protect Our Care.

189 Thank you all for joining us today. Your written statements will be made part of
190 the hearing record, and you each have five minutes to deliver your remarks.

191 Mr. Hazen, you may begin when you are ready.

192

193 STATEMENT OF SAM N. HAZEN, CHIEF EXECUTIVE OFFICER, HCA
194 HEALTHCARE

195

196 *Mr. Hazen. Chairman Smith, Ranking Member Neal, and members of the
197 committee, thank you for this opportunity to testify on health care affordability. I am Sam
198 Hazen, chief executive officer of HCA Healthcare. I have been with the company for 43
199 years, and throughout my career I have remained grounded in a simple belief: health care
200 is deeply personal and essential to everyone.

201 I was raised in the coal mining communities of rural Kentucky, where access to care
202 was often limited by distance, income, and infrastructure. Those experiences reaffirmed
203 my commitment to high-quality health care, accessible and cost-effective for all. I am
204 honored to lead HCA Healthcare, a network of 190 hospitals and more than 2,500 sites of
205 care.

206 Last year HCA served 47 million patients, including many in rural and underserved
207 communities. Our hospitals operate 24 hours a day, 365 days a year. They are designed
208 to operate under extreme conditions and remain open and responsive throughout public
209 health emergencies like the COVID-19 pandemic, hurricanes such as Hurricane Helene,
210 and other disruptions. We provide critical lifesaving services, and we care for every
211 patient who comes through our emergency room doors, regardless of their ability to pay.

212 Last year alone we provided approximately \$4.5 billion in uncompensated care,
213 including charity care and financial assistance for uninsured patients. That number
214 reflects commitment to our mission and the essential role our hospitals play in communities
215 across the country.

216 The reality of our system today is clear: health care in this country has never been
217 better nor more advanced, but it is also too expensive for too many people. Whether it is

218 the price of a prescription, insurance premiums, or an unanticipated emergency room visit,
219 the financial pressures associated with health care affect every American household. We
220 ask this committee to consider three ways to address the affordability challenges.

221 First, one of the most effective ways to address this challenge is to ensure stable and
222 affordable health insurance coverage. When patients have reliable coverage they have
223 greater access and can seek care earlier, manage chronic conditions more effectively, and
224 avoid costly emergency interventions. Coverage is an essential starting point, but
225 coverage alone is not enough. Providers must also deliver care more efficiently, with
226 higher quality and greater consistency. At HCA Healthcare we are investing in
227 technologies, workforce development, and care delivery models that improve outcomes,
228 expand access, and reduce unnecessary costs. We are working to give patients better
229 information about the cost of their care while recognizing that true transparency requires
230 coordination across the entire system.

231 Second, fair competition matters too. When providers compete on quality, service,
232 and access, it drives better patient care and lowers costs. Certificate of need laws,
233 originally intended to control costs, now do the opposite: limiting competition,
234 constraining supply, and increasing prices. Revisiting these laws would encourage
235 innovation and improve access, especially in underserved areas.

236 Third, we also see firsthand the toll of administrative complexity. Insured patients
237 and providers routinely face barriers including prior authorization and payment disputes
238 such as care denials and underpayments. These frictions translate directly into delayed
239 diagnosis, reduced access, and higher costs. HCA is attempting to work with payers to
240 address some of these challenges, and I am encouraged by early progress.

241 At the same time, hospitals must comply with hundreds of overlapping and
242 sometimes conflicting Federal and state requirements. While these regulations promote

243 quality, their volume can often create inefficiencies that divert time and resources away
244 from the patients they are meant to protect.

245 In conclusion, the best way to improve health care in the United States is for all
246 participants to work together toward the shared goal of building a system that serves
247 everyone. At HCA Healthcare we are committed to playing an active role in that effort.

248 Thank you again, and I look forward to our discussion today.

**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*

April 28, 2026

Chairman Smith, Ranking Member Neal, Members of the Committee, thank you for the opportunity to testify. I am Sam Hazen, Chief Executive Officer of HCA Healthcare. I have been with the company for 43 years, previously serving as President and Chief Operating Officer, President of Operations, and President of our Western Group.

As it is for so many Americans, healthcare is personal to me. I was raised in the coal mining communities of rural Kentucky, and my mother and father lived there their entire lives. Access to care was often limited by distance, income, and infrastructure. Those experiences reaffirmed my commitment to making healthcare accessible and affordable.

I am proud to lead HCA Healthcare, a network of 190 hospitals and more than 2,500 sites of care that had 47 million patient encounters last year, including many in rural and underserved areas. Our hospitals provide critical, lifesaving services to our communities 24 hours a day. We care for everyone who comes through our emergency room doors, regardless of ability to pay. Last year alone, HCA Healthcare provided approximately \$4.5 billion in uncompensated care, including charity care and financial assistance for uninsured patients.

Supporting our commitment to our patients requires not only clinical capability, but also a strong and sustainable financial foundation. As a publicly traded company, we operate with a high degree of financial discipline and transparency, supported by a broad base of stakeholders made up of many of the Americans we serve as patients, including public pension funds, retirement systems, and our own employees.

Healthcare in this country is too expensive for too many people. Affordability is a barrier to care. Whether it is the price of a prescription, the growing weight of insurance premiums, or the burden of an unanticipated emergency room bill, the financial pressures associated with healthcare affect nearly every American household. These challenges are real, and they demand the urgent attention of everyone in healthcare.

The starting point is insurance coverage. When patients have reliable coverage, they seek care earlier and better manage chronic conditions, and they can often avoid the need for expensive and emergency-driven treatment. When coverage is not available or affordable, patients delay care, arriving at hospitals sicker and often in the most expensive setting—the emergency room. Ensuring patient access to Medicaid, Medicare, and the individual insurance marketplace is one of the most direct and efficient ways to lower healthcare costs.

We know, however, that coverage alone is not enough. Our job as providers is to control what we can, by focusing on our patients and improving the efficiency and quality of care while increasing transparency of their healthcare costs. When we do that, we reduce complications and unnecessary utilization and ultimately reduce costs for everyone.

There is more to be done, and we are committed to improving value for patients, investing in our communities, and engaging with policymakers about the challenges and tradeoffs. We look forward to working with you and healthcare stakeholders to implement balanced, evidence-based solutions that benefit our patients and taxpayers.

HCA Healthcare and Its Commitment to Patients and Communities

For almost 60 years, HCA Healthcare has played a pivotal role in communities across the country. Founded in 1968 in Nashville, Tennessee, we have grown from a single hospital into one of the nation's leading healthcare providers. Today, we operate a broad network of inpatient and outpatient facilities, all focused on providing patient-centered, high-quality care. Our facilities include acute care hospitals, surgery centers, freestanding emergency rooms, urgent care clinics, behavioral health facilities, and other points of care, supporting 47 million patient encounters last year. HCA Healthcare is also one of the largest providers of trauma care in the country. We dedicate significant capital—\$5 billion in 2025 alone—to expanding access, modernizing facilities, and deploying technologies that improve clinical outcomes and patient safety.

Rural Care and Outreach

We invest to support rural and underserved areas. In many places, our hospitals are among the largest providers of Medicaid services and uncompensated care, helping ensure that vulnerable populations have access to essential care regardless of their ability to pay. In harder-to-reach areas, we leverage our network to connect people with the care they need. In addition to operating 35 rural acute care hospitals throughout the country, initiatives like our HealthONE Rural Network help to provide access to highly specialized care quickly, without requiring patients to leave their communities.

Additionally, we recognize that improving outcomes requires work outside of our hospitals. Thus, we partner with local organizations, sponsor community health initiatives, and support programs that address underlying barriers to healthcare access. For example, our hospitals engage in extensive collaboration with community partners, including Federally Qualified Health Centers, free clinics, and local nonprofits to improve patient care, particularly after discharge. These partnerships provide comprehensive care for underserved populations, ensuring access to primary care, preventive services, and necessary social support. And last year we engaged more than 160 community organizations through intervention programs focused on maternal health outcomes, chronic disease management, and nutrition.

Crises and Disasters

Hospitals play a unique role in times of crisis. Our hospitals are designed to operate under extreme conditions and remain open and responsive throughout public health emergencies, natural

disasters, and other disruptions. When disasters strike, our focus is simple: care first. We coordinate across our network to move supplies, deploy caregivers, and support affected communities. For example, we used our national scale to support patients, clinicians, and communities during the COVID-19 pandemic. We expanded bed capacity, redeployed clinical staff across markets, and established system-wide protocols to manage surges while maintaining continuity of care for non-COVID patients. We also used data and clinical analytics capabilities to identify emerging trends, guide treatment approaches, and share real-time insights across our network. We simultaneously invested in personal protective equipment, testing infrastructure, and vaccination efforts, including hosting community vaccination sites and partnering with public health authorities. As public health conditions stabilized, **we returned approximately \$6 billion in CARES Act funding**, in recognition of the fact that those resources may have been needed elsewhere.

More recently, during Hurricane Helene, our colleagues maintained 24/7 hospital operations despite complete infrastructure failures in western North Carolina. That meant digging wells and running continuous water trucks to ensure a safe water supply; constructing a 6,500-foot dam to protect our facilities from flooding; housing staff who could not return to their homes in more than 500 hotel rooms; and coordinating constant fuel deliveries to power nearly a dozen electric generators. Our hospitals were a refuge, providing lifesaving care, stability, shelter, and support. I am proud of our colleagues for meeting the challenges in their communities. HCA Healthcare nurses, doctors, and other team members show up when it matters most—from the mass shooting in Las Vegas, to Hurricane Katrina, and other large disasters.

Financial Support for Those in Need

At HCA Healthcare, we are committed to maintaining financial assistance programs that make care more accessible and affordable for our patients. In 2025, HCA Healthcare provided approximately \$4.5 billion in uncompensated care, including charity care and financial assistance for uninsured patients—one of the largest financial assistance efforts in healthcare.

Our financial assistance programs are intended to help patients who have received hospital care focus on their health, in part by meeting them wherever they are on the income spectrum. Our hospitals across the United States maintain comprehensive financial assistance policies that include full 100% write-offs of patient balances for the most vulnerable (generally those with household incomes below 200% of the federal poverty level). We extend these policies further by providing sliding scale caps on out-of-pocket balances owed by patients, based on their annual household income. We work to make the financial assistance application process as simple as possible for our patients.

We also prioritize flexibility and fairness in how patients meet their financial obligations. For example, we offer interest-free payment plans tailored to individual circumstances, and **we do not report medical debt to credit bureaus, nor do we pursue litigation or liens against patients for unpaid bills.**

We understand that healthcare insurance and the hospital billing process can be confusing and stressful for patients. Our dedicated patient benefit advisors and financial counselors work with

patients to understand their specific financial circumstances and coverage options, identify available assistance, and apply for Medicaid or other coverage programs. We encourage patients to seek assistance as soon as issues or questions arise.

Price Transparency

Timely, understandable information about healthcare costs helps patients make informed decisions about their care. HCA Healthcare has been a leader in price transparency, publishing consumer-facing pricing information well before federal requirements were established and investing in tools that make that information more accessible and actionable.

Today, our hospitals offer 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. We also provide comprehensive machine-readable files that are required by federal transparency rules as well as financial counseling services to help patients navigate their insurance coverage and payment options. For uninsured and self-pay patients, we furnish good faith estimates that outline anticipated charges in advance of care to reduce uncertainty and help avoid unexpected bills.

These efforts are part of our broader commitment to provide patients with clear, usable information. But they are only a partial solution. It is important to recognize the limits of provider-only transparency and communication. The out-of-pocket costs a patient may be required to pay depends not only on hospital charges, but also on insurance plan design, network status, deductibles, and other insurance plan-specific factors that only insurers know. Without real-time, integrated data from health insurers, even the most robust and well-intended provider tools will not provide a complete picture to patients.

Improving price transparency will, therefore, require coordinated action across the healthcare system. We support efforts to improve data sharing and standardize formats and to ensure that providers and payers are creating a consistent, accurate, and transparent framework for patients. We are committed to working constructively with policymakers, regulators, and other stakeholders to advance transparency, so that consistent, accurate, and truly useful information is provided to patients.

Education for Doctors, Nurses, and Caregivers

Ensuring access and meeting the growing demand for healthcare services requires sustained investment in workforce development and clinical education. We are 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. We also are making significant investments to expand the pipeline for skilled nurses. Our 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.

Beyond nursing, we have expanded workforce training programs through our Workforce Development Center of Excellence, which has supported more than 1,450 graduates and now

offers 28 programs in critical specialties such as imaging and sterile processing. Additionally, we invested more than \$50 million in tuition assistance and student loan support for our colleagues last year, including \$35 million to help 11,500 individuals pursue nursing degrees. These investments strengthen our workforce and help to ensure that the next generation of healthcare professionals will be there for patients and their communities.

Solutions to Improve Access and Affordability

We believe there are three key policies that can improve access and affordability: promoting affordable insurance coverage, fostering competition, and simplifying administrative and regulatory burdens. HCA Healthcare is prepared to engage with policymakers to identify and implement solutions that align with these goals.

Affordable Insurance Coverage

The availability of stable and affordable insurance is the key to determining how and when patients interact with the healthcare system and to improve outcomes, while also better controlling costs.

Insurance directly impacts patient behavior. Research consistently shows that covered individuals are much more likely to receive preventive services, maintain continuity of care, and manage chronic conditions. Conversely, uninsured individuals are more likely to delay or avoid costly healthcare; the result in such scenarios is predictable—conditions worsen, and treatments become more complex and costly.

We see these patterns every day. When coverage is unreliable or lost altogether, patients are more likely to seek care later and when sicker, often from emergency departments. That is not optimal for patients or the healthcare system.

Strong, stable coverage programs are essential. Medicaid, for instance, provides coverage to more than 65 million Americans, including many of the most vulnerable patients, while Medicare serves nearly 70 million seniors and individuals with disabilities. Ensuring these programs are adequately funded and that reimbursement remains aligned with the cost of care is critical to maintaining access.

Equally important is the individual insurance market. More than 20 million Americans now receive coverage through the health insurance exchanges, which have expanded access to affordable, market-based options. Policies that strengthen these markets are essential to reducing coverage gaps and promoting continuity of care.

Coverage stability also enables hospitals to support essential services, invest in workforce and technology, and remain prepared for emergencies. In many of the communities we serve, particularly in high-growth states like Florida and Texas, HCA Healthcare is among the largest providers of Medicaid services, underscoring both our commitment to vulnerable populations and the central role coverage plays in maintaining access to healthcare.

Competition

HCA Healthcare believes that fair competition, where hospitals compete on quality and outcomes, improves care delivery and lowers costs. Barriers to competition can drive up costs. One area where federal and state governments may help promote competition is through the elimination of certificate of need (CON) laws. CON laws were originally intended to help manage costs and prevent duplication of services, but decades of evidence suggest they often do the opposite, by limiting competition, constraining supply, and driving up prices. Revisiting these laws would encourage new entrants, foster innovation in care delivery, and help address capacity shortages in both fast-growing and underserved areas. Earlier this month, Tennessee became the latest state to enact legislation that would ultimately end CON.

Administrative and Regulatory Simplification

For coverage and competition to improve access and affordability, they must function properly at the site of care. Too often, insured patients face administrative barriers that delay or limit access, including prior authorization requirements, network restrictions, and payment disputes. In a 2024 survey by the American Medical Association, nine out of 10 physicians reported that prior authorization has a negative impact on patient outcomes and delays access to care, with nearly a quarter reporting that it led to an adverse clinical outcome for a patient. All the while, denials and delays have become more prevalent, increasing administrative costs and creating uncertainty for providers. These frictions directly affect patients, who experience delayed diagnoses, postponed procedures, and reduced access to timely care.

A well-functioning healthcare system requires accountability across all participants. Insurers, providers, and policymakers each play a role in ensuring that coverage and competition translate into real, timely access to medical services. That means aligning incentives around transparency, reducing unnecessary administrative burden, and ensuring that payment policies support the delivery of high-quality care. When that alignment is achieved, patients benefit from a system that is more responsive and efficient, and ultimately, more affordable.

Further, hospitals face an extensive and fragmented regulatory burden, with hundreds of various federal and state requirements. While these regulations are intended to ensure safe, high-quality care, their volume and overlap have significantly increased administrative demands and often limit efficiency. As a result of the complex regulatory overlay, clinicians and staff spend more time on administrative activities, driving up costs, creating barriers to care, and reducing the time available for direct patient care. Federal regulatory requirements should be better aligned across agencies, consistently applied, and regularly reviewed to ensure their benefits outweigh the administrative burden. We would encourage policymakers to focus on transitioning toward voluntary Medicare demonstration models, standardizing insurance-related administrative transactions, and migrating to streamlined digital quality reporting.

Conclusion

HCA Healthcare wants to partner with policymakers and other stakeholders to improve healthcare access and affordability. We believe the best way to improve the healthcare system is to ensure that all participants—patients, hospitals, doctors, pharmaceutical companies, health insurers,

regulators, and policymakers—work together. I look forward to today’s discussion about how we and others across the healthcare system can help to advance durable, patient-centered policies that expand coverage, strengthen access, promote transparency, and support innovation.

253 *Chairman Smith. Thank you.

254 Mr. Lassiter, you are now recognized.

255

256 STATEMENT OF WRIGHT LASSITER III, PRESIDENT AND CHIEF EXECUTIVE
257 OFFICER, CommonSpirit HEALTH

258

259 *Mr. Lassiter. Chairman Smith, Ranking Member Neal, and members of the
260 committee, thank you for the opportunity to testify on an issue that affects every individual:
261 health care affordability. I am Wright Lassiter, president and CEO of CommonSpirit
262 Health. I am proud to be here representing our Catholic non-profit health system that
263 operates 158 hospitals across 24 states, including 41 rural facilities and, among them, 29
264 critical access hospitals, making us one of the nation's largest rural health care providers.

265 Guided by a mission to serve all, especially those who are most vulnerable, we
266 provide 25 million patient visits each year. We are one of the nation's largest Medicaid
267 providers, and we deliver 1 out of every 42 babies in this country.

268 Health systems play a critical role in affordability by integrating hospitals,
269 clinicians, and care teams to reduce duplication and improve outcomes. Health systems
270 support information technology, electronic health records, and data integration. We also
271 create operational efficiencies, improve purchasing and contracting so more resources can
272 flow to patient care. That is especially important in rural and underserved communities,
273 where stand-alone hospitals often lack the ability to spread fixed costs, invest in innovation
274 and technology, or sustain essential services when reimbursement falls short and expenses
275 rise.

276 Since forming in 2019, CommonSpirit has reduced operating costs by \$3 billion
277 through scale, efficiency, and innovation. We have also used that scale to strengthen

278 quality and safety across our health system. CommonSpirit has exceeded the national
279 average for CMS hospital quality star ratings for five straight years. We provide more
280 than \$5 billion in community benefit annually, including the unpaid cost of governmental
281 programs. We are consistently using new approaches to improve care and strengthen
282 operations. For instance, our sepsis surveillance program helped save more than 3,600
283 lives last year and reduce stays in the ICU by more than 33 hours per patient.

284 Our AI initiatives generate more than \$100 million in savings on an annual basis by
285 improving efficiency and reducing administrative burden. Our Virtual Integrated Care
286 program provides real-time remote support to nursing teams, helping us address workforce
287 shortages and support high-quality care. Virtual nurses help safely discharge more than
288 16,000 patients, freeing up bedside nurses from thousands of hours of paperwork.

289 Today health care affordability is being strained by four powerful forces: labor,
290 rising supply and technology costs, payer behavior, and regulatory burden. Labor alone
291 has risen more than 20 percent in the last 5 years, and now represents more than 54 percent
292 of our operating expenses. Prices of pharmaceuticals, medical supplies, and advanced
293 technologies each grew by more than 10 percent last year. For example, our spending on
294 IV fluids has increased by more than 14 percent since 2024.

295 Payer pressure is also intensifying. Billing for Medicare Advantage patients is
296 about 25 percent more expensive than for traditional Medicare patients, pulling staff, time,
297 and resources away from patient care. Commercial insurers increasingly deny claims or
298 underpay for services provided. Medicare Advantage plans are the most challenging.
299 Today we have \$4.3 billion in unpaid Medicare Advantage claims, with nearly 1 billion of
300 that being more than 150 days past due for care that CommonSpirit has delivered to
301 patients and communities that you represent.

302 Medicare and Medicaid represent nearly 70 percent of our patient volume, yet

303 Medicare reimburses approximately 80 percent of our costs to care for those patients.
304 Medicaid underpayment is also an access issue, especially in rural communities that
305 typically have higher rates of unemployment and poverty. When published -- when public
306 coverage falls short and more people become uninsured, uncompensated care rises,
307 pressures on hospitals intensify, and access becomes harder to sustain.

308 Regulatory burden for CommonSpirit adds another \$1 billion of costs to our
309 expenses on an annual basis. Those are resources that otherwise could be placed directly
310 towards patient care. We cannot solve affordability alone. Hospitals, providers, payers,
311 and the government must work together to ensure timely payment for care delivered,
312 adequate reimbursement for Medicare and Medicaid, relief from unnecessary regulatory
313 burden, and stronger accountability for health plans.

314 Thank you for the opportunity to be part of the discussion today.

Testimony
Of
Wright Lassiter, III., President and CEO
CommonSpirit Health
For the
Ways & Means Committee
Of the
U.S. House of Representatives
“Hearing with Health System CEOs”
April 28, 2026

Chairman Smith, Ranking Member Neal and Members of the Committee, thank you for the opportunity to testify on an issue that affects every individual: health care affordability.

I'm Wright Lassiter, president and CEO of CommonSpirit Health. Our Catholic nonprofit health system has 158 hospitals across 24 states, including 41 rural facilities, among them 29 critical access hospitals and 1 rural emergency hospital in San Augustine, Texas. Our rural footprint makes us one of the largest rural providers in the United States. I am proud to be here representing our more than 25,000 affiliated physicians and advanced practice practice providers, 160,000 employees including 45,000 nurses and thousands of volunteers who everyday touch patient's lives and provide healing and hope.

Guided by a mission to serve all, especially those who are most vulnerable, we provide 25 million patient visits each year. This includes care for 3.3 million Medicaid patients each year, making us one of the largest Medicaid providers in the country. We also deliver one out of every 42 babies born in the United States.

CommonSpirit continuously looks for ways to meet the evolving health needs of the communities we serve. One way we do this is through our investments in community benefit. We reinvest in our communities that range from remote towns like Williston, North Dakota, to major urban centers like Los Angeles. Last year alone, we provided more than \$5 billion in community benefit, including unreimbursed government programs, which is at least 2.5 times the value of local, state, and federal forgone taxes.

We tailor our investments to meet the health needs of each community. For example, there is a high prevalence of breast cancer rates in Yolo County, California, so we offer free preventative screenings to the community. In McMinnville, Tennessee, 25 percent of the town's residents smoke. Due to the rural location, McMinnville does not have a health facility that can offer lung cancer screenings, so our caregivers travel there to provide them. At our first screening, more

than 20 percent of patients had a lung abnormality. Now we go back every quarter. That is what we mean by mission-based health care committed to community benefit. Other investments range from providing car seats to low-income families in Park Rapids, Minnesota, to expanding substance use recovery and behavioral health support in Council Bluffs, Iowa.

In addition to the direct services we provide in communities across the country, we serve an essential role in educating and training the next generation of health care professionals. Our organization provides extensive medical education to nearly 3,200 residents and fellows each year, including 1,700 that train in CommonSpirit facilities. We also provide critical education and clinical training for nurses, radiation and laboratory technologists, phlebotomists, respiratory therapists, and many other allied health professionals. At a time when provider shortages are placing growing strain on the health care system and limiting access to care in many communities, this workforce development mission is a vital extension of our public service. By strengthening the pipeline of trained clinicians and caregivers, we are helping meet both today's health care needs and the challenges ahead.

What CommonSpirit is doing to lower cost and preserve access

We share the Committee's priority to make healthcare more affordable. As CEO of a large nonprofit health system, I take the responsibility of maintaining affordability and accessibility very seriously. Our scale allows us to integrate hospitals, clinics and care teams to reduce duplication, improve coordination and strengthen the efficiency of care delivery. It allows us to invest in technology, expand access in rural and underserved areas, stabilize essential services, strengthen our ability to recruit and retain clinicians, and negotiate more effectively with suppliers, which helps control costs across the system. Most importantly, it helps preserve local access to care.

For example, CommonSpirit Mercy Hospital in Durango, CO, provides crucial pediatric oncology care. This care is vital for children, including an 8-year-old we will refer to as Alex for privacy purposes, who is battling leukemia. Because of our services he can receive treatment closer to home and avoid the 6.5-hour drive to a specialized hospital. This local access significantly reduces the emotional, financial, and logistical burdens on rural families.

My philosophy is that we have to be two things at once: large enough to bring scale, resources and stability, and local enough to respond to the unique needs of each community we serve. Rural and community hospitals face the same market pressures as their urban and academic counterparts, only with fewer resources. They confront workforce shortages, declining patient volumes, rising labor and supply costs and an increasingly complex regulatory environment, often while operating on extremely thin margins. By bringing the resources of a larger system to those communities, we can help smaller hospitals manage expensive technology requirements, difficult payer contracting negotiations, workforce shortages and other pressures while addressing local gaps in care and preserving access in the 41 rural communities we serve.

Rural hospitals aren't simply places to receive health care. These hospitals serve as economic anchors for their communities. They support local jobs, sustain small businesses and contribute to the stability of schools, banks and civic institutions.

When one closes, the impact is immediate: jobs disappear, physicians and other clinicians leave, local businesses lose economic activity and families are forced to travel farther for care. Businesses are less likely to invest in or relocate to a community without a hospital. Over time, that loss can trigger a ripple effect that weakens the economic and social fabric of an entire region and ultimately leads to poorer health outcomes. For CommonSpirit, closing a hospital is the last resort. We have not closed a hospital in 13 years and even then we did not abandon the community. CommonSpirit repurposed the acute-care hospital to an outpatient center to meet the evolving needs of the patient population as there were three other hospitals in a 10-mile radius.

We put our scale to work through innovation, which expands access, strengthens the workforce and helps lower the cost of care. Our size allows us to direct resources where they are needed most and spread best practices quickly. As a result, patients gain access to a broader range of specialties and services closer to home, while clinicians benefit from stronger support systems and more sustainable career pathways.

As an integrated system, we equip our hospitals, clinics and rural facilities with capabilities they could not build or sustain on their own. For example:

- **We deploy virtual care models** like our Virtual Integrated Care program, which provides real-time remote support to bedside teams. Virtual nurses helped to safely discharge more than 16,000 patients, freeing bedside nurses from thousands of hours of paperwork. This approach allows on-site nurses to perform at the top of their license, improve patient outcomes and reduce administrative burden on clinicians.
- Telehealth flexibilities supported by this Committee have been critical to creating pathways for enhanced clinical care in rural and underserved communities. These flexibilities allow us to extend specialty care into rural and underserved communities. These capabilities ensure patients receive timely care without the added cost of travel or delayed treatment. Telehealth has allowed CommonSpirit to create a **virtual team of physicians who support Critical Access Hospitals on nights and weekends** to admit patients remotely. Most Critical Access Hospitals do not have a physician on-site for nights and weekends, so patients cannot be admitted and must be transferred to another hospital farther away. This program allowed 16 percent more patients to stay local.

- **We invest in advanced technology and infrastructure** that smaller standalone facilities often could not access on their own. CommonSpirit’s outpatient care centers, clinics and community and rural hospitals have access to technological tools that they would not have the resources or staff to implement alone. For example, we have implemented Care Base, a virtual hospital program that integrates virtual nurses and providers and AI-enhanced technology to support nurses at the bedside and monitor patients remotely—enabling earlier discharge. Care Base benefits patients like a grandmother from Washington state who was able to go home from the hospital just six hours after deep brain stimulation, whereas patients would typically have to stay overnight. Patients rest and recover better in their own environment having the reassurance that they are being monitored. Care Base also gives new moms peace of mind by providing postpartum remote blood pressure monitoring, reducing readmissions and ER visits.
- We are also creating efficiencies to reduce cost through operations and supply chain. Standardization in supply chain contracts helps larger organizations like CommonSpirit keep costs down, and the scale of a large system provides greater stability for communities across the country.

Faced with an IV fluid shortage due to a weather-related disruption, CommonSpirit facilities were again able to share and redirect supplies when other hospitals had to transfer or delay care.

During a recent nationwide saline shortage, our 108-bed hospital, serving rural Yolo, Solano and Colusa Counties in California secured a vital supply of sterile saline due to the large-system purchasing power of CommonSpirit Health, ensuring uninterrupted patient care without paying a premium for this high-demand item.

- CommonSpirit has also made investments in artificial intelligence that generate more than \$100 million in annual savings by improving efficiency that we can reinvest directly into patient care. Our AI tools have also significantly reduced the administrative burden on our physicians, one of the leading causes of clinical burnout. In some of our regions clinicians were spending over 1,000 hours per month to answer questions from patients via the online electronic health record patient portal. AI has allowed us to filter these messages so those requiring a clinician reach one directly, while messages better suited for other care team members are routed to them. This has reduced charting time for our clinicians and given them more time with patients

We use advanced automation tools to identify care gaps. For example, AI-enabled chart review has helped us identify tens of thousands of patients with risk factors who need cancer screenings. This has helped us detect disease earlier, when treatment is often more effective and less costly.

- We invest in workforce pipelines. Our year-long nurse residency program helps new graduates transition into practice and has achieved a 91 percent retention rate, which reduces costly turnover and helps stabilize care delivery.

We created a national internal travel nurse program that allows nurses to serve in regions of our system where they are most needed, while reducing reliance on expensive contract traveling nurses. While still relatively new, the internal travel nurse program is projected to save our health system \$18 million, returning dollars to direct patient care.

CommonSpirit's size allows us to offer competitive compensation, expand training and reduce burnout, which are key drivers of affordability. A stable workforce reduces reliance on high-cost travelling labor, lowers turnover, and improves continuity of care.

In addition, CommonSpirit has 42 graduate medical education programs across our 24 states. This means we graduate 1,731 physicians every year that are placed into the health care workforce, oftentimes in rural areas where shortages persist.

CommonSpirit understands that in order to achieve continued affordability we must create innovative solutions. Since forming in 2019, CommonSpirit has reduced costs by \$3 billion through scale, efficiency and innovation. Some of these innovative solutions have included:

- **Operational Alignment.** We consolidated our original operational structure from twelve regions into five, and streamlined the associated executive governance accordingly.
- **We recently reached a three-year national agreement with Humana** to help preserve patient access, secure more appropriate rates and improve payment timeliness to providers.
- **We have begun to insource a significant amount of our revenue cycle management operations**, aiming to boost efficiency and improve patient experience. We believe this move will reduce our cost to collect by 50 percent.

Understanding the drivers in rising health care costs

Health care is inherently complex. Unlike most industries, it involves highly specialized labor, decision-making to improve the health status of those who serve, rapidly evolving science and technology, and it is one of the highest regulated industries. It's important to note that our operating margins are very slim, even in financially stable years. Over the last five years CommonSpirit has lost \$3 billion and the losses continue to rise. We believe our financial challenges are strained by four powerful forces:

- **Labor costs and workforce shortages continue to rise.** Health care is a uniquely human endeavor. The federal government has estimated that the U.S. will be short 141,000 physicians, including 70,000 primary care physicians and 109,000 registered nurses, within 12 years. Certain specialties like behavioral health will be hit especially hard: by 2038, the U.S. will only have 61 percent of the needed child and adolescent psychiatrists, 50 percent of the needed adult psychiatrists and 30 percent of the needed addiction counselors. Rural states like Texas, Arizona and Florida are also harder hit than the U.S. at-large.¹

Labor accounts for over 54 percent of CommonSpirit's operating expenses, and labor costs across our health system have risen by more than 20 percent over the last five years.

- **The price of pharmaceuticals, medical supplies and advanced technologies continue to climb.** Health care delivery today demands both clinical excellence and financial resilience—and the reality is that the cost of delivering that care continues to rise at an unsustainable pace. Pharmaceutical prices, essential medical supplies, and advanced technologies have increased by 10 percent. An example of supply increase, our systemwide spending on IV fluids alone has grown substantially over the past two years. This surge was initially driven largely by a supply disruption from a major manufacturer following Hurricane Helen in 2024, which resulted in price increases exceeding 14 percent, but prices have not reduced when the plant came back online. For one manufacturer, the price of a 1000mL bag of sterile saline solution increased by 13%, or \$1.45, between 2024 and 2025. But because CommonSpirit uses over 420,000 bags annually, this equated to a \$522,357 cost increase in one year. This is just one product out of hundreds of thousands we purchase each year. Events like this underscore the fragility of the health care supply chain and the direct impact external forces can have on patient care costs. It also highlights one of the strengths of being a large system as we were able to move around our supplies and prevent the cancellation of surgeries unlike many smaller systems.

At the same time, we are making critical investments in technology. Advanced diagnostic capabilities—such as MRI, CT, PET, and ultrasound—along with life-saving therapeutic platforms including surgical robotics, radiation therapy systems, and cardiac catheterization labs, are essential to delivering high-quality, timely care. These technologies, however, come with extraordinary costs—not only in acquisition, but in installation, maintenance, and the continuous upgrades required to keep pace with innovation and safety standards.

¹ National Center for Health Workforce Analysis, Health Resources Services Administration. *Workforce Projections, 2023-2038*. December 2025.

Equally significant are the investments required to sustain a secure and integrated digital infrastructure. Hospitals today rely on sophisticated electronic health records, complex billing platforms, and expansive data management systems to operate effectively. Layered onto this is the growing necessity for robust cybersecurity capabilities to protect sensitive patient information in an increasingly complex threat environment. These systems require ongoing capital, specialized expertise, and constant vigilance.

- **Administrative complexities and inefficiencies imposed by health insurers continue to drive up costs:** Payer pressure continues to intensify and it comes at a significant administrative cost. For example, managing the billing process for Medicare Advantage (MA) patients costs approximately 25 percent more than for patients covered by traditional Medicare. This is especially challenging when MA makes up 28.1 percent of our payer mix.

Also costly are the contracting and revenue cycle infrastructure needed to manage increasingly complex coverage, billing and prior authorization processes, along with the advanced analytics, reporting and clinical integration required to support value-based purchasing across independent providers. We spend more than \$360 million each year to address denials and patient responsibility, both of which could be handled more efficiently by the payer. We also must interface with more than a dozen different Medicaid payment platforms, which creates significant administrative burden and is extremely inefficient. And we must communicate with many proprietary platforms used by commercial insurers. Together, these layers of complexity help explain why the American Hospital Association now estimates that 25–35 percent of all health care spending goes to administrative staff and technology.

In addition, commercial insurers increasingly deny claims and underpay for services. MA plans are among the most challenging in this regard. Currently, we have \$4.3 billion on our balance sheet from unpaid claims from MA. Nearly \$1 billion in unpaid claims is older than 150 days.

MA was a program designed to be a more efficient and effective version of traditional Medicare. Yet, it has turned into the exact opposite and putting patient access at risk. We thank many members of this Committee for their bipartisan effort to address timely payments from Medicare Advantage. The measures that have been introduced in this Committee would ensure providers are paid timely for the care delivered.

Lastly, government reimbursement remains below the actual cost of care. Medicare and Medicaid represents nearly 70 percent of our patient volume, yet Medicare only reimburses about 80 percent of the cost to care for Medicare patients. Medicaid underpayment is also an access issue, especially in rural communities that typically have

higher rates of unemployment and poverty. At CommonSpirit, 56 percent of the babies we deliver are covered by Medicaid. When public coverage falls short and more people become uninsured, uncompensated care rises, pressure on hospitals intensifies and access becomes harder to sustain.

- **Regulatory burden adds \$1 billion in additional costs:** Health care is one of the most heavily regulated industries, and complying with state and federal requirements carries a significant administrative cost. An American Hospital Association study found that hospitals spend approximately \$50,000 per inpatient bed each year to manage and comply with federal regulations. For CommonSpirit, that means nearly \$1 billion annually, much of it tied to outdated requirements duplicative of state law that drive up the cost of care.

For example, electronic health records, quality reporting metrics and cybersecurity tools create tremendous value for our patients and clinical teams. But the regulations governing these tools were developed independently and for different purposes, often resulting in duplication or even contradiction. Numerous quality measures are reported across multiple quality programs, which is duplicative and costly to administer. Other quality measures have essentially topped out, meaning that nearly all hospitals are achieving very high scores. Yet those measures are still designed to classify one-quarter of hospitals as below average, one-half as average and one-quarter as above average. The result is lower reimbursement for high-performing hospitals and a disincentive for continued improvement.

Hospitals are complex, highly regulated buildings. Construction, maintenance, utilities, including electricity, water and specialized gases, and repairs are enormous costs. Hospitals require specific ventilation, infection control and sterile environments. We have reduced our vendor costs by bringing much of our clinical engineering teams in-house, but maintaining a hospital and all of its equipment will always be an expensive endeavor. Even though this does not fall into Congressional jurisdiction, it's important to note that hospitals operate in states with unfunded mandates related to our buildings, for example specific retrofitting that costs hospitals billions of dollars to comply.

How we can partner together to make health care more affordable

This Committee's focus on affordability is essential. But hospitals cannot solve this challenge alone, and affordability is not solely a provider issue. Providers, payers and government all have to be part of the solution. Specifically, that means:

- timely payment from Medicare Advantage and stronger accountability for health plans;
- sufficient reimbursement from Medicare and Medicaid; and
- relief from unnecessary regulatory burden.

Timely payment from Medicare Advantage and stronger accountability for health plans:

As noted above, CommonSpirit has \$4.3 billion in unpaid claims from Medicare Advantage and nearly \$1 billion of that is over 150 days old. We commend the leadership from many of the members from this Committee to ensure Medicare Advantage returns to being an efficient and effective program for seniors, as it was designed. We believe the health care system should be good stewards of taxpayer dollars and we urge the Committee to pass the following pieces of legislation:

- Medicare Advantage Prompt Pay Act led by Reps. Jodey Arrington (R-Texas) and Linda Sanchez (D-Calif.)
- The Prompt and Fair Pay Act led by Reps. Greg Murphy (R-N.C.) and Lloyd Doggett (D-Texas)
- The Medicare Advantage Improvement Act led by Rep. John Joyce (R-Pennsylvania)

Other policy ideas include:

- Standardizing the process for plans and providers to request and transmit clinical information needed to adjudicate claims, improve prior authorization and complete other revenue cycle processes to eliminate duplication due to insurer variation.
- Requiring stronger insurer coverage for mental health services and network adequacies.
- Pursuing direct contracting arrangements between providers and purchasers to bypass the costs associated with insurers and other middlemen in contracting and administration.

Sufficient reimbursement from Medicare and Medicaid:

Nearly 70 percent of CommonSpirit's patient volumes come from Medicare and Medicaid. However, we continue to face shortfalls from these government programs that don't cover the cost of care. Historically we have relied on commercial insurers to help supplement the shortfall, but over the last few years we have seen double-digit premium increases for patients yet very nominal, 2 to 4 percent, reimbursement increases for providers, which are not keeping pace with basic inflation. Hospitals and health systems today have to rely on the patchwork of various programs to achieve sustainability.

In addition, the Medicaid changes from H.R. 1 will reduce CommonSpirit Health's Medicaid reimbursement by \$5 billion over the next 10 years. At full implementation we anticipate a loss of \$1 billion annually.

We urge the Committee to preserve the safety-net and support hospitals' ability to maintain access, especially in rural areas. Until reimbursement levels from Medicare and Medicaid are more commensurate with the approximate cost of care, the patchwork of programs that currently make the system work need to be protected.

Relief from unnecessary regulatory burden:

Health care is one of the most regulated industries and we have estimated we spend an average \$1 billion a year in managing various regulations across our footprint. There is an opportunity for this Committee to examine which regulations can be deemed low value and streamlined to ease the administrative and financial burden on hospitals.

Examples of opportunities to reduce administrative costs include:

- The American Hospital Association has compiled a [list](#) of suggestions to help reduce the burden on hospitals and providers. We support this list and urge the Committee to remove some of these outdated and redundant regulations.
- Support AI policies that allow for innovation and protect patient safety.
- Create one claims system for Medicaid across the country. We spend a significant amount of resources and time adjudicating claims and interfacing with different platforms, not to mention all the private plans who administer Medicaid managed care plans.

More specifics on reducing administrative costs include:

- Reduce and simplify the number of quality and efficiency measures required in various hospital quality programs. There are too many unique measures in general across and within quality programs—the more measures, the more administrative burden and cost to collect, code, validate, and report. While each quality program has between 2–16 measures, the total burden is greater than 40 when added together.
- Streamline care plan documentation requirements. We are trying to provide higher quality, more holistic care to our patients through interdisciplinary teams. These teams may include a range of clinical professionals, such as nurses, therapists and social workers. When used, these teams develop what is known as an interdisciplinary care plan. Yet, outdated regulations require nursing-specific care plans.
- Redesign the Medicare GME program to allow successful, existing education programs to grow their resident caps rather than making new hospitals create new programs. If the reimbursement rules were changed to allow for growth, well-established programs could increase the number of residents being trained without duplicating program management costs.

Conclusion

As a national nonprofit health system, our responsibility is to use our scale to expand access, improve quality and make care more affordable. That requires strong governance, transparent accountability and decisions grounded in mission, stewardship and the needs of the communities we serve. I commend the Committee's focus on affordability and we look forward to partnering with you on ways we make health care more affordable and accessible for all.

319 *Chairman Smith. Thank you.

320 Mr. Donley, you are now recognized.

321

322 STATEMENT OF BRIAN G. DONLEY, PRESIDENT AND CHIEF EXECUTIVE
323 OFFICER, NEW YORK-PRESBYTERIAN

324

325 *Dr. Donley. Good morning, Chairman Smith, Ranking Member Neal, and
326 distinguished committee members. My name is Brian Donley, and I serve as president and
327 CEO of New York-Presbyterian.

328 I am also a doctor with more than 20 years of experience caring for patients. I
329 joined New York-Presbyterian three years ago as the chief operating officer, and I assumed
330 the CEO role 12 weeks ago. I was raised in Pittsburgh, and caring for people was a central
331 part of my upbringing. My mother is a nurse and my father was a community pharmacist.
332 They instilled in me that health care is grounded in empathy, respect, and the sacred trust
333 between a patient and a caregiver. I come before you today as both a doctor and a health
334 system leader, deeply focused on compassionate, high-quality, accessible, and affordable
335 care.

336 I want to begin by acknowledging what New York-Presbyterian patients and
337 patients across this country are experiencing: the cost of care is a real and growing
338 concern. I recognize that hospitals are one part of a broader health care system that
339 contributes to these costs, and I take that responsibility seriously. New York-Presbyterian
340 is committed to working with policy-makers, payers, pharmaceutical companies, and the
341 many other health care stakeholders to find solutions that make care more affordable and
342 more accessible to Americans.

343 New York-Presbyterian is one of the nation's oldest academic systems, with 10

344 hospitals, nearly 45,000 employees, and more than 2 million patients served annually. We
345 are among the largest providers of care to Medicaid patients in New York, and we serve
346 patients from all 50 states. We care for some of the most complex and vulnerable
347 individuals in the country. In fact, our children's hospital provides some of the highest
348 acuity of care of any children's hospital in the nation. For 250 years our approach has been
349 grounded in an enduring set of commitments, including putting our patients first, investing
350 in our people, and maintaining deep connections to the communities that we serve. Our
351 mission is straightforward: to provide the highest quality of care to all patients, regardless
352 of their ability to pay.

353 But delivering on that mission comes with real financial pressures. We are facing
354 substantial cost pressures such as labor, supplies, and pharmaceuticals, with drug costs
355 alone rising by 25 percent. Compounding these challenges, government payers do not
356 reimburse the full cost of care.

357 We also face growing administrative burdens driven by the current insurance
358 environment that creates unnecessary cost and frustration for both patients and providers.
359 In response we are focused on four key areas to make care more affordable for our patients.

360 First, we are doubling down on high-quality care because when care is better not
361 only do patients do better, but care is less costly. That means fewer readmissions, fewer
362 hospital-acquired infections, and fewer complications.

363 Second, when it is right for the patient we are shifting care to lower-cost settings
364 through hospital-at-home programs, virtual nursing, ambulatory care, and telehealth.

365 Third, we are using technology to drive efficiency by cutting waste, improving
366 productivity, and reducing administrative burden, especially around insurance denials and
367 prior authorization.

368 And fourth, we are investing in our communities to reduce chronic disease. We are

369 working with partners on programs that improve health upstream, and therefore help
370 prevent avoidable hospitalizations.

371 Beyond patient care, New York-Presbyterian provides significant community
372 benefit. Last year alone this totaled \$2.4 billion, more than 20 percent of our operating
373 expenses, supporting important community-based services and school-based health centers
374 that serve 28,000 children in New York City public schools. These investments are core
375 to our mission, but they rely on a sustainable financial foundation.

376 Affordability in health care requires a shared responsibility of all stakeholders.
377 The 45,000 dedicated people of New York-Presbyterian are committed to caring for
378 patients with compassion, to advancing treatments that save lives, and to strengthening the
379 communities we serve. We stand ready to work together to make high-quality health care
380 more accessible and more affordable for all Americans.

381 I appreciate this opportunity to engage in a meaningful discussion so that we
382 together can be better for the patients and communities that we care for and that you
383 represent. Thank you.

Written Testimony of Dr. Brian G. Donley
Chief Executive Officer, NewYork-Presbyterian
House Ways & Means Committee Hearing on Healthcare Affordability
Tuesday, April 28, 2026

Chairman Smith, Ranking Member Neal, and distinguished committee members: Thank you for the opportunity to submit this testimony on the critically important topic of healthcare affordability. My name is Brian Donley, and I am the President and CEO of NewYork-Presbyterian.

I'm grateful for the opportunity to discuss an issue that is not only an organizational priority at our hospital but is also deeply important to me personally.

I grew up in Pittsburgh, the son of a nurse and a community pharmacist. I still recall the sense of pride I felt as a child when people came to our home to ask questions about their health. My parents instilled in me the importance of caring for people, and I understood early on that healthcare is about empathy, respect, and the sacred trust between a patient and caregiver. Those experiences shaped my decision to become a physician and have guided every role I have held since.

I joined NewYork-Presbyterian as Executive Vice President and Chief Operating Officer in 2023 and was honored to become the CEO approximately 12 weeks ago. I am an orthopedic surgeon with 20 years of experience at the bedside - and that is the perspective I bring to my job every day: how to best serve our patients.

I took this role because of NewYork-Presbyterian's mission-driven culture, its history of clinical excellence, and the chance to make a real difference for our patients, team members and communities.

NewYork-Presbyterian is one of the nation's most comprehensive, integrated academic healthcare systems. With ten hospitals, over 4,000 beds, more than 10,000 affiliated physicians, 14,000 nurses - 45,000 employees in total - we serve more than 2 million patients each year. We take great pride in caring for every person who comes through our doors, including patients from all 50 states. We deliver 22,000 babies and see approximately 620,000 patients in our emergency departments each year. We are also one of the largest providers of behavioral healthcare in our region, operating 500 inpatient beds, and one of the largest providers of care to Medicaid-insured New Yorkers. For the last reportable year, we provided \$2.4 billion in community benefit, 21% of our total operating expenses.

NewYork-Presbyterian has a profound commitment to our patients, our employees, and the communities we serve. We believe high quality healthcare must be accessible and affordable for all Americans, and we dedicate considerable time and resources to deliver on that mission. However, we recognize our individual initiatives must be part of a broader collaborative effort by all stakeholders. I thank the members of this committee for holding this hearing. Ensuring every

American has access to affordable, high-quality care is among the most pressing obligations we share, and it deserves sustained attention.

NewYork-Presbyterian is one of America's oldest and most respected hospitals. We treat some of New York's and this country's most complex and vulnerable patients, and we have done so for more than 250 years. Several factors have contributed to NewYork-Presbyterian's success and longevity: a commitment to our patients, mission, and world-class teams, as well as a deep connection to our local communities.

A commitment to our patients

Every day, the remarkable teams at NewYork-Presbyterian strive to provide the highest quality, most compassionate care to thousands of New Yorkers and to patients from across the country. Our teams work tirelessly to maintain our standing as a national leader in quality, safety, patient experience, and clinical outcomes.

Working with our academic partners, we develop and deliver breakthroughs that redefine what's possible in medicine and create solutions that benefit patients nationwide. For example, our children's hospital in Northern Manhattan provides among the highest acuity care of any children's hospital in the United States.¹ Over the past two years, NewYork-Presbyterian has proudly provided care to more than 1,500 children from states represented by members of this committee outside of New York.

We pride ourselves on pairing innovation with empathy, striving every day to make care more human, more personal, and more accessible for every patient—regardless of insurance status or ability to pay. There are countless stories that capture our commitment to exceptional, compassionate patient care and to groundbreaking procedures that save lives.

- Born with sickle cell disease, a seventeen-year-old patient spent much of his childhood cycling through pain crises and hospitalizations, with few treatment options available. When a clinical trial for a new gene therapy opened at NewYork-Presbyterian, he became one of the youngest patients to enroll in a procedure that involved editing his own stem cells and reintroducing them into his body. Today, he lives the normal life of a teenager, free of pain crises. That outcome required sustained investment in research infrastructure, clinical trial capacity, and the specialized teams capable of executing a procedure of that complexity. It is precisely the kind of investment that a challenging reimbursement environment puts at risk.
- In 2025, our teams completed the first Domino-split-liver transplant in adults in the United States — this rare procedure involves four patients: the primary recipient receives a new liver, while the recipient's original liver, which did not function properly for them due to a metabolic disorder but was otherwise healthy, is split to benefit two additional patients with liver failure.

¹ Internal analysis of the Children's Hospital Association Pediatric Health Information System (PHIS) database.

- When triple-negative breast cancer spread to a young mother’s brain and then her spinal fluid, she believed she had only months to live. Our teams collaborated across disciplines to tailor a complex treatment plan that helped the artist and mother of two beat the odds. Today, this young mom is a full-time artist in Connecticut who uses her talent to promote breast cancer awareness and screening.
- Perhaps most illustrative of where medicine is heading, EchoNext is an AI-powered tool which can identify structural heart disease from an EKG, something even an experienced cardiologist cannot detect with the naked eye. In 2025, after a young man presented to our emergency department with shortness of breath but no other abnormalities; EchoNext flagged him with a high-risk score, and our team discovered he carried a gene mutation that can cause sudden cardiac death if left untreated. As a result, our team performed one of the first heart transplants prompted by an AI-model finding, and today that patient is back home with his wife and daughter.

These outcomes are not accidents — they are the product of sustained, deliberate investment in people, technology, and infrastructure. They represent what an academic medical center, working at the top of its capabilities, makes possible, and they are what is at stake in the policy decisions before this committee.

More of these inspiring stories can be found at <https://www.nyp.org/healthmatters>.

A commitment to our mission

Providing care to all is fundamental to who we are as an institution. As mentioned, NewYork-Presbyterian is one of the largest providers of care to New Yorkers insured by Medicaid. We treat more Medicaid patients with complex conditions and provide more transplant and pediatric care to Medicaid patients than any other health system in New York State.² In addition, other than New York City’s public hospital system, we are the largest provider of Medicaid emergency department visits state-wide.³

Regardless of insurance coverage, or lack thereof, we believe every patient should have access to our care. No patient should ever have to skip or delay care they need because of their ability to pay. We have a generous financial aid policy and a team of more than 200 patient navigators to help people understand their coverage and apply for Medicaid or financial aid. We do not sue patients, garnish wages, place liens, or report to credit agencies for unpaid care.

We believe that greater transparency is essential and patients should better understand the cost of their care prior to treatment. However, in U.S. healthcare, both because of the complexity of the healthcare system and the need for flexibility in clinical care, helping patients accurately assess their personal financial responsibility before receiving care remains a challenge. We welcome the

² New York State Statewide Planning and Research Cooperative System (SPARCS), 2023.

³ New York State Institutional Cost Reports, 2024.

opportunity to build on the bipartisan efforts of Congress and the Administration to make pricing information more user-friendly for patients.

This commitment extends to teaching and preparing the next generation of physicians. Our Graduate Medical Education (GME) programs train approximately one in seventy of the country's physicians each year, helping to address a growing national need as our population ages and the number of physicians fails to keep pace with demand.⁴ It's projected that by 2036 there will be a shortage of 86,000 physicians nationwide.⁵ Preparing the next generation of physicians to treat patients across the country is core to our mission.

We are grateful for Medicare's role in supporting the costs of GME. However, Medicare alone cannot meet the growing demand, which is why we train more than 500 residents above our GME cap, absorbing \$720 million in costs annually.

The cost of providing care

Our work is extensive—and it costs a great deal. It has become increasingly difficult to secure adequate resources to keep reinvesting in our patients, people, and infrastructure, especially in New York City, one of the most expensive regions in the world. Inflation in the New York City metropolitan area has consistently ranked among the highest of any major U.S. city, hovering around 4% and frequently outpacing the national average.

While hospitals—including ours—have an important role to play in lowering the cost of healthcare, it is important to note that many cost drivers are external: administrative expenses driven by insurer practices and rising drug and supply prices, the increasing complexity of care for an aging population, and chronic disease becoming more prevalent.

We face sustained cost pressures from rising patient complexity, increasing cost of goods, and persistent administrative burdens imposed by payors. In addition, the evolving demands of our environment—cybersecurity, other critical safety protections, and the ongoing need to update our physical infrastructure—increases capital costs. Across our ten campuses, approximately half of our space is over 50 years old.

With a 3% margin, we must increasingly rely on generous donors and our investment portfolio to maintain the high-quality care and experience patients expect from us.

Our labor costs represent 58% of our expenses and are rising at a rate that far outpaces inflation. Even with optimizing our purchasing efforts and success in deploying technology to drive efficiencies, supplies, goods and other costs rose significantly – with drug costs alone growing by 25% in 2025 over the year prior.

⁴ Medicare Cost Reports, Healthcare Cost Report Information System (HCRIS), 2024.

⁵ *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*, Association of American Medical Schools, March 2024.

And while we are a leading provider for New Yorkers insured by Medicaid and Medicare—treating more individuals enrolled in Medicaid than any other top 20 *U.S. News and World Report* ranked hospital—these payors do not cover the full cost of care.⁶

In New York, Medicaid pays approximately 70 cents on the dollar and Medicare less than 90 cents of the cost of care.⁷ MedPAC has acknowledged that Medicare payments to hospitals remain well below costs, with margins at -12.1% in FY 2023 and projected to reach only -10% in FY 2026.⁸ Given the volume of Medicaid and Medicare patients we serve, we are preparing to absorb significant reductions in federal reimbursement over the next decade as a result of recent changes in federal law.

Among the most significant and least visible cost drivers in our system is the administrative infrastructure required to navigate insurer practices. NewYork-Presbyterian employs 160 people whose sole function is managing prior authorization claims, and an additional 60 whose sole function is appealing coverage denials. In New York, approximately 25% of inpatient hospital claims are initially denied by commercial health insurers, while 66% of denials are successfully overturned and result in payment (either full or partial).^{9,10} The cost of that process — in staff time, delayed treatment, and administrative overhead — is borne entirely by hospitals and patients.

Affordability solutions

As a world-class provider, we are committed to investing in innovation and streamlining processes—from novel, safe, and ethical applications of AI to virtual nursing and Hospital at Home programs—that expand affordable access for patients, while helping our teams deliver the highest quality care. We are focused on four key areas to address the affordability crisis:

Continuing to advance the highest quality care. Higher quality care reduces the likelihood of readmission and further costly treatment. Better patient outcomes and adherence to best practices eliminate costly inefficiencies, prevent complications, and decrease hospital admissions and readmissions, reducing overall healthcare costs.

NewYork-Presbyterian has a CMS five-star rating, a distinction earned by only 10.1% of rated hospitals nationwide. We are also Leapfrog Grade A for nine of our ten campuses, one of the first hospital systems to achieve the “Excellent Health Outcomes for All” Joint Commission Certification, and Magnet designated by the American Nurses Credentialing Center for excellent nursing care at all ten of our hospital campuses.

⁶ Medicare Cost Reports, Healthcare Cost Report Information System (HCRIS), 2024.

⁷ Greater New York Hospital Association analysis of New York State Institutional Cost Reports, 2021 and 2022.

⁸ *March 2026 Report to the Congress*, Medicare Payment Advisory Commission.

⁹ Greater New York Hospital Association analysis of New York State Division of Financial Services Health Care Claims Reports, available at: [Reports and Publications: Health Care Claims Reports - Current Calendar Year | Department of Financial Services](#).

¹⁰ Greater New York Hospital Association Member Survey, 2023.

Shifting care to lower cost settings whenever clinically appropriate. This includes implementing outpatient focused care models that reduce avoidable hospital stays. We thank Congress for extending the Acute Hospital Care at Home Waiver for an additional five years, alongside the critical extension of telehealth waiver flexibilities.

- Our Hospital at Home program provides a comfortable, safe option for patients to receive care in the least restrictive setting. Launched in late 2025, we have treated 182 patients already, with fewer than 2% needing to return to the inpatient setting, improving throughput at our two largest campuses during the height of respiratory virus season.
- NewYork-Presbyterian was an early adopter of telehealth which improved access for patients and addressed throughput challenges across our campuses. We continue to see value from the program, which lowers overhead costs, along with the access benefits noted above. Extending telehealth waiver flexibilities can reduce the cost of care, in addition to improving access.

Investing in operational efficiency to reduce the burden on our workforce and better manage costs. This includes using technology and automation to reduce administrative burden and free clinicians to spend more time with patients. We have also implemented billing and purchasing strategies to limit price escalation.

- We use Ambient Listening technology to improve the note-taking process for our front-line clinicians in outpatient settings.
- Our Procure-to-Pay team has increasingly streamlined the ordering and payment processes for hospital supplies and services by deploying automation technologies.
- We have more than two dozen hospital-wide “Value-Based Management” teams standardizing products and processes across all our hospitals—driving down pricing in categories ranging from surgical supplies to exam gloves.

Community health programs. At NewYork-Presbyterian we offer evidence-based programs in clinical and community settings that reduce the burden of chronic disease, support patient navigation, reach people where they are, and help reduce unnecessary hospital utilization.

- Our Center for Community Health Navigation has 200 staff providing peer-support in our emergency department (ED), inpatient, outpatient, and community settings. To date, the program has served nearly half a million New Yorkers by connecting them to the appropriate care location, minimizing unnecessary ED use.
- Our mobile medical units, including our mom and baby bus, mobile stroke treatment unit, and our lung cancer screening van, are cost-effective tools that allow us to reach New Yorkers where they are—offering services that keep people healthy, enable early detection, and

prevent unnecessary hospital visits.

- We screen patients for non-medical needs, including housing and food insecurity, and connect them with community-based organizations that can help. Research indicates that pairing screening with referrals reduces healthcare utilization. In 2025 alone, we completed 330,000 such screenings and made more than 2,700 direct referrals to assist patients.

Conclusion

The financial pressures described in this testimony are not unique to NewYork-Presbyterian — they are structural features of the environment in which academic medical centers operate, and they have consequences for all patients. But the burden is most acutely felt by Americans who are least able to bear them.

We appreciate the opportunity to discuss the role hospitals play in providing Americans with innovative, high-quality care that is accessible and affordable. We welcome the opportunity to work with this committee and partner with payers, medical device companies, biopharma organizations, physicians, and policymakers on collaborative solutions.

The 45,000 dedicated people of NewYork-Presbyterian are committed to caring for patients with compassion, advancing treatments that save lives, and strengthening the communities we serve. In an increasingly challenging healthcare environment, this work gets harder every day—and, yet, it has never been more fulfilling. We stand ready to work together to make high quality health care more accessible and more affordable, for all Americans.

Thank you for the opportunity to engage in a meaningful discussion so that we together can be better for the patients and communities we care for—and that you represent.

###

388 *Chairman Smith. Thank you.

389 Dr. Waldrum, you are now recognized.

390

391 STATEMENT OF MICHAEL WALDRUM, CHIEF EXECUTIVE OFFICER, ECU
392 HEALTH

393

394 *Dr. Waldrum. Good morning, Chairman Smith, Ranking Member Neal, and
395 members of the committee. My name is Mike Waldrum. I am a critical care physician
396 and chief executive officer of ECU Health, a non-profit, mission-driven health care system
397 located in rural eastern North Carolina. I am honored to offer testimony before you today
398 on health care affordability and share the realities of sustaining access in our region.

399 The barriers facing rural health systems are real and structural. I look forward to
400 working with this committee on solutions that strengthen access and affordability to ensure
401 people living in rural communities are not disadvantaged simply because of where they
402 live. My hope is that this testimony shines a light on ECU Health's experience on
403 delivering care to 1.4 million people living in a vast rural region about the size of
404 Maryland.

405 I have dedicated my life to helping people in need and in places where I can make
406 the greatest impact, taking care of the sickest and most complex patients. I moved to
407 eastern North Carolina specifically to work on the issues that rural communities face, and
408 that is why I am here with you today. I recognize and I appreciate the monumental task
409 before Congress to address rising health care costs while protecting access to care. But the
410 challenges we face continue to mount. It is urgent we go beyond a one-size-fits-all
411 solution to solve the rural health care crisis.

412 I have trained and worked in some of the nation's most prestigious health care

413 organizations. I have also seen the other side: patients who lack access to even basic
414 health care needs. I have witnessed the damage to communities and hard-working rural
415 citizens when access to care diminishes as resources increasingly are concentrated in urban
416 markets. I have experienced how health care operates under very different conditions and
417 constraints, and how those differences shape health care access, affordability, and
418 outcomes.

419 This is the story of two health care markets in our country: urban and rural. The
420 realities of rural health care are complex: sicker, older populations; flat or declining
421 growth; and patients spread across vast, challenging landscapes.

422 In eastern North Carolina -- if eastern North Carolina were its own state, it would
423 rank among the country's poorest and sickest. These realities, coupled with regulatory
424 pressures, have driven hospitals and clinic closures. Consolidation in our market is not
425 driven by preference. It is how we survive. As some exit and others enter with profit-
426 driven agendas, systems like ECU Health are left to serve as the safety net. The result is
427 reduced access, worsening outcomes, and increasing costs. These dynamics are not
428 theoretical. This is the reality of the rural health care crisis in America.

429 Despite the persistent headwinds, ECU Health has sustained access across our 29-
430 county region through a hub-and-spoke model where our community hospitals are
431 supported by the resources generated by our academic medical center. We have grown
432 into a 9-hospital system with more than 1,200 providers not in pursuit of scale, but out of
433 community necessity. We are transforming our rural, academic, regional system of care to
434 lower costs, sustain and grow access to essential services, and support the economic vitality
435 of rural communities. We have made significant progress, but we have much work to do.

436 As this committee considers Federal health care policy, I encourage you to design
437 solutions that are tailored to the 66 million people living in rural communities. Policies

438 that do not account for the differences between urban and rural markets risk leaving those
439 communities behind. We know this work cannot be done alone. We stand ready to
440 partner with you on a solution. Thank you.

Written Testimony of Michael Waldrum, MD, MSc, MBA
Chief Executive Officer, ECU Health
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
Hearing with Health System CEOs

Tuesday, April 28, 2026 – 10:00 am
1100 Longworth House Office Building
Washington DC 20515

Chairman Smith, Ranking Member Neal, and members of the Committee on Ways and Means:

Thank you for the opportunity to testify before you on the topic of health care affordability and the challenges sustaining access to high-quality health care, particularly in rural areas of our country. My name is Michael Waldrum and I serve as the chief executive officer for ECU Health, a nonprofit and mission-driven academic health system located in one of the most challenging health care environments in my state, and perhaps our nation.

As a critical care physician and health care administrator, I have dedicated the better part of my life to helping people in need and in places where I can make the greatest impact – whether taking care of some of the most complex patients in the ICU, or as CEO of a rural safety net health system where I am fortunate to have the opportunity to help solve the unique challenges of rural healthcare. I have trained and worked in some of the most prestigious and well-resourced health care organizations in our country delivering care to those fortunate to have access. I have seen the incredible outcomes that access to high-quality medicine can create. But I have also seen the other side – the patients who lack access to even basic health care needs. I have witnessed the damage to communities and hard-working rural citizens when access to care diminishes as resources are concentrated in urban or otherwise growing markets. Their experience is the story of America’s rural health care crisis.

The rural health care crisis is not theoretical – it is playing out every day in rural communities across the country at a pace that continues to be hastened by profit-driven industry behavior among for-profit and nonprofit entities alike.

Nowhere in eastern North Carolina is this reality clearer than in Williamston, North Carolina – a rural community abandoned by for-profit health care in 2023, years before the expiration of the lease obligation. Abandonment that occurred so swiftly that nearly three years later there is still evidence of the patient care that was being delivered in the moments before individuals were escorted out and the doors of the hospital were locked. While closure was abrupt, the underlying challenges developed over time. Vulnerable facilities like Martin General Hospital in Williamston, North Carolina are increasingly acquired by large, often cross-market organizations with a promise of investment and stability. But in many cases, those commitments are tied to financial models that prioritize near-term performance over

long-term community sustainability. Rural hospitals operate with low patient volumes, high Medicaid reliance, significant uncompensated care and challenges in recruiting and retaining licensed clinical professionals. Sustaining them requires a hub-and-spoke approach whereby stronger facilities support those that cannot stand alone. However, many corporate structures are not designed to allocate resources in that way, particularly when returns are evaluated at the level of individual facility return-on-investment. As a result, when expected margins are not achieved, capital investment commitments are deferred, services are reduced, and facilities are ultimately moved toward divestiture. In fragile rural communities this dynamic accelerates the loss of essential services as unprofitable and resource-intensive services are eliminated.

Maternity wards across the nation continue to close, disproportionately so in rural areas where birth rates are flat or declining. The provision of maternity care is costly for hospitals of all sizes, but particularly rural facilities with lower volumes. In addition to obstetrician-gynecology specialists, other licensed and specially trained clinicians are necessary: labor and delivery and recovery and postpartum registered nurses, anesthesiologists or certified registered nurse anesthetists, surgical teams, newborn nursery nurses, and sonographers, among others. Even with low delivery volumes, sufficient 24/7 coverage and an operating room must be available to handle unpredictable emergencies, and ongoing competency training and emergency simulation are essential not only for the core obstetric team, but for emergency department staff who may respond to local OB emergencies. This is a high fixed cost model, which is difficult to sustain despite low birth volumes, high Medicaid payor mix, and the challenges of recruiting to rural areas.

The consequences for maternal and infant health outcomes in rural communities are devastating. In eastern North Carolina, the infant death rate is 8.9 per 1,000 live births, which is the second highest in our state, and exceeds the U.S. infant death rate of approximately 5.6 per 1,000 live births. That is why, despite the extraordinary financial costs of maintaining local labor and delivery for volumes that average one delivery per day in some areas, ECU Health has historically been steadfast in maintaining these services for our rural communities. We have done so because we know when those services disappear, our mothers and babies are at higher risk of becoming part of our national maternal and infant mortality statistics.

In addition to maintaining local labor and delivery, ECU Health's Women's and Children's Service Line is a state and national leader in implementing innovative approaches to solving the maternal health crisis. Through critical federal and state funding, ECU Health is leading the "I Gave Birth" initiative in North Carolina's Perinatal Region VI, for example, to reduce maternal morbidity and mortality. Following implementation, ECU Health Medical Center's postpartum readmissions declined from 2.24 percent in January 2019 to 1.47 percent in June 2022, an early outcome that was directly correlated with program implementation. We partner with providers across our region through perinatal outreach to provide simulation-based training and implementation of standardized approaches like the Levels of Care Assessment Tool. These services and programs remain at risk as rural safety net systems like ECU Health face ongoing payment and policy pressures. Without meaningful changes, sustaining labor and delivery services in rural communities will become increasingly difficult and local access cannot be guaranteed.

The Abandonment of Rural Health Care

My observation is that there are two health care markets in the United States – urban and rural. While federal policy recognizes this in important ways, it often does not fully account for the realities of rural care delivery, leaving gaps that impact access and affordability. Until we correct for this, affordability efforts will not only fall short of desired outcomes but reinforce the flow of limited taxpayer dollars to well-resourced areas and accelerate the decline of markets that need help the most. Rural health care operates under a distinct set of structural realities: higher chronic disease burden, older populations, declining and dispersed populations, and persistent social and economic challenges. These factors drive higher utilization and greater complexity of care, while payment disparities, uncompensated care, and reliance on government payors strain limited resources.

Consolidation is occurring at a rapid pace across the health care industry. But rural consolidation, uniquely, is a survival response. Hospitals and practices consolidate in rural areas to avoid closure. When for-profit operators enter rural markets with a promise of investment and stability, then exit when margins disappoint, they do not leave behind a competitive landscape. They leave behind a community without access to local care. That is what happened in Williamston, North Carolina in August 2023, and that is what is happening across rural America at an accelerating pace.

The disparities between urban and rural health access and outcomes underscore the importance of our nation's safety net health care system. For many Americans, the safety net is not one of many options but rather, it is the primary, trusted source of care. In rural markets, a single provider often exists out of necessity. Low volumes, mostly governmental payor mix, and high fixed costs make it difficult to sustain multiple systems, which is very different from urban markets where consolidation is often driven by competition for market share and increased leverage rather than the preservation of access.

Affordability and access are so inextricably connected in rural America such that they are the same problem. When the only hospital within 60 miles closes, care does not become cheaper – it becomes unavailable. Disruptions in rural care do not disappear because a hospital closes. The care must shift, and the assumption that urban providers can absorb rural demand is not realistic. Many urban systems are already operating at- or near-capacity, and shifting large amounts of additional patients into those settings risks longer wait times, overcrowding, diminished access and higher costs across the board. The failure of rural hospitals and practices is not solely a local issue. It is a national cost driver that this Committee has the tools to address.

Hospitals are 24/7 operations, and health care providers are the only segment of the health care industry delivering direct, hands-on patient care. All hospitals participating in Medicare are required to serve all patients regardless of their ability to pay. This is a critical safeguard. However, approximately 70 percent of ECU Health patient revenue is derived from government payors—Medicare and Medicaid—whose reimbursement rates are set administratively and have historically fallen below the actual cost of delivering care. These rates, and others including commercial reimbursement in rural areas, often does not reflect the realities of rural healthcare, where providers face limited scale, high

fixed infrastructure costs, and labor expenses comparable to or exceeding those in urban markets. Since 2021, ECU Health has provided over \$660 million in Community Benefit, and in FY25 alone, the system provided nearly \$74 million in charity care as defined by IRS Form 990 Schedule H reporting. This is in addition to numerous programs and services we are providing in our communities every day despite operational losses or through reliance on state and federal grants or the generosity of our philanthropic partners.

Because of our delivery model, systems like ECU Health are far more vulnerable to the impacts of broad and sweeping policy changes and there continues to be fundamental misalignment between how rural health care operates and the payment systems upon which we rely.

The burden of these structural realities is compounded when profit-driven agendas enter rural markets. For-profit healthcare, specifically, is structured to drive profits, often targeting markets with advantageous payor mix and growth opportunity, but proximal to markets with safety net providers who carry a disproportionate share of the uncompensated care burden. They benefit from revenues generated through government sources while also enjoying commercial offsets for losses. In 2025, the largest health care provider in the country, with more than 200 hospitals across at least 20 states and the United Kingdom, reported total revenues of \$75.6 billion, yet has a Medicaid payor mix of only between 10 and 12 percent of revenue, while enjoying a commercial mix of approximately 50 percent. By comparison, ECU Health's Medicaid mix in FY25 was 20.3 percent, which is among the highest across peer organizations, and a commercial mix of 24 percent, which is among the lowest among peer organizations. Further, the nature of for-profit health care ensures that profits are returned to shareholders living far from the communities served, while organizations like ECU Health are returning limited resources, much of which accrue through government programs and subsidies, directly back into our communities. To be clear, nonprofit designation is not necessarily a safeguard against profit-driven behavior, as some nonprofit health systems exhibit financial and operational behaviors that closely mirror those of for-profit entities. Also, this profit-driven behavior is not exclusive to hospitals – it exists across the entire health care delivery system – insurers, drug manufacturers and pharmacy benefit managers, durable medical equipment suppliers and post-acute care providers.

This is not an indictment of urban or for-profit health care. Rather, it is about the need to design policies that make rural health care delivery viable for all types of providers – nonprofit and for-profit alike. That means aligning incentives so that limited taxpayer resources flow to, not away from, areas with the greatest need, and ensuring a level playing field that sustains access to care. If we get that right, rural health care becomes a more attractive environment for productive investment and participation, enabling all providers to serve fairer shares of high public payer mix and uncompensated care while preserving local access.

ECU Health and Health Care Delivery in Rural Eastern North Carolina

ECU Health serves a vast 29 county region of approximately 1.4 million people with a mission to improve the health and well-being of eastern North Carolina. Importantly though, our work as a mission-driven

organization extends far beyond clinical care delivery. We are deeply committed to the advancement of local medical education, and the creation of a healthcare ecosystem that allows local business and community-based organizations to thrive in support of more prosperous rural communities.

We are the largest employer in our region, which is approximately the size of Maryland, and the majority of our communities are among the most economically distressed in the state of North Carolina. The health care affordability crisis is exacerbated in our region due to a high concentration of chronic disease burden, an aging population, widespread poverty, significant social vulnerability and great distance between healthcare facilities while traveling on aged and limited infrastructure and without public transportation. If eastern North Carolina were its own state, it would rank among the sickest and poorest in the nation. In our rural region, people with Type 2 diabetes – a preventable and reversible condition – are twice as likely to die as the rest of our state and the country, making our Diabetes Self-Management Education & Support program and healthy food initiatives, for example, critically important. These factors and others drive increased utilization and higher acuity of care, often in our most resource-intensive settings – 24/7 emergency rooms and inpatient facilities – rather than physician practices.

We serve a vastly underserved region: all 29 of our counties are Health Professional Shortage Areas (HPSAs) for primary care and mental health, and 25 counties are dental HPSAs. Across our region, provider supply is severely limited, with averages of just 3.73 primary care physicians, 9.42 physicians, 3.65 physician assistants, and 7.65 nurse practitioners per 10,000 people. This shortage is especially pronounced given 27 counties in our 29-county service area are considered rural where recruitment challenges and limited infrastructure further constrain access to care. In stark contrast, U.S. metro areas, on average, have significantly higher provider availability per 10,000 people: 8 primary care physicians, 32 physicians, 6 physician assistants, and 13 nurse practitioners – highlighting a substantial disparity in access between rural and urban areas.

ECU Health has grown over time from one small county-owned hospital to a nine-hospital regionally integrated academic health system with more than 1,200 providers across more than 120 locations. This growth has occurred primarily through consolidation, born from the need to preserve local access rather than in pursuit of greater network size and profits.

INNOVATION DESPITE LIMITED RESOURCES: WE ARE DOING MORE WITH LESS

Much of our success can be attributed to our hub and spoke model, whereby our community hospitals are supported in large part by the clinical capabilities, infrastructure, and financial strength of our academic tertiary medical center, a model that allows us to extend specialized care and other limited resources across a large and rural region. But delivering care across a geographically dispersed, low-density population area requires more – not fewer – resources. The American College of Cardiology, for example, advises that about 13 cardiologists per 100,000 population is necessary to improve cardiovascular disease related outcomes. In rural regions like ours, we often must meet or exceed those benchmarks simply to ensure reasonable *local* access, because centralizing services would require

patients to travel significant distances. To bridge this gap, we are advancing new care models – expanding the use of advanced practice providers and leveraging telemedicine – to bring care closer to patients while maintaining quality and access.

Just as solving the affordability crisis cannot be untangled from the issues of rural health care access, affordability also demands that we address our nation’s persistent health care workforce needs. ECU Health Medical Center in Greenville, North Carolina serves as the academic teaching hospital for Brody School of Medicine at East Carolina University, which ranks among the top medical schools in the nation for graduating family medicine, internal medicine, pediatrics, and OB-GYN physicians, and ranks in the top 10 percent of U.S. medical schools for graduating physicians who practice in our state, practice primary care, and practice in underserved areas. Among the Class of 2025 students, 52 percent will enter primary care residencies, 42 percent of which will stay in North Carolina, and 20 percent were matched at ECU Health Medical Center for residency. We are also proud that Brody School of Medicine prioritizes reducing medical student debt, recognizing that education costs are a significant barrier to recruiting and retaining a rural workforce. We must support rural medical education *in and for* rural communities not only through Graduate Medical Education (GME) funding that is protected for rural providers, but also through workforce development grants, tax policies, loan forgiveness/repayment and payment models that reflect the difficulty of maintaining sustainable practices, coverage models, and specialty care access in rural communities. At ECU Health, we are leading this work, developing innovative models like our Rural Family Medicine Residency Program and a two-year Family Medicine-Obstetrics Fellowship to support unique rural workforce needs. At present, ECU Health is training 440 residents and fellows—165 residents over our direct graduate medical education (DGME) funded cap, and 209 residents over our indirect medical education (IME) funded cap. Medicare-supported GME is an important and unique public-private partnership between teaching hospitals and the Medicare program that supports our nation’s ability to meet care demand for Medicare beneficiaries. Teaching hospitals like ECU Health Medical Center are committed to partnering with the federal government to train the next generation of the physician workforce, which is currently and projected to suffer from significant shortages. For rural communities, this is not just a national workforce issue. It is an access issue and an economic vitality issue. We know that when physicians train in rural areas they are more likely to remain in the community to practice. Without intentional investment in rural training through GME, shortages will persist and access gaps will widen in communities that need care the most.

We are aligning our efforts and partnering locally to solve access and medical education and training needs through unique models like our Primary Care Learning Center, which is a partnership between ECU Health, Brody School of Medicine, the City of Greenville, NC and our generous philanthropic partners. This model – an example of a scalable, collaborative solution – serves as a local training site for growing medical school, physician assistant, and nurse practitioner programs while addressing a dire need for comprehensive primary care and access to social support in a community with high rates of social vulnerability, transportation barriers, and high volumes of low-acuity or otherwise avoidable ED visits. This model is also proposed to include pharmacy services in our quest to address the rising rate of pharmacy deserts in rural communities.

ECU Health is transforming the care delivery system to shift more care to lower-cost settings and implementing new care models based on community need. The closure of Martin General Hospital is only one example of hospital failures in our market. ECU Health has itself, in its history, closed a rural hospital. Pungo District Hospital – later Vidant Pungo Hospital – was built in 1949 and acquired by ECU Health in 2011 when local management was unable to ensure solvency. The decision to close a rural hospital is never easy and has lasting repercussions for rural communities. However, instead of abandoning Belhaven, North Carolina when the local hospital was found to be beyond repair, ECU Health developed a modern multispecialty clinic, inclusive of a helipad, to ensure the local community maintained access to care. Located in a community of just over 1,400 people, ECU Health Multispecialty Clinic-Belhaven has been a successful model offering local family medicine and primary care, immediate and walk-in care, behavioral health, heart and vascular care, and therapy and rehabilitation – services informed by our community health needs assessment and careful evaluation of patient utilization data. The multispecialty clinic is not financially solvent on its own, but through integration into the ECU Health regional system of care, we are able to proudly continue serving the community, despite the loss of hospital-based services. Similarly, despite projected losses, we are partnering in Martin County, North Carolina to consider models that would re-establish essential health care services for a community left without local access to care, including assessing the viability of the Rural Emergency Hospital designation Congress established through the Consolidated Appropriations Act of 2021.

Unfortunately, where one lives in America is still a great predictor of health outcomes. Innovation and adaptability are critical to closing care gaps despite the complex structural realities of rural health. We have invested in targeted virtual care models like tele-ICU and tele-specialty care to extend the reach of our providers into our rural communities. The North Carolina Statewide Telepsychiatry Program (NC-STeP), established in 2013, is a nationally recognized program in the Center for Telepsychiatry and e-Behavioral Health at Brody School of Medicine at ECU that extends the reach of limited psychiatric professionals into rural and underserved regions to solve persistent ED boarding challenges, reduce avoidable psychiatric hospitalizations, and improve equitable access to behavioral health services. Since 2013, the program has resulted in more than 67,500 ED psychiatric assessments, prevented 11,802 hospitalizations, and generated \$63.7 million in cost savings through a funding partnership between ECU, state government and in some cases, philanthropic organizations. The program has successfully expanded over time to meet the rising demand for pediatric behavioral health and university student mental health access. ECU Health also partners with NC-STeP through the Maternal Outreach Through Telehealth for Rural Sites (MOTHeRS Project) to integrate mental health and maternal-fetal medicine to improve outcomes among high-risk mothers in rural areas.

At ECU Health, innovative technologies are becoming part of how we drive efficiency, deploy new care models and expand access across the continuum from direct-to-patient ambulatory visits, remote patient monitoring, inpatient care and specialty consultation, and critical care support. Each program is deliberate, governed, and measured, and together they are designed to ensure that every patient in our system has access to the same quality of care available at our academic medical center, regardless of where they live. For example, eastern North Carolina carries a disproportionate burden of hypertension and congestive heart failure—two leading drivers of preventable hospitalization, emergency utilization,

and cardiovascular mortality in our region. Remote Patient Monitoring allows for continuous blood pressure monitoring for our high-risk hypertensive patients and can capture the early warning signals – weight and fluid changes and other signs of decompensation – that indicate intervention is needed among our congestive heart failure patients. Eastern North Carolina is often considered the ‘buckle of the stroke belt’ due to higher-than-average rates of stroke and stroke mortality, and in stroke, minutes matter. We have deployed a highly successful tele-stroke program across all hospitals in our region, leveraging provider-to-provider telehealth in our EDs to connect regional providers with neurologists in our hub for guided treatment and transfer decisions to optimize the intervention window for our patients. Our medical center is the region’s only Joint Commission Certified Comprehensive Stroke Center, and all our community hospitals are now recognized as either Primary Stroke Centers or Acute Stroke Ready Hospitals by the Joint Commission. Over the past two years, median door-to-needle times have trended toward national best-practice targets and more than 90% of stroke patients were consistently receiving thrombolytic therapy within the recommended 60-minute window. We are keeping more stroke patients in our community hospitals who previously would have required transfer to our academic medical center – the costliest model of care for our patients.

As a nonprofit health care organization, we are not only required to conduct a Community Health Needs Assessment (CHNA) every three years, but we take seriously our obligation to ensure our actions are aligned with community need. In 2023, ECU Health launched a Health Hub initiative, which is a strategic effort to bridge gaps in community need with the resources of the health system to meet patients where they are. The Health Hubs, which are located in ‘access deserts’ or areas of high vulnerability, are deployed in partnership with trusted community organizations like churches and businesses and serve as opportunities to provide access to virtual primary care, health education, and navigation. Hubs are equipped with computers and webcams, vital sign monitors like blood pressure cuffs, pulse oximeters, and thermometers, which support virtual visits for patients without access to technology or broadband at home. In addition to Health Hubs, we partner with community-based organizations to bring vital health screenings to our communities, and pair this outreach with access to healthy food boxes in partnership with local farmers. This is critical community-based outreach that is funded through health system operations and grant funding, but many of these services and programs are not eligible for Medicare and Medicaid reimbursement. Our work extends deep into our communities to solve for the non-clinical drivers of health outcomes, which make up 80 percent of the factors that contribute to health outcomes.

These efforts and others demonstrate how we are implementing scalable, coordinated community networks and programs in rural areas to improve access to care, address health disparities, and integrate health and social services to drive improved health outcomes and reduce costs.

I am honored for the opportunity to share with you the story of ECU Health and our region. We have made significant progress but have much work to do. It is my hope that this testimony shines a light on our unique experience of delivering care to a vast rural region. It is also my hope that this testimony highlights the implications for rural communities and health systems when policies and programs are

not developed through the reality of the two-market system, urban and rural, within which health care operates in the United States.

SOLUTIONS

As we look ahead, I encourage Congress to consider federal health care policy through the lens of the complex structural realities of rural health care delivery and avoid one-size-fits-all approaches that do not account for the amplified effects in rural areas as compared to urban areas. We want to partner with Congress in solving these complex challenges. We are already doing the work in eastern North Carolina to find practical, innovative ways to restore and sustain access to care. But we cannot do it alone. Sustainable rural health care requires strong federal partnership, thoughtful policy, and targeted investment. Below are examples of solutions to consider:

- Pause/delay implementation of planned cuts to State Directed Payments to allow more time to thoroughly study the impacts on truly rural health systems.
- Define rurality for healthcare in a way that acknowledges the structural realities of rural health care operations.
- Funding and support for rural GME to address rural workforce shortages.
- Additional direct funding to providers through the Rural Health Transformation Program for hospital infrastructure modernization projects for rural hospitals operating in original Hill-Burton facilities; expansion of infrastructure funding to modernize ambulatory facilities in rural areas.
- Avoid implementation of new policies in ways that risk destabilizing rural access; policies should be phased and tested in markets better positioned to absorb change.
- Standardization of community benefit, charity care, and bad debt reporting with the goal being transparency and comparability across all hospitals, for-profit and nonprofit.
- Extension of rural classifications and enhanced payment such as the Rural Health Clinic model to rural ambulatory settings in a way that supports rural ambulatory care delivery while also streamlining billing and lower out of pocket costs for patients.
- Enhanced reimbursement for rural community hospital outpatient care and safeguards or carve-outs for rural community hospitals in the implementation of site neutral payment policies.
- Improved coordination with states to ensure Medicaid alignment for new federal provider models. For example, the Rural Emergency Hospital designation which was established under the Consolidated Appropriations Act of 2021, is reimbursed under a hospital-based framework in Medicare. However, states are not required to adopt a comparable approach in Medicaid leaving the model vulnerable to clinic-based reimbursement under state Medicaid plans. This is not financially sustainable for areas with high Medicaid payor mix, particularly given the requirement to maintain 24/7 operations, licensed clinical staff, and advanced diagnostic capabilities to treat emergency conditions.

- Solving administrative barriers that prevent timely access to care and hospital payment, such as prior authorization and denials.
- Centers for Medicare and Medicaid Innovation models that contemplate the structural realities of rural health care delivery; meaningful design in partnership with rural health systems to encourage wider rural health system participation; longer-term stability and relevancy of models.

If we get this right, we can protect access, improve outcomes, and ensure that the 66 million Americans across our nation's rural communities are not left behind simply because of where they live.

Thank you for the opportunity to offer testimony on the critical topic of health care affordability and offer our rural experience.

445 *Chairman Smith. Thank you.

446 Mr. Woodhouse, you are now recognized.

447

448 STATEMENT OF BRAD WOODHOUSE, PRESIDENT, PROTECT OUR CARE

449

450 *Mr. Woodhouse. Thank you so much, Chairman Smith, Ranking Member Neal,
451 and distinguished members of the committee. Thank you for the opportunity to testify
452 today. My name is Brad Woodhouse. I am the president of Protect Our Care. Our
453 mission is to make high-quality, affordable health care a right and not a privilege for
454 everyone.

455 I am here today because that mission is under threat. We are facing a health care
456 affordability crisis. H.R. 1 made the largest cuts to health care in American history to fund
457 tax breaks for billionaires and big corporations. No amount of finger pointing can distract
458 from the reality that H.R. 1 cut 1 trillion from Medicaid and the Affordable Care Act which
459 will rip lifesaving coverage away from 15 million Americans, including seniors, children,
460 and people with disabilities. That same bill handed out 730 billion in tax breaks to
461 corporations and 890 billion in tax breaks to millionaires.

462 Today, nearly a year later, roughly four million people have already lost their health
463 care. But that is not all. Costs are skyrocketing for millions of Americans, families are
464 being forced to make impossible choices between paying for groceries and seeing a doctor,
465 and small businesses are closing their doors. The ripple effect of these cuts has catapulted
466 health care to the number-one issue in America. Recent Gallup polls showed that the
467 availability and affordability of health care top the chart of American worries about key
468 issues, ranking higher than the economy and inflation.

469 One of the biggest impacts of H.R. 1 is on our nation's hospitals. Following the

470 passage of H.R. 1 is on our nation's hospitals. Following the passage of H.R. 1, Protect
471 Our Care launched a Hospital Crisis Watch. It is an interactive map on our website that
472 tracks hospitals, nursing homes, and other care facilities that have shut down, cut services,
473 or are at risk due to H.R. 1's devastating cuts to health care.

474 When a hospital closes its doors, everyone feels the pain. Patients have to travel
475 further for care. Families face longer wait times and overwhelmed emergency rooms.
476 Moms are left without maternity care, putting their lives and their babies' lives at risk, and
477 entire communities will be left without access to care while CEOs and billionaires get
478 another tax cut.

479 Here are some key numbers from our Hospital Crisis Watch tracker. As of this
480 morning, 889 hospitals, clinics, and nursing homes have either shut down, cut services, or
481 are at risk of doing so since Congress passed H.R. 1. That includes nearly 60 hospital
482 wards which have shuttered, including 30 maternity wards. Over 240 clinics have been
483 forced to close, and over 400 hospitals remain at deep risk of closure or cuts. And
484 everyone is paying the price because Congress put tax cuts for billionaires and big
485 corporations above the needs of working people.

486 When a hospital closes, costs rise by an estimated \$500 per hospital stay to a nearby
487 facility. This means higher health insurance premiums for everyone, regardless of where
488 they get their coverage. As the sixth largest employer in the country, hospitals are key
489 economic drivers, especially in rural America. But because Congress passed the largest
490 cuts to health care in history, nearly 500,000 health care workers could lose their jobs.
491 Communities are so desperate to save their local hospitals that counties and states from
492 California to Alabama are raising property taxes to stop their hospitals from closing.

493 As our map shows, the consequences of H.R. 1 are already playing out, and the
494 things will only get worse in the years to come as these cuts come into full force. Here are

495 a few stories illustrating the impact of the cuts and closures that have occurred since H.R. 1
496 passed.

497 In Nebraska's 3rd congressional district a nursing home, a primary care clinic, and a
498 critical dialysis unit were all forced to shutter, and five hospitals remain at risk of cuts or
499 closures. A rancher in that district from Hay Springs is now spending nine hours each
500 week driving to and from Scotts Bluff for his dialysis.

501 In New York's 24th congressional district, a dialysis unit was closed there. Now
502 patients are scrambling to find a new place to get lifesaving treatment. Five hospitals in
503 that district are also at risk of closure or cuts.

504 In Ohio's 7th congressional district five clinics were forced to close due to these
505 Medicaid cuts, leaving families with fewer options for care.

506 Look, Protect our Care has been criss-crossing America to sound the alarm on how
507 these cuts are pushing hospitals to the brink, stripping care from communities, and putting
508 lives at risk. Every day presents a chance to stop this health care crisis, but this
509 Administration has not lifted a finger to deliver relief to the American people. Congress
510 should be focused on making health care more affordable and accessible, not ripping it
511 away to give tax breaks to the rich.

512 Thank you for the opportunity to be here, and I look forward to your questions.

**PROTECT
OUR CARE**

**Written Testimony of
Brad Woodhouse
President, Protect Our Care**

before the
Committee on Ways and Means
U.S. House of Representatives

"Full Committee Hearing with Health System CEOs"

April 28, 2026

Introduction

Chairman Smith, Ranking Member Neal, and distinguished members of the committee, thank you for the opportunity to testify today. My name is Brad Woodhouse, and I'm the President of Protect Our Care. Our mission is to make high-quality, affordable health care a right, and not a privilege for everyone in America. I'm here today because that mission is under direct threat.

By passing H.R. 1, President Trump and Congress delivered the [largest cuts to health care](#) in American history, all to fund [tax breaks](#) for billionaires and big corporations. They slashed over \$1 trillion from Medicaid and the Affordable Care Act (ACA), which will rip lifesaving coverage from [15 million](#) Americans, including seniors, children, and people with disabilities.

Already, nearly [four million](#) people have lost their health care coverage. Costs are skyrocketing for millions more, and patients are making impossible choices between paying for groceries and seeing a doctor. Small businesses are shutting down and families are being left with nowhere to turn. The ripple effect of these cuts have catapulted health care as the number one issue in America. A recent Gallup Poll [showed](#) that “the availability and affordability of health care” topped the chart of American worries about key issues, ranking higher than the economy and inflation.

Following the passage of H.R. 1, Protect Our Care launched [Hospital Crisis Watch](#), an interactive map tracking hospitals, nursing homes, and other types of care facilities that have shut down or are at risk of shutting down or cutting services due to these devastating funding cuts. This project has already reached the grim milestone of over [800](#) hospitals or health facilities that have closed, announced cuts, or are at high risk.

When hospitals close, patients have to travel further for care, families face longer wait times in overwhelmed emergency rooms, expectant moms are left without accessible maternity care, and costs go up for everyone. As the sixth largest employer in the country, hospitals are key economic drivers, especially in rural areas. But because of Congress, nearly [500,000](#) health care workers could lose their jobs. Entire communities will be left without access to care while CEOs and billionaires get even richer. As our interactive map and report show, the consequences of H.R. 1 are already playing out, and things will only get worse in the years to come.

H.R. 1: Increased Costs and Millions More Americans Without Insurance

No matter where they live or work, or who they voted for, the American people want health care to be more affordable and accessible. However, H.R. 1 is sweeping across our country ripping care away from millions and forcing people to pay more for less. These unprecedented cuts to health care:

- Cut funding for Medicaid and the ACA by [over \\$1 trillion](#) to pay for tax breaks for [millionaires](#) and [corporations](#).

- Will rip health care away from [15 million Americans](#), including [seniors](#), [children](#), [veterans](#), and [people with disabilities](#).
- Doubled and tripled premiums for over [20 million](#) hardworking Americans, including [small business owners](#), [farmers](#), and [older adults](#).
- Generated billions in tax breaks for the rich by choking seniors and working families in red tape and making it harder to enroll in [Medicare](#), [Medicaid](#), and [ACA coverage](#).
- Led to over [800](#) hospitals, clinics, and nursing homes shutting down, cutting services, or being at risk of closure and cuts
- Robbed [11 million](#) low-income Americans of zero-dollar premiums.
- Funneled [millions](#) of families into [reduced](#) coverage that will force them to pay thousands more each year in health care costs.
- Pressured countless families to [cut back](#) on food, clothing, and other basics to afford health insurance and greater out-of-pocket costs.

In the same bill, Congress doled out [\\$730 billion](#) in tax breaks to corporations and [\\$890 billion](#) in tax breaks to millionaires.

In recent hearings, administration officials twisted numbers from Congressional Budget Office (CBO) data to assert that there have been no cuts to Medicaid. Not only is that assertion plainly [false](#) but it conveniently leaves out details from the [same projections](#) that provide clear evidence of the damage of the health care cuts. To begin, CBO estimated [7 million](#) Americans will lose Medicaid coverage by 2032. In addition, CBO estimated [11.2 million](#) Americans or half the Americans who rely on ACA tax credits, will lose their tax credits completely by 2028. Between the cuts to Medicaid and the cuts to the ACA, CBO projected the number of Americans who are uninsured will skyrocket to 35.3 million, or [increase by a third](#), by the end of the Trump administration.

Administration officials and lawmakers also claim the only Americans losing their health care are illegal. From our line of work, we know that is categorically false. Our teams are on the ground in 14 states working alongside blue collar Americans who have lost their health care, in order to make their stories heard. Over the past year, we've heard from [farmers in Iowa](#), [small business owners in Virginia](#), and [caregivers in Michigan](#) who have all had their health care jeopardized by the decisions of Congress and this administration. We have collected over 300 [stories](#) of working Americans who are losing their health care or making sacrifices to pay the arm and leg it now costs for their health care. Today, I'd like to share the stories of two of them: Teresa Acosta of Atlanta, Georgia and Lester Johnson of Richmond, Virginia.

Teresa Acosta is a single mother in Atlanta, Georgia. After Congress allowed the enhanced premium tax credits to expire in favor of giving tax breaks to the wealthy, Teresa's premium skyrocketed six fold. She closed her small business in order to afford her health care and her first insurance bill still left her with [\\$74](#) in her bank account just weeks before Christmas. Her daughter is now taking a break from college to help Teresa pay the bills.

Lester Johnson is a dad and small business owner in Virginia. After Congress eliminated the enhanced premium tax credits, Lester's premium doubled. Now, Lester worries about keeping his business open and keeping his 40 employees on the payroll. Teresa and Lester are not alone. Every day, millions of families are being forced to make brutal decisions to afford their health care costs:

- [37 percent](#) of Americans with Marketplace coverage are cutting back on food, clothing, or other basic household items
- [13 percent](#) are skipping or delaying paying other bills
- [30 percent](#) were forced to switch plans, many to reduced coverage with higher out-of-pocket costs
- [30 percent](#) say their health care costs are making it difficult to afford their rent or mortgage

Even with their sacrifices, recent data shows that [one in seven](#) people who renewed their coverage could not afford their first premium payment.

These policies aren't "America First." When people lose their health care, it doesn't just hurt their families, it hurts their community. Massive losses in coverage result in loss of revenue for hospitals and clinics that affect their ability to keep their doors open. H.R. 1's incoming cuts to provider taxes and state-directed payments only compound the issue, making it harder for rural hospitals, primary care clinics, and maternity wards to survive.

H.R. 1: Hundreds of Hospitals and Clinics Across the Country In Danger

The health care cuts passed by Congress are putting the entire health care system on life support. H.R. 1 cut nearly a trillion dollars from Medicaid, including an estimated [half a trillion](#) dollars from hospitals. Medicaid accounts for [one-fifth](#) of spending on hospitals, [one-fifth](#) of hospital discharges, and at least [one in five](#) inpatient days in nearly every state. Medicaid is also the largest payor of [maternal health](#), [mental health](#), and [nursing home care](#) in the country. Since H.R. 1's passage, over [800](#) hospitals, nursing homes, maternity wards, and other critical providers nationwide have shuttered, cut services, or are at risk of doing so. Every hospital or clinic that closes its doors puts patients' lives at risk, strips communities of vital services, and forces families to make impossible choices just to access the care they need – all so Congress can make the rich richer. Across America, health care is vanishing, and millions of Americans are left with rising costs, longer journeys to care, and, in far too many cases, no care at all. With Protect Our Care's Hospital Crisis Watch, we've been exposing the full scale of harm H.R. 1 is inflicting on America's health care system—community by community, hospital by hospital. So far we have tracked:

- Over [800](#) hospitals, clinics, and nursing homes that have shut down, cut services, or are at risk of doing so since Congress passed the largest cuts to health care in history.
- [Multiple hospitals](#) that have converted to standalone emergency departments and [over a dozen](#) hospitals have fully shut down.
- Nearly [60](#) hospital wards have shuttered including nearly [30](#) maternity wards.
- Over [240](#) clinics that have been forced to close.

- And over [400](#) hospitals remain at deep risk of closure or cuts

The cuts to health care are affecting everyone, everywhere, regardless of where they get their coverage. When hospitals or emergency departments close, emergency cases are [diverted](#) to other hospitals, leading to longer travel times for ambulances, overcrowding in emergency rooms, and longer waits to see a doctor. Studies find that ambulance transport times increase by [11 to 16 minutes](#) following a rural hospital closure — a life or death difference for patients having a stroke, heart attack, or internal bleeding. Costs will also spike for everyone as hospitals [close](#), driving up costs at nearby facilities by an estimated [\\$500](#) per hospital stay. Everyone will pay the price because Congress put tax breaks for billionaires and big corporations above the needs of working people.

Here are just a few stories illustrating the impact of cuts and closures that have occurred since H.R. 1 passed: In Jersey City, New Jersey, a hospital that had supported the community for [over 150 years](#) shuttered under the pressure of Medicaid cuts, leaving a city of nearly 300,000 with only one emergency room. In rural Farmville, Virginia, moms are [driving an hour or more](#) for prenatal appointments after their local maternity ward closed. In Santa Rosa, California, families with sick children will need to [fly by helicopter](#) to Bay area hospitals to get pediatric care they need after a ward at their local hospital closed.

In Nebraska's 3rd Congressional district, a nursing home, a [primary care clinic](#), and a [critical dialysis unit](#) were all forced to shutter and [five](#) hospitals remain at risk of cuts or closure. A rancher from Hay Springs is now spending nine hours each week driving to and from Scottsbluff for his dialysis.

In Missouri's 8th Congressional district, a [local maternity ward](#) was forced to close and another hospital was forced to close entirely. Two remaining hospitals in the district are at [risk of closure or cuts](#).

In West Virginia's 1st Congressional district, pregnant women are driving nearly two hours to Charleston to give birth after the closure of the maternity ward. Children with psychiatric issues are left with few options for inpatient treatment after a local facility was boarded up. Five hospitals in the district remain [at risk of closure or cuts](#).

In New York's 24th Congressional district, a dialysis clinic was forced to close. Now patients are scrambling to find a new place to get lifesaving treatment. Five hospitals in the district are at risk of closure and cuts.

In Ohio's 7th Congressional district, [five clinics](#) were forced to close due to Medicaid cuts - leaving families with fewer options for care.

Protect Our Care has been crisscrossing America sounding the alarm on how these cuts are pushing hospitals to the brink, stripping care from communities, and putting lives at risk across the country. At one event in Michigan, the CEO of Hillsdale Hospital [said](#) "Cuts to Medicaid

translate directly to hospital closures, service disruptions and detrimental losses in our care system across rural America. Rural hospitals like Hillsdale Hospital rely on Medicaid because of our disproportionate payer mix, and when that source of basic reimbursement disappears, our patients are forced to choose between paying high Marketplace premiums or going without coverage entirely. That is not sustainable for rural communities or hospitals.” A former Alaska hospital CEO [said](#): “Cutting Medicaid in Alaska to the bare bones is a very bad idea—for population health, for women delivering babies, and for older folks.”

H.R. 1: Failing Rural Communities

H.R. 1 is a betrayal to rural communities. By gutting Medicaid, Congress gutted the health care [1 in 4](#) rural Americans rely on, while [raising premiums](#) for millions more – all to give tax breaks to [billionaires](#) and [corporations](#). More than [three million](#) rural Americans rely on the Affordable Care Act. Premium hikes hit them [28 percent](#) harder than urban residents. By gutting over \$1 trillion from Medicaid and the ACA, Congress also put over [330](#) rural hospitals at risk of closure and service cuts and [shuttered rural clinics](#) across the country. H.R. 1 is crumbling an already strained infrastructure, expanding maternity care deserts, and leaving Americans from [Iowa](#) to [Georgia](#) more than 45 minutes away from the care they need. Entire communities are finding themselves without care nearby. Local economies are suffering as health care jobs vanish. The so-called “rural health transformation fund” falls far short of what rural communities need, leaving families stranded without access to life-saving care.

The rural health fund is woefully underwhelming and nowhere near a solution. The grants will do little to nothing to help rural health care providers facing over [\\$130 billion](#) in cuts. The meager \$50 billion fund already failed to scratch the surface of the hundreds of billions in cuts to hospitals, before the Trump administration said no more than [15 percent](#) can be used to help rural health providers stay afloat. Meanwhile, administration officials are touting “[AI nurses](#)” as the solution. Policy experts at KFF [said](#) “It is highly unlikely that any state will receive more money from the rural health fund than it will lose from the historic cuts to federal funding for health care in the 2025 reconciliation law and from other federal policy changes.” The executive director of the Nebraska Rural Health Association [said](#) “rural health transformation will not save a single hospital in our state. I don’t think it will save a single hospital nationally.”

H.R. 1: Rural and Urban Hospitals Feeling the Pain

Though Congress has largely focused on H.R. 1’s impacts on rural communities, rural hospitals are not the only ones feeling the pain. According to a Harvard study, urban safety net hospitals make up [85 percent](#) of those at highest risk from cuts, yet H.R. 1 does not set aside a single penny for urban hospitals. In Los Angeles, Martin Luther King Jr. Community Hospital is preparing to lose 15 to 20 percent of its revenue. In 2024, Medicaid paid for over [seven in ten](#) patients at MLK Jr. Community Hospital. “There aren’t enough things for us to cut to make up for that loss,” [said](#) Dr. Elaine Batchlor, M.L.K. 's chief executive.

In Long Island, New York, Nassau University Medical Center faces great [risk of cutting services or closing](#) in the face of the H.R. 1. In 2024, Medicaid paid for nearly [40 percent](#) of patients at Nassau University Medical Center. Without the maternity ward or ER at Nassau, patients would be forced to travel [30 minutes](#) to the nearest facility - critical time for a mom in labor or a senior with a stroke. These hospital closure risks are not colorblind either; around a fifth of all hospitals at risk of closure are within the five states where [42 percent](#) of Black Americans reside. Americans across all communities will pay the price for H.R. 1.

Communities are so desperate to save their local hospitals in the wake of H.R. 1 that counties from [California](#) to [Alabama](#) are instituting higher property taxes to fund infusions to stop their hospitals from closing. Countless hospitals still are [begging](#) for taxpayer-funded infusions from their state government to stay afloat because the so-called "Rural Health Transformation" fund doesn't do much to help. What we are seeing is only the beginning. Once millions begin to lose their health care due to paperwork designed to rip away their coverage and deep cuts to provider taxes and state-directed payments take effect in 2027 and 2028, the crisis will only worsen, leaving millions of Americans in the dust.

Conclusion

Thank you for the opportunity to participate in this hearing today. Every day presents a chance to stop this health care crisis, but this administration has not lifted a finger to deliver relief to the American people. Congress should be focused on making health care affordable and accessible, not ripping it away to give tax breaks to the rich. I look forward to taking your questions and working with you to make that a reality for everyone in America.

517 *Chairman Smith. Thank you. I thank you all again for being here. I will now
518 begin the question-and-answer session with the vice chairman of our Health Subcommittee,
519 Mr. Buchanan.

520 *Mr. Buchanan. Thank you, Mr. Chairman, and I want to thank all of our
521 witnesses.

522 I want to shift gears a little bit in my five minutes and get your input. So that is
523 kind of where I am going to go. Bill Frist was here in front of us. We had a hearing.
524 Bill Frist was here, and he talked about the landscape of obesity and related diseases that
525 defined America. Then he said the surest and safest way to maximize your health is food
526 as medicine. So he took -- for an hour or two talked about food as medicine.

527 So I believe personally myself it is something -- we didn't talk about, nobody
528 brought it up, but I am sure, you know, we were focused on the other stuff -- I believe that
529 prevention and eating real food is the key to making health care more affordable. The
530 U.S. has spent \$5.3 trillion on health care, yet we are getting sicker as a nation. Six in ten
531 Americans, ninety-five percent of Medicare beneficiaries, have at least one chronic disease.
532 Roughly half of the adult population is obese. And when you look at -- and the thing that
533 makes me sad, we have 10 grandkids, but -- children, 20 percent of the obesity for -- kids
534 are obese, 20 percent, and ones that would serve maybe in the military, 20 to 30.
535 Basically, there is -- 30 percent are obese. I believe the problem stems from unhealthy and
536 ultra-processed food. We must prioritize prevention. In other words, don't get sick in the
537 first place to the extent we can.

538 You know, they said that if you have cancer and you catch it early, you can do it --
539 there is a good chance you are not going to have to deal with it. We must prioritize
540 prevention as a key to reversing trends in heart disease, obesity, and diabetes.

541 Hospitals not only treat people with -- that are sick, but hospitals can and should

542 take more time to make sure that what we are doing is the right thing long term. I want to
543 applaud HHS, its efforts to create a new food pyramid which prioritizes real food and
544 makes hospitals' food healthier pledge. So I guess one of the things I would like to ask all
545 of you, have you taken a look at that pledge and whether -- does that make sense to you in
546 terms of signing on?

547 If you haven't signed on, will you sign on? Anybody that has taken the pledge, go
548 ahead. Yes, go ahead. Did you want to --

549 *Mr. Lassiter. Yes, Vice Chairman Buchanan, so thank you for the comments.

550 I would say that at CommonSpirit Health we follow the Make Hospital Food
551 Healthier pledge that HHS has put forward. We certainly believe in food as medicine, as
552 part of what we do to serve communities. In a number of communities where we serve
553 where there are food deserts, our facilities offer food pantries with fresh produce to provide
554 those resources for those who don't have access, and so we certainly support the notion of
555 healthy food, sir.

556 *Mr. Buchanan. Mr. Donley, go ahead. Just -- what is your thoughts on that? I
557 know I touched base with you, we talked about it a little bit.

558 *Dr. Donley. We -- yes.

559 *Mr. Buchanan. But I think it is huge.

560 *Dr. Donley. Yes. Thank you, Congressman, for your advocacy of living
561 healthier lifestyles. It is one of the four things that we are working on in order to develop
562 more affordable care.

563 I strongly agree with you, and what we do is we are embedded in our communities.
564 We work with our schools. We work with faith-based organizations. We work with non-
565 profit organizations around teaching healthier lifestyles, around teaching proper nutrition,
566 around teaching healthy exercise. We work with our schools so that we can reach people

567 at a younger age because then the impact is longer lasting. They also work with their
568 families.

569 *Mr. Buchanan. Do you find that statistic, 20 percent of children are obese, is that
570 legitimate? Is that a number -- that is the number I have heard. It is outrageous to me.

571 *Dr. Donley. I don't know the exact statistic, but I know it is unacceptable, and
572 every one of us should understand the role that we can play, and especially in health care,
573 in a preventive way because that decreases --

574 *Mr. Buchanan. You guys are in the health business. We have got to get people
575 healthy.

576 Mr. Hazen, you want to give us your thoughts on that?

577 *Mr. Hazen. Well, I think anything, Congressman, that we can do to make people
578 healthier will drive down costs for sure in the system.

579 Just to give you one perspective, one of the drivers we have seen in our
580 organization over the last 10 years is the complexity of the patients we have to deal with
581 have numerous complications, comorbidities, obesity, diabetes, and so forth. And that
582 forces more resource consumption --

583 *Mr. Buchanan. Yes, I have only got a couple of minutes -- seconds.

584 Let me just say I hear what you are saying. I want to try to help people be able to
585 not get to that level. Someone said that if you have a heart attack, 50 percent of people
586 don't live to see the next day. How about not having a heart attack in the first place?

587 I think a lot of it is diet-related, obviously movement exercise, as well, but that is
588 kind of where I am coming from.

589 *Mr. Hazen. Yes.

590 *Mr. Buchanan. We all have a responsibility. We are spending \$5.5 trillion --
591 basically, \$5.3 trillion in health care, and we are getting sicker. That has got to change and

592 change now.

593 Thank you. I yield back.

594 *Chairman Smith. Mr. Neal.

595 *Mr. Neal. Thank, Chairman. So let me acknowledge, just as I begin my
596 questioning, the hard-working people who are part of this debate today, and that is
597 members from 32BJ SEIU from New England who do a great job for all of us every day,
598 and they understand what is going to happen with the impact of the cuts that are coming to
599 Medicaid and to the ACA. They, like all members of the American family, are going to be
600 facing the reality of what the tax bill that the Republicans embraced will do.

601 America needs 86,000 new doctors. That is where Graduate Medical Education
602 comes in. That is where our academic centers come in. Every Member of Congress
603 ought to spend a Friday night or a Saturday night in an emergency room to see what it is
604 really like for people who arrive there without a lot of answers or perhaps that mom with a
605 sick child.

606 Do Members understand what disproportionate share hospitals do? The testimony
607 was exceptional today. It is not about rural versus urban; it is about making sure that when
608 a rural hospital perhaps can't solve a certain problem, that they might move to an urban
609 setting or vice versa where, as noted here, would perhaps lower costs. It could happen.
610 But people that show up at an emergency room on a Friday/Saturday night, they are
611 unlikely to be too concerned about cost, and that is where advocacy comes in. These cuts
612 that are being proposed don't make any sense.

613 And let me say something about Baystate Medical Center again, and Mass General
614 Hospital. If you have got a sick child anywhere in America, I could recommend those
615 hospitals to you. The work that they perform is extraordinary.

616 Do members of the committee and Congress understand what technology has done

617 to driving health care costs? Does anybody know what the cost is of a linear accelerator?
618 It is top-notch health care. And again, the argument today is we should justify these tax
619 cuts by denying people basic health care at our hospitals.

620 This committee, as I noted in my opening statement, on a bipartisan basis, we
621 expanded Graduate Medical Education opportunities to help address the issue of a shortage
622 of 86,000 doctors across America. I am proud of what we have done over many years
623 here by incrementally improving the opportunities for people as it relates to health care.
624 But let's also be honest. The emergency room is a bad place to have to get health care.
625 That is just the reality. And getting out front on a lot of these issues could be very helpful
626 to, again, the American family.

627 Your testimony has been right on target. So let me ask you, Mr. Woodhouse, tell
628 us about the 15 million Americans who are about to be denied health care because of the
629 tax cut bill that our Republican colleagues have embraced.

630 *Mr. Woodhouse. Sure. Thank you, Chairman Neal.

631 And as you know, Protect Our Care is all across the country, and we are collecting
632 stories constantly about people who are facing these challenges. We have heard from
633 farmers in Iowa, small business owners in Virginia, caregivers in Michigan who have had
634 their health care jeopardized by these cuts, in some cases particularly by the elimination of
635 tax credits. We collected hundreds of stories of working Americans who are losing health
636 care or making sacrifices to pay what is now double, triple, and quadruple their health care
637 premiums.

638 I will give you two stories. Janine Shackelford is a realtor in Youngstown, Ohio
639 who is self-employed -- was self-employed because the Affordable Care Act made her
640 health insurance affordable, around \$200 a month. In 2026 her premiums jumped to \$900
641 a month, more than her mortgage. She could no longer afford it, and she has been forced

642 to leave -- quit her job, which was self-employed, to try to find a job with insurance.

643 Rena Bumbury Graves is a home care worker in Woodbridge, Virginia who cares
644 for two relatives with disabilities. She and her husband's premiums spiked from \$544 a
645 month to over 1,300 a month. And you know what? They are just not going with health
646 care right now. They simply can't afford it.

647 So they were -- those are two stories --

648 *Mr. Neal. Yes.

649 *Mr. Woodhouse. -- but there are dozens and dozens, and actually hundreds that
650 we have collected that are just like that.

651 *Mr. Neal. Thank you. So I hope that all members of the committee might
652 consider perhaps on a Friday or Saturday night getting in an ambulance and making a
653 patient run to see what it is like for senior citizens -- perhaps where one is confused but
654 there is a real emergency.

655 I think that we are misunderstanding the realities of what a breast cancer imaging
656 machine might cost, what a linear accelerator might cost, what the best doctors in the world
657 and nurses and health care professionals might cost.

658 This could be addressed in a bipartisan manner, absent what the big bill did.

659 And I yield back my time.

660 *Chairman Smith. In January this committee heard from the CEOs of the biggest
661 health insurance companies. When asked what is driving up premiums for Americans,
662 they pointed their finger at all of you, the hospitals. They have a point. The data clearly
663 shows that hospital prices have risen faster than any other part of the economy, nearly 300
664 percent in just the past 20 years. And one third of all U.S. health spending is on hospital
665 care, more than any other part of the system: \$1.6 trillion a year.

666 However, hospitals and health care providers are the ones delivering medical

667 services. I believe every Member of Congress has been in an emergency room with a
668 family member or a friend, so I don't think we have to, like, address that. I think we all
669 understand health care.

670 Let's start with a show of hands. I am going to ask a few different questions.
671 Raise your hand if you agree that insurance providers are too big and are taking advantage
672 of health care providers. It is for all of you.

673 So two of you agree with that.

674 Raise your hand if your hospital or an association that you are a member of lobbied
675 to expand the expanded Obamacare tax credits that would have funneled \$400 billion
676 directly into the pockets of those same insurers.

677 Only one of you -- so two of you. You just have to raise your hand at the same
678 time when I ask it. If you don't agree with a statement, don't raise your hand. But if you
679 agree with a statement, raise your hand. It is pretty simple. So just one.

680 Mr. Hazen, thank you for being honest. This is one of the problems with health
681 care. Hospitals, they blame insurers and drug companies. Democrats blame Republicans.
682 Republicans blame Democrats. Insurers blame hospitals and drug companies. Drug
683 companies blame PBMs and hospitals. But when it comes to fixing the system, the only
684 thing you all agree on, really, is that it is some other people, other issues that is the
685 increase.

686 Raise your hands if you believe hospitals deserve to be paid more than independent
687 physician practices for the exact same service.

688 Thank you. This is another serious problem. Hospital empires are being
689 financially incentivized to reduce access in rural communities, and are working to game the
690 systems to get the highest possible reimbursements. But when you talk about policies that
691 create competition and more access for patients, you get vocal opposition from you and

692 your Washington representatives. Medicare relies on outdated and misaligned
693 reimbursements that pay more for the same services delivered in a hospital clinic than an
694 independent physician's office.

695 Let's talk about what that means for a senior living in my district in Festus,
696 Missouri. Raise your hand if her Medicare bill for a standard X-ray image would be
697 higher in your hospital-owned clinic than if she went to her local doctor's office.

698 Right. Raise your hand if your hospital makes more revenue for that service than
699 the doctor down the street.

700 Now raise your hand if you would support legislation that equalizes such payments
701 at the doctor rate so folks can have more access to care and a bill that they can afford.

702 Unfortunate. A troubling development in Medicare over the last decade has been
703 sophisticated: wealthy hospitals and health systems in urban cities leveraging a loophole
704 to classify themselves as rural, even when they treat few, if any, rural patients. They do
705 this to reap a windfall of benefits intended to support truly rural hospitals, including higher
706 residency training, funding, and easier access to heavily discounted drugs under the 340B
707 program, a highly lucrative revenue stream for hospitals. Rural classifications have risen
708 from only 3 hospitals in 2017 to 425 by 2023, a 14,000 percent increase. All of this is the
709 expense of truly rural communities.

710 Dr. Donley, as you know, I represent one of the most rural districts in Congress,
711 made up of farmers and ranchers who drive up to more than an hour for basic care at a rural
712 facility that is reimbursed four percent lower than the national average. You have chosen
713 to self-classify your flagship hospital in your New York-Presbyterian system as rural.
714 Meanwhile, you get reimbursed 40 percent higher than the national average.

715 To be clear, there are zero farms there in mid-town Manhattan. I have been there,
716 and no crops are growing on East 68th Street next to your supposedly rural hospital

717 campus. Correct?

718 *Dr. Donley. That is correct.

719 *Chairman Smith. So how exactly do you justify this clear abuse of the Medicare
720 program, where big-city hospitals drain the Medicare trust fund of billions of dollars meant
721 to support truly rural, independent hospitals?

722 *Dr. Donley. First of all, I would like to thank you, Chairman, for your advocacy
723 for rural hospitals.

724 You know, as a physician I can tell you that rural hospitals are critical to health care
725 in this country, and it is important that all of us concentrate to make them strong for the
726 health of this nation.

727 We are not a geographically rural hospital, but under CMS we are designated a rural
728 referral center. We are proud of the role that we play for rural hospitals. We see
729 thousands of patients referred from rural hospitals when those patients and those doctors
730 have nowhere to turn, and we are proud to take care of those patients. We are also proud
731 of the 2,500 residents that we train; 65 percent of them leave NYP and go across the nation,
732 including into rural America, to take care of patients.

733 *Chairman Smith. How many rural patients do you refer?

734 *Dr. Donley. We receive referrals of -- we saw 8,000 patient visits.

735 *Chairman Smith. And how many patients visits did you have all of last year?

736 *Dr. Donley. We had two million patients that we took care of. Eight thousand
737 doesn't seem a lot. But I will tell you, when you are one of those patients, and you are one
738 of those doctors, and you have nowhere to turn for a really complex problem, I think those
739 are some of the most gratifying patients that we have.

740 *Chairman Smith. So do you think just because you served 8,000 patients out of 2
741 million that were rural, that you should get the benefits of a rural independent hospital in

742 Salem, Missouri that is barely struggling to keep their doors open?

743 *Dr. Donley. I think under the rules and regulations of CMS, we meet the
744 qualifications to be designated a rural referral center.

745 *Chairman Smith. Do you think those rules should be changed?

746 *Dr. Donley. I think if we look at opportunities to change those rules, we have to
747 make sure that they balance the health of rural hospitals, but also the importance of urban
748 hospitals that support rural health care.

749 *Chairman Smith. I am just reminded by what health care professionals have told
750 me all the time is that health care follows the dollar. We are seeing that today just unfold,
751 that health care follows the dollar and people in rural areas have a lower life expectancy
752 rate than those in rural areas because the dollar is not going into rural areas and they are
753 dying. People are dying in rural areas because they are not getting access of rural health
754 care.

755 This is not urban versus rural. This is about every single American having access
756 to health care, but they don't. They don't. And the only way we will fix the system is if
757 all the entities -- the insurers, the hospitals, the drug manufacturers, the Democrats, the
758 Republicans -- will come together and stop talking about other bills that have passed and
759 focused on new bills that need to pass. Until we get to that point, we are only going to see
760 health care continue to skyrocket and health care companies, insurers, hospitals continue to
761 have large profit margins.

762 We saw UnitedHealthcare have the highest earnings ever reported last quarter.
763 That is a broken system which we have to address.

764 And so I am done. Mr. Doggett.

765 *Mr. Doggett. Well, thank you, Mr. Chairman. There are a number of the
766 concerns that you have raised this morning that I share. I think hospital costs are high and

767 they are soaring higher.

768 The problem is, when you talk about new bills that need to pass, the bills you
769 propose to address any of these problems don't get to the core of the problem. The leading
770 bill that this Administration pushed was to get more price disclosure information, which is
771 unlikely to have a significant impact on desperate, sick people seeking care. The site
772 neutrality provision may have some merit. It is a fairly narrow focus. And at the same
773 time you talk about new bills that need to pass. Where there are actions this committee
774 could take that would make a real difference, you obstruct and block consideration of the
775 legislation. That is why I agree with Mr. Neal that this is more a deflection hearing than a
776 hospital hearing.

777 Let's talk about three areas that are being blocked and obstructed that could make a
778 real difference in accord with the testimony we have heard this morning.

779 The first one is stable coverage. This is a committee and an Administration that
780 has done more to take away health care coverage from American people than any in
781 American history. And what happens is, as Mr. Hazen indicated, is that when people don't
782 have stable coverage, when their Medicaid is taken away, when they can't afford their
783 marketplace plan, they don't get treatment when they need it. And so they show up in the
784 emergency room, and some of those folks are going to show up in the emergency room and
785 they don't have anything to pay the bill. And the hospital can't pay its nurses and
786 physicians and its staff and its administrative cost with an IOU. It needs to pass those
787 costs along to all the rest of us who have decent insurance plans. The lack of stable
788 coverage that is the direct responsibility of this committee and the Trump Administration in
789 those cuts is having a huge impact on hospital costs and on costs that are borne by all of us.

790 The second area where this committee could do something but refuses to act and
791 obstructs those of us who want to act is with regard to pharmaceuticals. The TrumpRx is

792 as phony as a diploma from the failed Trump University. This committee is under a
793 stranglehold by big pharma. It won't even hold a hearing on the actions of pharmaceutical
794 manufacturers. And yet, as Dr. Donley has pointed out -- and I am sure it is true in some
795 of the other systems -- in one year the drug costs at his hospital went up over 25 percent.
796 You cannot deal with high hospital costs unless you look at pharmaceutical costs, and this
797 committee refuses to do it.

798 And the third area where we can't get action is Medicare Advantage. And we have
799 had testimony this morning about what a difference that makes.

800 Let me ask you, Mr. Lassiter, a little more about that. I have authored the
801 bipartisan Prompt and Fair Pay. And when I talk about Republicans, I am not talking
802 about all Republicans. Dr. Murphy, Dr. Harris, Chuck Edwards, Congressman Thompson
803 have all joined in that effort to get prompt and fair pay. You mentioned that at your
804 hospital -- how many billion dollars is it that you have in bills that Medicare Advantage has
805 not paid?

806 *Mr. Lassiter. Thank you, Congressman Doggett. We have \$4.3 billion in --

807 *Mr. Doggett. Four point three billion.

808 *Mr. Lassiter. -- unpaid claims for Medicare Advantage.

809 *Mr. Doggett. Well, our bill is one that is focused on getting prompt and fair
810 payment. We learned in prior hearings that sometimes Medicare Advantage doesn't even
811 pay the cost of traditional Medicare in reimbursing for health care services.

812 You have mentioned your support for this prompt and fair pay bill that we have
813 introduced on a bipartisan basis in your written testimony. Can you describe some of the
814 difficulties that you have been having there?

815 *Mr. Lassiter. Yes, sir. I would say yes. I would say thank you to you and to
816 Representative Arrington for sponsoring the Prompt Pay Act bill. We are supportive. As

817 I mentioned in my testimony, we have significant unpaid claims, and we have claims --
818 about \$1 billion that are over 150 days old.

819 I would say that for Medicare Advantage it costs us 25 percent more to get -- to
820 process a Medicare Advantage claim than it does traditional Medicare. And so -- and we
821 also suffer, as you indicated, from the fact that the reimbursement level for Medicare
822 Advantage patients often times does not cover the full cost of care. That is correct, sir.
823 Thank you.

824 *Mr. Doggett. Thank you.

825 *Chairman Smith. Mr. Smith.

826 *Mr. Smith of Nebraska. Thank you, Mr. Chairman, and thank you to our
827 witnesses today. I know that -- I don't have to announce the purpose we are having this
828 hearing today, but certainly the numbers do speak for themselves.

829 I want to first touch on Mr. Woodhouse's testimony, where he alleges that the
830 passage of the One Big, Beautiful Bill caused a nursing home in my district to close.
831 Now, that nursing home, CHI Health Saint Francis, a skilled nursing facility in Grand
832 Island, is owned by CommonSpirit. Incidentally, we have got the CEO of CommonSpirit
833 here.

834 Mr. Lassiter, thank you for being here. Did the passage of the One Big, Beautiful
835 Bill actually cause that skilled nursing facility to close?

836 *Mr. Lassiter. Good morning, Representative Smith. Thank you for the question.

837 That facility closed because of extremely low volume. We operate a number of
838 skilled nursing facilities in multiple communities. We felt that we could provide the
839 access to that skilled nursing service within the hospital, and not within a separate skilled
840 nursing facility. And so it was closed because there was not sufficient volume to support
841 the cost structure of an independent, skilled nursing facility.

842 *Mr. Smith of Nebraska. Not because of the passage of the bill that was
843 referenced?

844 *Mr. Lassiter. I am not commenting specifically on his commentary, I am giving
845 you my answer as to why that facility closed.

846 *Mr. Smith of Nebraska. Okay, so perhaps there is a little -- a few facts on the
847 ground that were omitted in the previous reference. And I understand, you know, debates
848 that we have across America. I would hope that we would meet the expectations of the
849 American people, and that is to have a good conversation, a back and forth, a thoughtful
850 conversation on how we can address many of the challenges that we face.

851 And so, you know, that certainly leads me to speak more directly in terms of how
852 hospital prices are set and why is the price of hospital services so high. How are prices
853 determined? And obviously, to state the obvious, if the price of health care is high, the
854 costs borne by the payer of health care is going to be high. If providers charge high prices,
855 insurance companies must set premiums and deductibles accordingly.

856 The average cost to insure a family of four in the U.S. is a surreal \$27,000 per year,
857 just the average family of 4, average cost. And so why does insurance cost so much?
858 High prices lead, obviously, to high premiums.

859 [Chart.]

860 *Mr. Smith of Nebraska. If you look at the chart behind me you can see that the
861 price of hospital services has risen faster than any other area of the economy since 2001.
862 It is not even close. Since 2001 average hourly wages have risen 131 percent: pretty
863 decent. Medical care services have risen 147 percent. The price of hospital services has
864 risen 281 percent. Again, 281 percent, far greater than any other area of the economy.

865 To be clear, there are issues in the health insurance industry, but how are insurers
866 supposed to keep premiums down if the cost of hospital services go up 281 percent in 25

867 years? Thank you.

868 Mr. Hazen, I am going to direct the question to you since your written testimony
869 certainly references the need for affordable insurance coverage. HCA charges commercial
870 insurers more than three times the Medicare rate. How can insurers lower premiums if
871 HCA charges three times the Medicare rate?

872 *Mr. Hazen. Congressman, thank you for sharing the chart, and thank you for that
873 question.

874 We believe three drivers. Let me start with that with respect to the hospital cost, or
875 evident at least in our markets.

876 One is demand is growing significantly. In the last 10 years we have seen a 2.5
877 percent per year growth in demand for our services and services in general for health care.

878 The second thing I would tell you is the complexity of care -- which is connected to
879 that chart, I believe -- has grown significantly also. So the patients we are taking care of
880 are more complex and require more services.

881 *Mr. Smith of Nebraska. Technology and new methods, new research. That is
882 not buying any savings?

883 *Mr. Hazen. Well, I think it is the patient population, Congressman. They are
884 sicker. And we talked about that earlier with complications -- obesity, diabetes, and so
885 forth.

886 *Mr. Smith of Nebraska. Well, given the fact that I have got limited time here, I
887 do want to point out that data shows that market power is much more strongly correlated
888 with high commercial prices, as well. And if I had more time I would ask Mr. Donley, is
889 it merely a coincidence that the highest-priced hospitals operate in the least-competitive
890 markets? Can you answer in 11 seconds?

891 *Dr. Donley. I will just tell you I feel that. In New York City we operate in one

892 of the most competitive health care markets in the country. Recent RAND data that was
893 analyzed showed it to be the second most competitive health care market in the country.
894 We have six major health systems in our neighborhood.

895 *Mr. Smith of Nebraska. But for those other markets where there is less
896 competition, I mean, there -- the trends seem fairly glaring.

897 *Dr. Donley. Yes, and I wouldn't be familiar with the other markets. I am
898 certainly familiar with the New York market, which is highly, highly competitive.

899 *Mr. Smith of Nebraska. Okay. Well, I wish I had more time here to dig a little
900 deeper here, but obviously there are trends here that concern all Americans, and especially
901 those who were told their care was going to be more affordable.

902 Thank you. I yield back.

903 *Chairman Smith. Mr. Thompson.

904 *Mr. Thompson. Thank you, Mr. Chairman, and thanks to our witnesses who took
905 time to be with us today.

906 Mr. Chairman, we are here today to discuss the affordability of health care, and I
907 share some of your concerns, some of the issues that you raised today. But it is recent
908 Republican policies that are making health care affordability worse today. When you cut
909 \$1 trillion from the health care system, it forces providers to cut services and in some cases
910 shut down all together. And as has been pointed out by a number of folks, this is going to
911 be especially difficult in rural areas.

912 Congressional Republicans say they only cut Medicaid, but the ripple effect will
913 make health care accessibility more difficult for everyone. Our expert witnesses who run
914 hospitals understand what Republican cuts will do to the delivery of health care. Mr.
915 Hazen, in his testimony, said -- and I quote -- "Ensuring patient access to Medicaid,
916 Medicare, and the individual insurance marketplace is one of the most direct and efficient

917 ways to lower health care costs.’‘ And yet congressional Republicans cut \$1 trillion from
918 Medicaid and failed to extend the premium tax credits that helped millions of Americans
919 better afford their insurance coverage. This doesn't assure patient access; it hampers it.

920 Congressional Republicans kicked 15 million people off their insurance so they
921 could give their billionaire donors a tax break. And it should be noted they also added
922 over \$4 trillion to our national debt. These impacts will be devastating for hard-working
923 Americans.

924 Mr. Lassiter, who runs Woodland Memorial Hospital, which, coincidentally is in
925 my district, talked about the Medicaid cuts and H.R. 1's impact on his health care system.
926 He said that when people become uninsured, access becomes harder to sustain. That is a
927 quote. And I can translate that for you. Republicans are cutting Americans' health care
928 and kicking 15 million people off of their insurance. And now hospitals will eliminate
929 services and some will close. I can't say whether that will happen to any of the systems
930 that the witnesses today represent, but I can promise you it will happen.

931 And our rural communities will be hit especially hard. Another witness here today,
932 Dr. Waldrum, explained how rural health care will be impacted by cuts in H.R. 1. He said,
933 quote, "When the only hospital within 60 miles closes, care doesn't become cheaper, it
934 becomes unavailable.’‘

935 Mr. Chairman, you have heard me say this for a year since we have been dealing
936 with the big bill, H.R. 1. And I hope now that the expert witnesses that you called here to
937 testify are sounding the alarm, it will make folks listen. Republicans' health care cuts will
938 devastate health care access across our nation, and especially in rural areas.
939 People won't stop getting sick, they won't stop getting injured, they will just stop getting
940 treatment and some will die. Many will be sicker, and treatment will cost more, all so the
941 Republicans could give billionaires and corporations a big tax break and, as I said, add \$4

942 trillion to our national debt.

943 Someone said -- I think maybe it was Mr. Waldrum -- that food is medicine. Was
944 it you? So if people don't have access -- does everybody agree with that, food is
945 medicine?

946 Okay, so if we don't have good food and good eating habits, people are going to get
947 sicker. So just a show of hands -- I will use the chairman's method here -- a show of
948 hands. Who thinks that cutting \$186 billion from SNAP benefits is going to make people
949 healthier?

950 So no one thinks that. I am glad.

951 Do your hospitals have separate services for Medicaid, uninsured, and privately
952 insured patients?

953 Nobody? So when a hospital closes or eliminates a service, does that mean
954 everyone in the local community loses health care access?

955 Everybody is nodding yes. So it doesn't matter how they pay for it. If they have a
956 truckload of money or the best insurance coverage in the world, they are going to be hurt.

957 Thank you, Mr. Chairman. Thank you, witnesses.

958 I yield back the balance of my time.

959 *Chairman Smith. Mr. Kelly.

960 *Mr. Kelly. Thank you, Chairman, and thanks for holding this today.

961 First of all, thank you for taking a day out of your lives to come here.

962 So Dr. Donley, I am going to assume -- you say you grew up in Pittsburgh.

963 *Dr. Donley. I did.

964 *Mr. Kelly. So my family was in the fruit and vegetable business. You may have
965 purchased there. And the Kellys started off on the railroads. And then my dad started in
966 1953 in a little town called Verona with a one-car showroom and about five service bays,

967 which I was able to purchase from him, and now my sons run it. We are Pittsburgh proud.

968 *Dr. Donley. I am, too.

969 *Mr. Kelly. Yes. Well, listen, you know, listen, everything we are talking today
970 is math. And when you hear about there is no coverage in the rural areas -- just because
971 this is what I have done all my life, in 1970 there were over 6,000 Chevrolet dealerships.
972 Today there is 2,800. So people say, where did they go? Well, they are not in the country
973 anymore because the market wasn't big enough for them to be in business.

974 You are going through the same thing. The market is not big enough in rural areas
975 to have people out there. You have got a facility, you have got people there, and you have
976 got people who clean the place, who do all the stuff, and I don't think people understand it
977 all comes down to math. Everything we are talking about is math. And when we talk
978 about all these different cuts, we are talking about taxpayer-funded health care.

979 Now, I don't know how you keep up with costs. I mean, we can't. We are trying,
980 but we can't. This year we are going to spend \$1.5 million on health care coverage for the
981 people that work at the dealership. So we have huge deductibles, and I am always
982 fascinated that -- and the same thing. We also have a body shop. Until you reach your
983 deductible, the insurance company doesn't kick in. And so when I hear about all these
984 things you have to write off, I get that. I get all that because it is math. It is math.

985 But moving forward, if you can just tell us, I mean, what is the answer? Is it more
986 government support? Is the cost of all this taking place because there is no taxpayer
987 putting more money into the system?

988 If you can't exist in a small market, that is not because you don't want to be there, it
989 is because you can't afford to be there. You can't have the people in the lobby looking for
990 help when you don't have a doctor or a nurse to take care of them. It is just that simple.
991 So when I hear all this stuff going back, and who it is that did this or who it is that did that,

992 and we cut costs, and we took health care away from people, and millionaires and
993 billionaires are getting all these tax breaks, I want to be a billionaire because I need a tax
994 break, and I don't give a damn what it is. It is every single thing we do in life we pay taxes
995 on. The locals get you, the state gets you, the Feds get you, and they all start at the same
996 top dollar and take a percentage of it. Every time you go out and buy something, there is a
997 tax on it.

998 I am just trying to figure out how the hell much more money do we have to have
999 taxpayers assisting in in order to keep your businesses open. And I sure as hell hope they
1000 don't start screwing around with the car dealerships because you know what? I have got
1001 too many people I got to pay every two weeks, and I don't want anybody running a
1002 business that is \$39 trillion in debt tell me how to run my business.

1003 Now, all of you took a day out of your life to come here today. What could we do?
1004 What could we actually do? If each of you could just take a few minutes or a few seconds
1005 and say, what could we do?

1006 I am glad we are having this, but it is math. You are not in rural areas because you
1007 can't afford to be there. The cost of operation is absolutely ruining everybody. But
1008 please, if you can start, Mr. Hazen, and go down. And I want to hear from Mr. Donley
1009 because he is a Pittsburgher. And go Steelers.

1010 *Mr. Hazen. Well, thank you Congressman. Three things, and we said this.

1011 One is coverage. Coverage is absolutely essential to rural markets, it is essential to
1012 urban markets, it is essential to Americans for affordability, for access, and for good health.
1013 That is number one.

1014 Number two is more competition. There are opportunities in some communities
1015 where certificate of need laws prevent access in -- capital flowing into rural markets. That
1016 is number two.

1017 And then number three -- and we have talked about this -- is it is really complex
1018 administratively, regulatory. And if we can find ways as a system -- government, private
1019 sector, and so forth -- to simplify things, it makes it easier for all people.

1020 One quick point and I will pass it. We have 35 rural hospitals. In -- since the
1021 pandemic we have acquired eight hospitals in this large company that I have the privilege
1022 to run. Five were rural hospitals. So we have -- five of eight we have acquired, two
1023 bankrupt or almost bankrupt.

1024 *Mr. Kelly. Yes.

1025 *Mr. Hazen. Thank you.

1026 *Mr. Lassiter. Thank you, Congressman, for the question, and I will try not to
1027 replicate what my colleague to the right said.

1028 But let me just start off with the regulatory burden is a significant issue for us.
1029 You indicated that this is just math, and so the math that we deal with often times is the
1030 burden to comply with regulatory issues that at times are overlapping and are duplicative.
1031 And so I would ask you -- I would ask this committee to consider standardizing the process
1032 for plans and providers for requests to transmit clinical information.

1033 I would ask you to think about reducing and simplifying the number of quality and
1034 efficiency measures that we have to report on to multiple agencies.

1035 I would ask you to create one claim system for Medicaid, as opposed to 50 that are
1036 different that creates for organizations like mine and -- I won't speak for my colleagues to
1037 the right, but with organizations who serve patients in multiple states, that is a significant
1038 regulatory burden for us -- administrative burden for us, excuse me.

1039 I would ask this committee to think about stronger coverage for behavioral health.
1040 A lot of the costs that we incur in our emergency departments are because individuals do
1041 not have adequate coverage.

1042 *Mr. Kelly. We are out of time. But first of all, would you all submit to us in
1043 your highest priority the business model and what we need to do to improve it?

1044 The other thing, I got to tell you, we got to get on -- I don't know, in an outfit that
1045 puts such a burden on hard-working American taxpayers, is -- when is enough truly
1046 enough? And if you got the government out of the way, how much easier would it be to
1047 run your businesses?

1048 All right, thank you for being here today. We really appreciate it. Keep up the
1049 good work. And I know there is a lot of sick people out there. And look, we are trying to
1050 take care of everybody we can. This is not a Republican issue or a Democrat issue. We
1051 need to get off that kick, okay? And I -- whether it is the one beautiful bill, the one ugly
1052 bill, whatever the hell they want to call it, here is the thing. It is the bill. It is the bill.

1053 So thank you for being here.

1054 *Chairman Smith. Mr. Larson.

1055 *Mr. Larson. Thank you, Mr. Chairman, and thank you for this hearing, and
1056 especially the witnesses I want to thank, as well. It is nice when you have CEOs that are
1057 before you that are compassionate and concerned about America, about this great country
1058 we live in.

1059 So my question to all of you -- and I like what the chairman did before. I will take
1060 a show of hands. Do you all believe that health care is a fundamental right of every
1061 American citizen?

1062 You do. All of you believe that?

1063 Well, and do you believe from the testimony that -- so health care isn't a rural or
1064 urban issue or a wealthy or poor issue, it is something that impacts every single American?

1065 And yet there are, what, 28 million Americans -- even though health care is at a --
1066 the lowest it has ever been in terms of people that don't have insurance, 28 million

1067 Americans don't have any insurance. I believe -- and the health care costs, we have had
1068 hearings where everybody is pointing fingers the other way, and there is a lot of blame to
1069 go around.

1070 But has Medicare been a program that you dislike? Raise your hands if you dislike
1071 Medicare as a program and a way to make sure that people have coverage.

1072 So how many would be in favor of Medicare for all, something where every single
1073 American, rural or urban, is guaranteed by the very government that they are a part of that
1074 they have access?

1075 And then all these issues with respect to the coverage and the cost, et cetera, need to
1076 be worked out in conjunction with all the entities that are impacted by this.

1077 Mr. Donley, I had a question too that a constituent had, and I wanted to run it by
1078 you. The United States Department of Justice recently filed a suit alleging that the New
1079 York-Presbyterian violated antitrust laws by stifling competition between New York City
1080 providers. New York-Presbyterian has publicly commented that the suit is without merit,
1081 and its policies and procedures are pro-competitive. How are your policies and procedures
1082 pro-competitive?

1083 *Dr. Donley. As you note, Congressman, we were recently named in a lawsuit
1084 brought by the Department of Justice regarding our contracting practices, and therefore I
1085 can't discuss any of the issues relating to that case.

1086 We do believe that that case is without merit, and we do believe that we comply
1087 with all Federal and state laws.

1088 *Mr. Larson. Well, so while this investigation is going on, would you say that
1089 there is a cooperative nature of working towards a solution, or this is another example of
1090 people just taking sides?

1091 *Dr. Donley. We look to collaborate with all involved people to get to a solution.

1092 *Mr. Larson. Well, I thank you.

1093 I -- also, because of the discussion about CEOs that are here, I want to note the
1094 CEO of Hartford Hospital in my home state, Jeff Flaks. This is a CEO who goes out in the
1095 winter and finds people that are homeless, sleeping under bridges, et cetera, and brings
1096 them back to the only place that they will have refuge and care. And listening to the
1097 testimony here today, it appears clearly that -- why policy initiatives and the so-called
1098 solutions that might appear in future bills are actually right in front of us in a bill that has
1099 been in existence but isn't accessible to all Americans.

1100 Is there anyone that disagrees that Medicare for all should be something that every
1101 single American has so that they have the access to the very health care facilities conducive
1102 to make a better life, to get the kind of nutrition that has been discussed here, to have a path
1103 forward?

1104 And why should we be sitting in testimony instead of at odds, agreeing that this is
1105 what we have to do? Will all of you pledge to work towards getting all Americans
1106 covered under health care and improving Medicare for all so it accomplishes that goal?
1107 Raise your hand if you do.

1108 So two of you do.

1109 *Dr. Donley. I strongly support coverage for all. I am not a policy-maker, so I
1110 don't know all the specifics of that, but --

1111 *Mr. Larson. I didn't ask you to make the policy. I asked you if you were for
1112 coverage for all.

1113 *Dr. Donley. I am for coverage for all.

1114 *Mr. Larson. Thank you. You are --

1115 *Mr. Lassiter. Congressman, I am for coverage for all, as well, yes.

1116 *Mr. Larson. So -- and Mr. Hazen?

1117 *Mr. Hazen. We fundamentally believe coverage is the answer.

1118 *Mr. Larson. So with everyone believing that this is the answer, and knowing
1119 from your testimony that, you know, everybody needs this coverage -- and, Mr. Waldrum,
1120 you were especially articulate in pointing out what the chairman's district goes through, the
1121 inequities between rural and urban areas. I could, however, point out in urban areas like
1122 the one that I live in where people go without health care as well.

1123 I yield back.

1124 *Chairman Smith. All right, thank you.

1125 Mr. Schweikert.

1126 *Mr. Schweikert. Thank you, Mr. Chairman.

1127 As each of you as CEOs is listening to -- and hopefully you accept -- the premise
1128 we have turned health care into financial engineering, if you actually listen to us up here
1129 much of the discussion isn't actually about health care inputs, outputs, it is about the
1130 financial engineering. We have to deal with the reality. And I am still just stunned how
1131 little I get input from the health care community.

1132 Six and a half years, Medicare spending goes from one trillion to two trillion. In
1133 six years the trust fund is empty. So in 6 years you are all getting a 12 percent cut under
1134 the current law. But how much have you heard from that of the actual demographics?

1135 Look, we have an interesting issue. Next year the United States functionally has
1136 fewer 18-year-olds than we had 20 years ago, double the number 65 and up. I will be one
1137 of them next year. We have a demographic. I have had only one member of the panel
1138 sort of talk about -- and we are going to have a little discussion -- about your patient mix,
1139 severity mix, and some of the inputs with that.

1140 Look, it is -- one of my intense frustrations is we, as policy-makers, often are
1141 desperate to find someone to blame because we want to feed simplicity to our voters.

1142 What happens when the reality of a complex problem requires a complex solution, are we
1143 capable of doing complexity?

1144 Mr. Lassiter, if you were to actually say what is the difference in the patient
1145 presentations you have today compared to 20 years ago in health, obesity, complexity,
1146 multi-chronic issues, how different does your world look and your patient mix today than
1147 20 years ago?

1148 *Mr. Lassiter. So I would say -- I will speak in generalities, sir, only because I
1149 wasn't at my current organization 20 years ago, and so I can't speak to what that population
1150 --

1151 *Mr. Schweikert. It is a thought experiment.

1152 *Mr. Lassiter. No, I understand --

1153 *Mr. Schweikert. I am trying -- I am heading towards making a point here.

1154 *Mr. Lassiter. Yes, absolutely. So I think what you would find -- and I believe
1155 this would be shared across the panel -- you would find that patients that present to
1156 hospitals today are sicker, they have more comorbidities than they did 20 years ago. You
1157 would find, as you see in general research, that the level of obesity in our populations
1158 would be higher today than it was 20 years ago. Those are the things that you would see.
1159 Whether patients are presenting at a primary care physician's office or presenting at a
1160 hospital emergency department, that is what you would see.

1161 *Mr. Schweikert. To that point, does the panel substantially agree with this?

1162 I mean, you can just grunt at me yes or -- argue with me.

1163 *Dr. Donley. Yes, we are seeing much sicker patients.

1164 *Mr. Schweikert. So what would happen if one of the most powerful things we
1165 could do is actually having to do with Americans' health statistics?

1166 We have a data set that my Joint Economic Committee published about two or three

1167 years ago. Controversial. I thought we were going to get the crap kicked out of us
1168 because we told the truth about the math. We showed that almost 9.1 trillion over 10 years
1169 of health care costs was obesity, that 47 percent of U.S. health care costs were related to
1170 obesity, and yet somehow we think it is moral to hand someone an EBT card to go buy
1171 onion rings.

1172 We live in a time of technology miracles. Maybe part of our fixation is coming up
1173 with a much more holistic view of how you run your organizations. I am enraged, how
1174 much of a health care hospital bill is the air conditioning, is the parking lot, is the
1175 infrastructure. But that is what you are required to do in today's model. Maybe dealing
1176 with the reality of I have a population that is getting older very fast; I got, what, 76 million
1177 of my brothers and sisters who are Baby Boomers -- geriatric health care and the
1178 population. When 31 percent of Medicare spend is just diabetes, we actually know how to
1179 attack this and approach this, whether it be a combination of some of the new drugs that are
1180 on the market to incentives to actually be healthier.

1181 Maybe my solution -- maybe our solution as a society is deal with the reality of our
1182 demographics, try to help our brothers and sisters be healthier, and then we are going to
1183 have a world of how do I get market technology, whether it be wearables or other things, to
1184 basically make you all compete like crazy. Because honestly, in six years Medicare
1185 spending doubles, and the trust fund is gone, and we are not prepared to deal with the scale
1186 that is coming at us.

1187 And with that I yield back.

1188 *Chairman Smith. Ms. Sanchez.

1189 *Ms. Sanchez. Thank you. I want to welcome all our witnesses, and thank you
1190 for your testimony today.

1191 Mr. Lassiter, I agree that we should pass the Medicare Advantage Prompt Pay Act,

1192 and I assure you that Mr. Arrington and I are working to secure a legislative hearing on that
1193 piece of legislation. But I want to talk to you about something a little bit different today
1194 because I believe you are the only witness on the -- in our hearing today that has a presence
1195 in my district. I want to ask you about an issue that has impacted my constituents directly,
1196 and one that has been raised in many of the town halls that I have conducted.

1197 Last summer ICE began terrorizing the communities of Los Angeles. So I want to
1198 ask a very simple question: Do you believe that immigration enforcement should be
1199 conducted in a health care setting?

1200 *Mr. Lassiter. Congresswoman, thank you for the question.

1201 What I would say to you is this: I believe strongly that in a health care setting we
1202 should deliver health care, and we should do that in an unencumbered way. My
1203 organization, as I would presume all that are here, are committed to trying to deliver the
1204 best possible care to the patients who present to us.

1205 And so what I would simply suggest to you is that we should be able to deliver that
1206 care in an unfettered way, as seamlessly as possible to meet patients' needs.

1207 *Ms. Sanchez. Thank you. Do you believe that ICE agents or any Federal
1208 immigration officer should be present in an emergency department when a patient is
1209 seeking care there?

1210 *Mr. Lassiter. Well, CommonSpirit works very closely with law enforcement to
1211 ensure that there is appropriate respect of all local, state, or Federal officials.

1212 I won't opine explicitly on the issue around ICE, except to say again that I would
1213 not be in favor of anything that disrupts the ability of caregivers in an emergency
1214 department to deliver high-quality care that meets a patient's needs.

1215 *Ms. Sanchez. Okay, I appreciate your answer. I am asking about this because in
1216 July of last year U.S. Immigration and Customs Enforcement agents occupied Dignity

1217 Health Glendale Memorial Hospital for 15 days. And at times they were waiting for one
1218 patient in the emergency room, behind the reception desk, and in the patient's own room
1219 where they were getting care. Do you know if Glendale Memorial Hospital has a written
1220 policy and standard operating procedure for interacting with immigration agents? Do you
1221 have that policy?

1222 *Mr. Lassiter. Well, we certainly have a policy for interacting with all law
1223 enforcement. And again, we are respectful of boundaries for local, state, and Federal law
1224 enforcement.

1225 *Ms. Sanchez. So you do have a policy.

1226 *Mr. Lassiter. That is correct.

1227 *Ms. Sanchez. Thank you. I appreciate brief answers because we have limited
1228 time.

1229 In September California passed Senate Bill 81, which would require California
1230 health care facilities to create and designate non-public areas to protect patient privacy. It
1231 further directs health care providers to establish clear procedures for responding to
1232 immigration enforcement in health care spaces. This was a direct response to President
1233 Trump's executive order which, for the first time in a decade, allowed Federal immigration
1234 agents to conduct enforcement inside health care facilities.

1235 Mr. Lassiter, I understand you have overseen the entire health system since 2022.
1236 Can you speak briefly as to how President Trump's directive impacts routine patient care,
1237 specifically at Glendale Memorial?

1238 *Mr. Lassiter. Congresswoman, I don't know that I could speak specifically to
1239 what happens on a day-to-day basis at that facility because I am not physically there
1240 regularly, but what I would say to you is when we have individuals in the health care space
1241 that are not delivering health care, it can be disruptive.

1242 *Ms. Sanchez. Thank you.

1243 *Mr. Lassiter. And we work hard to make sure that we work collaboratively with
1244 law enforcement.

1245 *Ms. Sanchez. Thank you. I mean, prior to this there was a sensitive locations
1246 memo which did not allow ICE enforcement within a health care setting.

1247 In southern California alone, nearly 30 percent of patients have reported missing or
1248 canceling appointments due to immigration concerns. I understand and I just want you all
1249 to know that the health care industry is in very uncertain times. The Republican tax bill,
1250 which gave a tax cut to billionaires, just cut \$1 trillion from health care programs last
1251 summer. I know that tariffs, illegal tariffs, are driving up the cost of medical supplies,
1252 general hospital and health system costs, and procurement as well.

1253 Immigration enforcement is decimating our care-giving and long-term health care
1254 workforce. A cruel immigration regime is deterring people from getting to their doctors'
1255 appointments, so I understand you are facing a lot of headwinds. But I think it is
1256 incumbent upon a local hospital, especially one that was founded on caring for our most
1257 vulnerable community members, to provide a safe space for parents and their families.

1258 And I wanted to talk to -- about this particular issue today because this week the
1259 House is voting to progress another \$70 billion in funding for Trump's ICE and CBP
1260 enforcement, and that kind of enforcement isn't stopping any time soon. So I fear that if
1261 you do not have policies that put the patient's health above all else, this could also be a real
1262 disaster for our health care industry.

1263 And with that I will yield back.

1264 *Chairman Smith. Mr. LaHood.

1265 *Mr. LaHood. Thank you, Mr. Chairman, for having this important hearing today.
1266 I want to thank our witnesses for being here today and your valuable testimony.

1267 Obviously, the title of today's hearing is, "The Impact of Rising Health Care Costs
1268 on Patients and Families.'" And as we have heard this morning already, this is a topic that
1269 is top of mind for all of us from a public policy standpoint, from a political standpoint.
1270 We have to do something on health care. And so ideas, suggestions, proposals, comments
1271 are important.

1272 We also are building upon what we earlier this year had before the committee,
1273 which was the leaders of the major health care companies on how to address the challenges
1274 of limited access, rising premiums, and growing out-of-pocket costs for patients. Today's
1275 hearing is a continuation of that, and that conversation. And I believe that rising costs
1276 should be addressed comprehensively by the entire health care system. Insurers, hospitals,
1277 drug manufacturers, and PBMs all share responsibility for improving affordability and
1278 access. And I would argue we have an obligation and responsibility to move forward with
1279 that.

1280 I regularly hear in my own district from families and employers and providers
1281 across Illinois who are concerned about hospital consolidation, higher facility fees, and
1282 billing practices that are increasingly difficult for patients to navigate or to understand.
1283 Those pressures can increase costs without necessarily improving quality or access. In
1284 rural communities -- and I have a very rural district -- these challenges are even more
1285 serious. When a hospital closes, a service, loses staff, or reduces access, patients may
1286 have to drive hours for care, which is inconvenient and very, very difficult.

1287 I and many of my colleagues here strongly support market competition, and I also
1288 support vital safety net programs like Medicare and Medicaid and the 340B program.
1289 With Illinois having a significant participation in 340B, we must ensure that this lifeline
1290 reaches the vulnerable patients in rural hospitals that the program was intended to serve.
1291 That is why when market power grows significantly or when public programs are used in

1292 ways that we do not clearly benefit -- that do not clearly benefit patients, law-makers have
1293 a responsibility to intervene and assess what is broken within our system. And that is what
1294 -- part of what today is about.

1295 So I look forward to discussing on how we can lower costs, strengthen rural health
1296 care access, and ensure patients are kept at the center of our system. With that I want to
1297 ask a question regarding 340B which, of course, is the drug pricing program designed to
1298 lower outpatient drug costs for providers.

1299 Dr. Donley and Dr. Waldrum, can you please share on how you utilize 340B to
1300 provide better care for patients, and what oversight or reporting requirements must be
1301 followed to receive the 340B, ensuring that the resources are directed back to patients?

1302 *Dr. Donley. Sure, thank you for your question, and I agree completely with you
1303 that there is many stakeholders, and all of us, including hospitals, have to play a role in
1304 finding a solution.

1305 In regards to 340B, we do believe that we use the resources that we obtained from
1306 340B to take care of vulnerable patients as the program was designed. We have a \$2.4
1307 billion community benefit. That is over 20 percent of our operating expenditures. For
1308 non-profit hospitals the average is around 9 to 14 percent of operating expenditures for
1309 community benefit.

1310 Specifically, we provide \$1 billion shortfall of care to patients who are insured by
1311 Medicaid.

1312 *Mr. LaHood. Dr. Waldrum.

1313 *Dr. Waldrum. Congressman LaHood, I appreciate the question and the
1314 importance of affordability. I think that it is important.

1315 My whole career has been in safety net organizations, as I have mentioned, and
1316 using these programs to support our communities and make sure that they have access to

1317 care and the significant burden that we all face with uncovered lives, and so this is a really
1318 important program for maintaining access in rural populations.

1319 And I think it is important to point out that this is not a Federal -- the Feds don't pay
1320 for it. This is a program that is put in place -- and I get that pharma doesn't like it.
1321 However, this is really important for us to maintain the programs that we need to maintain
1322 to have the access. And it is not about convenience, it is actually about lives.

1323 We need to not increase the administrative burden. As we have mentioned, 20
1324 percent of our health care dollar is spent on administrative burden, managing the
1325 complexity of the insurance markets. Medicaid Advantage is overwhelming our staff and
1326 our reporting. And adding to the administrative burden of this important program will
1327 only increase the costs and diminish the benefits that it helps for safety net organizations.

1328 *Mr. LaHood. I am out of time. I yield back, Mr. Chairman.

1329 *Mr. Estes. [Presiding.] Thank you. I now recognize Ms. DelBene from
1330 Washington for five minutes.

1331 *Ms. DelBene. Thank you, Mr. Chairman. Thank you all for joining us today.

1332 Prior authorization is a tool that is used by health plans to manage costs by
1333 requiring health care providers to obtain pre-approval for medical services. Theoretically,
1334 people may think this sounds reasonable, but in reality it often denies beneficiaries access
1335 to services even when they meet coverage rules. In fact, one KFF analysis found that in
1336 2024 more than 80 percent of the appealed prior authorization denials were overturned.
1337 And ultimately, these unnecessary denials delayed patient care, added administrative
1338 burdens on clinicians, and hurt health outcomes for patients.

1339 Mr. Lassiter, you represent CommonSpirit, the parent organization of Virginia
1340 Mason Franciscan Health in my state of Washington, many clinics also in my district. I
1341 wondered if you could comment on how prior authorization has affected patients that you

1342 serve obviously in Washington, but across the country.

1343 *Mr. Lassiter. Thank you very much, Congresswoman, for the comment -- for the
1344 question.

1345 I would just simply say this. Prioritization, as you indicate, is a tool. Health
1346 systems are experiencing that tool being misapplied at times to procedures that should be
1347 quickly authorized that are not, or denied authorization for procedures that clearly are
1348 within the coverage plan that patients have. We experienced that frustration, we hear it.
1349 Our frontline teams hear it from patients who experienced delays in being able to schedule
1350 procedures, and that comment is sort of across the system, not specifically to Seattle or the
1351 State of Washington, but broadly.

1352 And again, we believe that some of the administrative oversight and the work and
1353 rework that is required there, we estimate that for us it is about \$1 billion worth of
1354 additional time and effort spent chasing down authorizations, pre-authorizations, denials, et
1355 cetera.

1356 *Ms. DelBene. And not only delaying and denying care for patients, but you
1357 talked about the burden on clinicians and others, the paperwork. When folks are spending
1358 more and more time doing paperwork, they are not able to actually see patients and do the
1359 work they are there for.

1360 You know, I absolutely believe we should look at innovative solutions to reduce
1361 hurdles that stand between Americans and the health services they need, so I was definitely
1362 alarmed to see this Administration do the opposite and leverage AI tools to deny people
1363 care in traditional Medicare.

1364 Two weeks ago we had Secretary Kennedy here. He came in to testify in front of
1365 this committee, and I asked him about the implementation of the new wasteful and
1366 inappropriate service reduction model, the WISeR model, which is actually is happening in

1367 Washington State. This -- it has launched in six states, including the State of Washington,
1368 and allows for-profit companies to use kind of black box algorithms to deny Medicare
1369 claims. And even worse, it financially rewards these companies with a share of the cost
1370 that they claim to have saved by rejecting physician-prescribed care.

1371 So, Mr. Lassiter, if we speak specifically about the WISeR model, which is in
1372 Washington, what is your relationship and communication like with these companies that
1373 are actually doing the prior authorization, the for-profit companies that are doing prior
1374 authorization in the WISeR model in states like Washington?

1375 *Mr. Lassiter. Congresswoman, thank you for the question.

1376 It is a little early for us to have a bottom line point of view about the WISeR model.
1377 We have concerns about entities that have incentives to disallow appropriate claims. We
1378 liken this to some extent to the days when we had those Medicare RAC audits and you had
1379 the audit firms who had a financial incentive to deny claims. We see it somewhat similar
1380 to that.

1381 Again, it is early. As you mentioned, it is in six states. Washington is one of
1382 those. Our team is closely monitoring the effects -- positive, negative, or neutral -- of the
1383 WISeR model, but I have some concerns about the misalignment of incentives between the
1384 firms that are doing it and what they are -- the basis of their payments.

1385 *Ms. DelBene. Yes, thank you. And we are hearing directly from patients across
1386 the state who are being impacted from providers who know their patients are having their
1387 care delayed. It is more expensive. So this idea that somehow this model was supposed
1388 to save money is actually -- make it harder and harder for patients.

1389 Thank you so much. I yield back, Mr. Chairman.

1390 *Mr. Estes. Well, thank you, and I now recognize myself for five minutes.

1391 I appreciate all the witnesses for being here today. You know, I want to start off a

1392 little bit first with just talking about some of the positive aspects that impacts on health care
1393 systems can have when they actively invest in the communities. In my own district,
1394 HCA's Wesley Medical Center is -- delivers more babies than any hospital in Kansas.
1395 And to address the severe workforce shortages, HCA recently opened a Galen Nursing
1396 campus in Wichita, fully funded by HCA and tuition without public dollars. They now
1397 have over 200 patients, and are proactively partnering with nine other local nursing schools
1398 to ensure no existing clinical rotations were disrupted. This is a true addition to our state's
1399 workforce and not a replacement. Wesley has hired over half of those graduates, and the
1400 rest are serving other communities across Kansas. That is the type of local investment we
1401 like to see, and I appreciate that effort.

1402 We do want to look, though, at -- as we talk about the broader national landscape,
1403 as has been brought up earlier, the rapid commercialization of our medical care is
1404 concerning. We are watching as these -- the large systems swallow up independent
1405 practices, creating local monopolies that drive prices for patients without necessarily
1406 improving the quality of care. A massive driver for this consolidation is, as we have seen -
1407 - and creates a heavy burden for -- a financial burden for our patients is the broken system
1408 around site neutrality.

1409 I mean, right now Medicare and commercial payers generally pay significantly
1410 more for care provided at an outpatient facility that is owned by a hospital compared to the
1411 exact same facility if it were owned by an independent doctor. Because of this, when large
1412 hospital systems buy up independent practices, they routinely add huge facility fees onto
1413 the regular outpatient services. In fact, patients can end up paying up to four times as
1414 much for routine care just because a hospital acquired the clinic, even though they see the
1415 exact same doctor. And this payment loophole incentivizes health systems to continually
1416 purchase independent practices simply to build at a higher rate.

1417 I want to talk a little bit about that. Obviously, I recognize that in a hospital setting
1418 there are some additional costs. I mean, having an ER, having maybe an on-site pharmacy
1419 or other facilities does add some of those costs, but it doesn't necessarily affect the actual
1420 services provided at an outpatient facility that may have been just recently acquired.

1421 One of the reasons why I want to talk about this is just the impact on seniors who,
1422 living on fixed incomes, sometimes pay 20 percent of their out-of-pocket for outpatient
1423 services. For example, a senior may pay a \$50 copay for a checkup at a doctor-owned -- at
1424 a hospital-owned clinic instead of a \$20 copay for an independent doctor. How do you
1425 look through that with your systems?

1426 I mean -- and this is kind of a question for anybody is, you know, is there a \$30
1427 value added to that patient because the facility is bought?

1428 Dr. Waldrum.

1429 *Dr. Waldrum. Yes, Congressman, I appreciate the question, and I think that the
1430 assumption that we are consolidating out of profit motive is wrong in rural America. In
1431 our market I can only speak to what we face, and I have never bought or sold a practice
1432 because any of the doctors or hospitals or communities wanted to actually make that
1433 happen. Our system grew because of all nine -- eight rural hospitals were failing, and
1434 were about to be closed when those communities approached us because they had years of
1435 deficits in their community and they were losing doctors.

1436 And in Martin County, a county about 45 miles north of Greenville, North Carolina,
1437 three years ago that rural hospital closed. It was a for-profit organization closed because
1438 they couldn't make it in that community. It left that community as one of the largest health
1439 care deserts in the country. And for us to sustain care and pay the overhead and to provide
1440 access in those communities, the provider-based reimbursement helps us meet that
1441 obligation.

1442 So we are working with the state. We would like to work with Feds, and we are
1443 working with that community to try to find a solution, and this is one of the programs that
1444 helps us meet --

1445 *Mr. Estes. And I think that is a good use of consolidation practices.

1446 I mean, I have a lot of counties in my district where -- 4,000, 5,000 population in
1447 the entire county, and that is not enough to support that ongoing either competition or -- let
1448 alone support a standalone hospital. And I am worried more about the standalone clinics
1449 that get bought that aren't necessarily a hospital, and the impact there.

1450 And so anyway, I have got so many other questions, a lot of things that we have
1451 talked about, rural classification and the impact there, and we have really got to figure out a
1452 different way of doing this. And so I have run out of time, but I want to make sure that we
1453 focus on how do we lower the health care costs for everybody across the country.

1454 Now, pursuant to committee practice, we will go to two-to-one questioning, and
1455 now I will call on Mr. Arrington for five minutes.

1456 *Mr. Arrington. Thank you, Mr. Chairman, witnesses. I want to follow on the
1457 line of questions that Chairman Estes articulated.

1458 First, I think it has probably been well established, I think everybody understands
1459 that the current system is broken, fundamentally broken. It is not delivering. In a country
1460 as wealthy and as capable technologically, as rich in resources and personnel and brick and
1461 mortar, we should not be the least efficient system in the developed world.

1462 A third of the budget and a third of what is driving us further into the tens of
1463 trillions in debt hole with a looming debt crisis is health care. It is 20 percent of the
1464 economy. You look at Medicare with 10,000 Baby Boomers retiring every day, we are
1465 going to go from a trillion to 2 trillion in less than 10 years. One in every four Americans
1466 in 2022 were on Medicaid. In 2022 Medicaid was almost \$600 billion. That was a 45

1467 percent increase from 2019. And these are just two programs, the largest health care
1468 programs in the Federal Government. We cannot sustain this, and it is going to end really
1469 badly if we don't do something about it.

1470 And I haven't even gotten to the consumer or the patient price unsustainability.
1471 But in 2015 Congress passed the Bipartisan Budget Act, established site-neutral payments
1472 under Medicare for services received at off-campus HOPDs -- basically, hospitals -- unless
1473 the location was already billing as a hospital department prior to the date of enactment.

1474 Mr. Chairman, this grandfathering clause and other exemptions in the law have
1475 resulted in a perversity that is driving cost up for patients, premiums for Medicare
1476 beneficiaries, and taxpayers that are paying the freight of the system. I am talking about
1477 site neutral, where -- in Plainview, Texas it is real simple. We are paying hospitals a
1478 whole lot more for the same outpatient procedures that physicians conduct with the same
1479 outcomes, often with the same mid-level support. And you have got, for example,
1480 biopsies today on average cost about \$150 at a physician's office. It is \$800 at a hospital
1481 setting. And there is a whole list of things. Epidural injection, \$250 at a physician's
1482 office, 740 because of that HOPD payment.

1483 Now, there are some things hospitals can do that outpatient physician groups can't.
1484 We want you to be motivated to do that and do that well. There is a cost structure
1485 associated with it. We want you to be adequately funded. But if we just did what
1486 President Obama suggested in his budget, what Joe Biden included in his budget -- and yes,
1487 Donald Trump included in his budget in his first administration -- we could save \$160
1488 billion that would go to reducing the deferred tax on our children or the national debt. We
1489 could, among other things, save 94 billion to beneficiaries, 672 billion for greater health
1490 care -- for the greater health care system, and on and on. It is a simple, straightforward
1491 thing, Mr. Chairman.

1492 And to my Democrat colleagues, this was led, I think, during the Obama years, and
1493 we have carried it over into all of our budgets.

1494 But just like we say we want to get rid of waste and fraud and we put it in the
1495 budgets as a saver so we can show that we are getting close to balance, we don't do jack
1496 squat about it. Now we did, and then we got vilified by our Democrat friends for
1497 supposedly cutting benefits, and all we were doing was cleaning up the system so we could
1498 sustain these programs and so that we could also steward tax dollars.

1499 But yet here we have another opportunity, Tom, another opportunity to do
1500 something that both sides have said is important. It is common sense, straightforward.
1501 Save the system money. Why wouldn't that -- raise your hand if you think that is a
1502 straightforward, common-sense idea that we ought to do to help save the system from
1503 collapse, if not the entire country from a fiscal or debt-related crisis that could be
1504 potentially irreparable. Do you think it is a good idea to have site neutral? Are you all
1505 against it?

1506 It is a no hands, no takers for -- but look, I will give you, Mr. Hazen -- give me your
1507 last -- your comments. I know my time has expired, so you will be the last word on this.
1508 But I didn't get any takers on site neutral.

1509 *Mr. Hazen. I think there are certain aspects of your discussion here that have
1510 merit. I think there is also merit to the hospitals receiving a premium in certain
1511 circumstances. So we would be more than willing to work with you on it.

1512 *Mr. Arrington. I think that is fair, and I want to be sensitive to those nuances so
1513 we don't hurt you while helping the system. So let's work together and get it done.

1514 I yield back.

1515 *Mr. Estes. Thank you. I now recognize Ms. Sewell of Alabama for five
1516 minutes.

1517 *Ms. Sewell. Thank you, Mr. Chairman. I want to thank all of our witnesses for
1518 being here today.

1519 My Alabama district is both urban Birmingham as well as rural, the Black Belt of
1520 Alabama, which is where I grew up in. And all -- what they have in common is that they
1521 are areas where underserved people live. And so there are lots of needs in my particular
1522 district. But if anyone knows what is possible from that district with resources,
1523 opportunities, it is me and my staff. And we work hard every day to try to provide those
1524 resources and opportunities to the people of the 7th congressional district.

1525 Alabama has a bare bone minimum Medicaid program. We have the lowest
1526 Medicare wage index, meaning that Medicare reimburses our hospitals at 65 percent of
1527 costs, compared to more wealthier cities and states at 150 percent of cost. We have fewer
1528 folks on private insurance, so our hospitals are heavily reliant on Medicaid and Medicare
1529 reimbursements.

1530 And most recently I held a roundtable with my rural hospital CEOs, and over seven
1531 of them attended as well as several executive directors and CEOs of community health
1532 centers. They are exhausted. They are exhausted because they feel like they are getting
1533 hit by all sides and that there is no end in sight. They aren't hopeful about the Rural
1534 Health Transformation Fund, because they don't think that it will trickle down to their
1535 hospitals. When compared to the pending Medicaid cuts as well, they think that they are
1536 in a no-win situation.

1537 Mr. Waldrum -- Dr. Waldrum, I want to thank you for being here today and for
1538 your work at UAB, the former CEO of University of Alabama Hospital in Birmingham. I
1539 also want to thank you for your leadership in the AAMC. I am proud of your partnership
1540 with -- on my bill to expand medical residency slots. I think all of us wanted to make sure
1541 that we have as many residents as possible, especially for rural parts of our districts.

1542 You are familiar with the state of Alabama's Medicare, and I wanted to see if you
1543 would give us an assessment on how you think that the rural and safety net hospitals will
1544 fare under the Medicaid cuts. And your thoughts about the Rural Hospital Transformation
1545 Fund, Dr. Waldrum?

1546 *Dr. Waldrum. It is good to see you, thank you. And as mentioned, I spent 20
1547 years in my career in Alabama running one of the country's largest safety net organizations
1548 in downtown Birmingham, and have visited every rural hospital in the State of Alabama,
1549 just as I have in our market of eastern North Carolina, and they are very similar
1550 demographically and from a rural context. So I very much appreciate and understand the
1551 issues that your constituents are facing.

1552 The fact is that when we look at the H.R. 1 and what it will do for funding in rural
1553 environments, we see a fairly large reduction in reimbursement. The year after next we
1554 will realize a \$30 million decrease, which starts to compound year over year, and over the
1555 next 10 years, conservatively, is \$1 billion in cuts to our rural delivery system.

1556 And then we appreciate the fact that the Rural Health Transformation Fund under --
1557 that underscores that there is really a difference in rural and urban environments --

1558 *Ms. Sewell. And I think we all know that.

1559 *Dr. Waldrum. Yes.

1560 *Ms. Sewell. And I think that --

1561 *Dr. Waldrum. The amount --

1562 *Ms. Sewell. -- the challenge, of course, in Alabama is that we didn't expand
1563 Medicaid. And we also have the lowest wage -- Medicare wage index. And I know that
1564 our whole delegation has been fighting to increase that. But to increase Alabama and
1565 other southern states means you have to decrease New York and other -- west and east
1566 coasts. And so it is a win-loss proposition for so many.

1567 Your thoughts about what we can do with the transformation fund, as well as your
1568 thoughts about -- you have said that the cuts will be devastating. How devastating will
1569 they be for rural and underserved communities?

1570 *Dr. Waldrum. Well, we are starting to plan, and it will -- if we don't get relief, we
1571 will be closing access and services. So that is just a mathematical reality. And so I think
1572 that that will play out. The amount in the Rural Health Transformation program will not
1573 offset and is not nearly -- and every state is different, so I don't know exactly how the
1574 Alabama program --

1575 *Ms. Sewell. Well, Alabama is getting \$200 million for that first year. But they
1576 have also said that that transformation fund -- and I know every state is different and can
1577 develop their own, but our transformation fund will only be for -- will not be for
1578 operational costs or deferred maintenance, both of which are critically important to those
1579 facilities staying open.

1580 Again, I want to thank all of our witnesses for being here today, and just wanted to
1581 say that we have a lot of work to do, Mr. Chairman, when it comes to really undergirding
1582 our rural hospitals, and I look forward to rolling up my sleeves and working in a bipartisan
1583 manner to make that happen. Thank you.

1584 *Mr. Estes. Thank you. I now recognize Mr. Smucker from Pennsylvania for five
1585 minutes.

1586 *Mr. Smucker. Thank you, Mr. Chairman. Thank you to each of you for being
1587 here. It is an important conversation. We all want to ensure that everyone has access to
1588 the health care that they deserve and at a price that they can afford, and to the insurance --
1589 access to insurance they can afford, as well.

1590 And there is a lot about the marketplace in health care that is not an efficient
1591 marketplace due to a lot of regulations and rules that have been put in place by, you know,

1592 many folks here and those that were here before us.

1593 But I do want to -- before I get -- just have a -- I want to get to a line of questioning,
1594 but I would like to respond to some of the things that Democrats have been saying and also
1595 their witness, Mr. Woodhouse.

1596 We heard Mr. Smith debunk one of the claims about a facility that closed in his
1597 district.

1598 I also want to say that the data that he cites, about 800 hospitals are at risk of
1599 closure, that data was available -- and the data he is using was from 2019, well before the
1600 bill that Republicans passed was even being considered or passed into law.

1601 *Mr. Woodhouse. Not true.

1602 *Mr. Smucker. He also quoted and Democrats have quoted 15 million people who
1603 will lose their health care. I have seen you all nod along. Do you know who is going to
1604 be losing their health care? Does any of you know, the 15 million people that will be
1605 losing their health care? Anyone?

1606 CBO actually addressed this, and I will tell you who it will be. So six million are
1607 able-bodied adults without dependents who are working age who choose not to meet
1608 modest Medicaid work requirements that have been put in place with this bill, or they
1609 choose not to fill out common-sense Obamacare verification forms. We want to ensure
1610 that taxpayer dollars are being spent on people who truly need it. So that is 6 million of
1611 them; 1.4 million are illegal immigrants. Some states allow illegal immigrants to access
1612 benefits. That is 1.4 million. Three million are people already ineligible for Medicaid,
1613 and they simply haven't been removed from the program yet or have access to other
1614 subsidized coverage besides Medicaid. And five million are potentially due to the
1615 expiration of the expanded Obamacare tax credits that Mr. Woodhouse talked about that
1616 have increased costs. Those were put in place by Democrats set to expire, and we see in --

1617 we are seeing the cost increase because of that. That is what CBO has said about the 15
1618 million people who will no longer be eligible.

1619 The other thing about Obamacare which Mr. Woodhouse talked about, the cost of
1620 Obamacare premiums has doubled in the last 10 years, has gone up well above business
1621 insurance plans. And in fact, it is almost double -- 180 percent -- of a business insurance
1622 plan that would be comparable.

1623 So there is a lot of work to be done. There is a lot of blame on Republicans, but
1624 those are just some of the facts.

1625 I want to talk a little bit -- I noticed one of you is a for-profit, three are not profit.
1626 And of course, we in the tax code designate non-profit status for companies that are
1627 providing some public benefit. And, of course, the governor -- the government, the
1628 Federal Government, gives up tax revenue as well as local communities. So for instance,
1629 in my community, Lancaster City, houses a lot of Penn Medicine's facilities and forgo -- or
1630 do not receive tax benefits as a result of that.

1631 When I look at your systems I don't know that I see a lot of difference between a
1632 for-profit and a non-profit. Mr. Hazen, you are the for-profit. Do you think there is much
1633 difference in the way hospitals that are designated for profit operate differently than a non-
1634 profit?

1635 *Mr. Hazen. Thank you, Congressman. I have had this question posed to me
1636 many times, and the short answer is no. We --

1637 *Mr. Smucker. Okay, thank you. And I am sorry I am running out of time. I
1638 would like to go to Mr. Lassiter.

1639 Your compensation seems to be maybe on par with the for-profit. I have seen --
1640 your compensation was 21 million last year. Is that correct?

1641 *Mr. Lassiter. That is not correct.

1642 *Mr. Smucker. Okay. What was it?

1643 *Mr. Lassiter. It was 14.

1644 *Mr. Smucker. Fourteen million? Okay. Is that on par with what a for-profit
1645 would be receiving, or is it more?

1646 *Mr. Lassiter. Well, I can't answer that explicitly. What I can say to you is my --

1647 *Mr. Smucker. Do you think that your system is using some of what would have
1648 been paid in taxes to compensate you?

1649 *Mr. Lassiter. No.

1650 *Mr. Smucker. Do you think that public benefit includes \$360 million invested by
1651 your organization in Central America and Europe?

1652 *Mr. Lassiter. We don't -- we have no operations in Central America.

1653 *Mr. Smucker. You invest in publicly-traded securities.

1654 *Mr. Lassiter. Okay.

1655 *Mr. Smucker. Is that right --

1656 *Mr. Lassiter. Yes.

1657 *Mr. Smucker. -- 718 million invested in publicly-traded securities, a \$134 million
1658 gain by those securities.

1659 *Mr. Lassiter. Yes.

1660 *Mr. Smucker. And 163,000 spent on board meetings in Europe, Canada, and
1661 Mexico?

1662 *Mr. Lassiter. That is not true.

1663 *Mr. Smucker. Okay.

1664 *Mr. Lassiter. We do not hold board meetings in --

1665 *Mr. Smucker. Can you explain to me --

1666 *Mr. Lassiter. -- countries outside the United States.

1667 *Mr. Smucker. -- why you should be granted non-profit status?

1668 Sorry, Mr. Chairman.

1669 *Mr. Lassiter. So on an annual basis CommonSpirit delivers about \$5.2 billion a
1670 year in community benefit. That is approximately 12 times our -- the value of our taxes
1671 foregone. When you think about the community benefit that my organization --

1672 *Mr. Smucker. And I am really sorry, I am out of time. I would love to ask Mr.
1673 Hazen how much community benefit they provide, just for comparison, because they --
1674 being a for-profit, but I know I am well out of time.

1675 Thank you, Mr. Chairman.

1676 *Mr. Estes. Thank you very much. The gentleman's time has expired.

1677 I now recognize Dr. Murphy for five minutes.

1678 *Mr. Murphy. Thank you, Mr. Chairman.

1679 I will say I have had an illustrious and very, very rewarding career practicing
1680 urology in eastern North Carolina. I also served as chief of staff of the ECU Medical
1681 Center, a 1,000-bed hospital, now a 1,000-bed hospital that serves a 29-county referral area
1682 and, as Dr. Waldrum pointed out, one of the poorest referral areas in the country.

1683 I know the vocabulary. I know how to speak the language. I know that health
1684 care is very complex, yet we are in a situation now that is untenable and must change. It
1685 must change. I will just -- before I get started I want to give a shout out to ECU Health. I
1686 have worked in that system for 35 years. It is the paragon of what mission health is
1687 supposed to be about: serving a poor, less accessible area, taking care of those who are
1688 marginalized, taking care of those who have no access to health care. And as Dr.
1689 Waldrum pointed out, accessing hospitals which would otherwise have failed. It has been
1690 my honor to take -- to work in that health care system, and I think they do a fabulous job.

1691 Sadly enough, the beast of our existence, UnitedHealthcare, they are now in

1692 negotiations with this. United, which earns billions and billions of dollars of profit every
1693 year, is now trying to skim pennies off a poor eastern North Carolina system.

1694 I wish you well in your negotiations. I hope someday the FTC breaks up
1695 UnitedHealthcare and turns them into dust as I asked that they be done before. It is
1696 ridiculous that for-profit insurance companies -- and I think all of us can agree on this -- are
1697 preying on the American patient, making partly health care unaffordable.

1698 Just as a recognition, I understand hospital costs have gone up. Regulations,
1699 government regulations, go up, labor costs have gone up. We saw that with traveling
1700 nurses during the pandemic. Medications have gone up, which in some ways is a good
1701 thing. We are keeping patients alive. Electronic medical record costs have gone up,
1702 liability costs gone up, C-suite compensations, they are ridiculous. They are ridiculous.
1703 And it is hard to make a justification for some of those sometimes when patients cannot
1704 afford health care.

1705 Democrats love to feed the beast of increasing health care costs. You talked about
1706 the ACA extended subsidies. All those did were insurance company benefits and profits
1707 during that time. That is what they were doing. And as my friend, Mr. Smucker, pointed
1708 out, what a great correction of the record about who is really getting their "health care
1709 removed."

1710 We need to rethink the urban-rural classification. We have institutions that are
1711 taking advantage of this. That is just wrong. It is just wrong. We need to rethink that
1712 completely. If you look at why rural health care is having -- suffering so much, it is
1713 because manufacturing has gone in eastern North Carolina -- or in all areas, especially in
1714 eastern North Carolina. Government subsidies are only a panacea. They don't get to the
1715 problem. I am glad we have a President that is trying to bring manufacturing back to this.

1716 So I racked my brain because I still see patients, and they come in and talk about

1717 the cost of health care. How do we do this? There is culpability everywhere, from
1718 hospitals to insurance companies to pharmaceutical companies. There is even plenty of
1719 culpability for physician associations for -- instead of teaching how to order one more test,
1720 how do we do things more slightly? We have to fix this problem. We have to fix this
1721 problem.

1722 Medicare for all is a ridiculous initiative. You want less government, you want
1723 less government in this situation because that is some of the worst problems that we have
1724 today.

1725 So it brings us back to why is health care so unaffordable these days? In many
1726 different institutions their for-profit status really -- I think we have to question it today. It
1727 was fine 10 and 15, maybe 25 years ago, but it has gotten to be out of control where now
1728 institutions are more aligned and care more about their dividends and their shareholders
1729 than the patients themselves. I have to stare directly at patients every day when I see
1730 patients and explain the system to them.

1731 Mr. Hazen, your institution I had the honor of going out to mission in Asheville.
1732 Tremendous job they did after Hurricane Helene, tremendous initiative putting in a drill, 48
1733 hours to get water. I was really blown away and thought they did a wonderful job right
1734 after the hurricane. But I need you to help me understand something. In this case of
1735 unaffordability, how can you justify a for-profit institution when you guys made 6, \$7
1736 billion in profit returned to shareholders, none of whom have anything to do with health
1737 care, when people cannot afford their health care premiums? Help me understand why we
1738 should allow for-profit systems to exist?

1739 *Mr. Hazen. Congressman, thank you for acknowledging our team at mission.
1740 That was a Herculean effort. I went through Katrina as well, so I am really proud of our
1741 folks there.

1742 I will tell you I think our model is the model. It is the solution in many instances.
1743 In addition to the \$5 billion roughly of uncompensated care --

1744 *Mr. Murphy. Look, I -- believe me, I get the whole concept of uncompensated
1745 care thing. I get it.

1746 *Mr. Hazen. We all --

1747 *Mr. Murphy. I understand this. But how can we justify in today's market, when
1748 people cannot afford health care, that there are systems that are survived just for profit?

1749 Now, I will extrapolate this to our wonderful United, to our health insurance
1750 companies. United is the third largest corporation in the country. How does this
1751 extrapolate to patients who cannot afford health care today?

1752 *Mr. Hazen. Well, our focus is on our patients. We have 33,000 patients right
1753 now, and we are 100 percent focused on --

1754 *Mr. Murphy. The bottom line is we can't justify it in today's market. We cannot
1755 justify that billions of dollars are taken out of patients' pockets, not being able to allow
1756 them to access health care, and that it goes for profit on stock markets. We just can't do
1757 that anymore.

1758 Now, I don't want to sound like a communist. I am not. I am a capitalist at heart.
1759 I absolutely believe in this. But if we now have institutions that put profits above patients
1760 -- and I will beat more on the insurance industry than anything -- we have to rethink this
1761 model.

1762 Thank you, Mr. Chairman. I will yield back.

1763 *Mr. Estes. Thank you. The gentleman's time has expired.

1764 The chair would like to remind members and witnesses to please limit your
1765 comments to the five minutes allotted and now recognize Ms. Chu from California for five
1766 minutes.

1767 *Ms. Chu. Mr. Woodhouse, undermining vaccines drives costs through the entire
1768 health care system, including hospitals. Preventable infections lead to more emergency
1769 room visits, more inpatient hospitalizations, more ICU admissions, and more
1770 uncompensated care.

1771 The Trump Administration has spent months undermining trust in vaccines. They
1772 fired independent vaccine experts, empowered vaccine skeptics, and spread serious doubt
1773 about vaccines that we know are safe, effective and lifesaving. One of the clearest
1774 examples is hepatitis B. For more than 30 years the recommendation was simple: every
1775 newborn should receive the hepatitis B vaccine within 24 hours of birth. That universal
1776 birth dose helped drive a nearly 99 percent decline in hepatitis B infections among children.
1777 But after Secretary Kennedy totally reshaped the CDC's vaccine advisory panel, the
1778 recommendation was overturned.

1779 So it is no surprise that just yesterday a new study in JAMA Pediatrics came out
1780 warning that even a short delay in the hepatitis B vaccine could mean hundreds of
1781 additional infections, more cases of liver cancer, more preventable deaths, and tens of
1782 millions of dollars in added health care costs. That does not sound like making America
1783 healthy again, and we are seeing the same dangerous erosion of trust around vaccines for
1784 measles, the flu, and COVID.

1785 So Mr. Woodhouse, can you explain how these attacks on vaccines are not only
1786 dangerous for public health, but are driving up costs for families, hospitals, and taxpayers?

1787 And what should Congress be doing right now to undo the damage that has been --
1788 and -- that has been occurring recently and restore trust in vaccines and stop paying for --
1789 so that we can stop paying for more preventable crises?

1790 *Mr. Woodhouse. Well, Congresswoman, thank you for that question.

1791 I would say the first thing that Congress should do -- or maybe President Trump

1792 should do -- is show RFK, Jr. the door. I mean, this is someone who came into this
1793 Administration having spent a dozen years or, you know, much of his adult life sowing
1794 conspiracy theories about vaccines. It was a gift. I mean, he had a non-profit that he was
1795 making lots of money off of that was selling disinformation about vaccines, selling
1796 disinformation about the measles vaccine causing, you know, autism. And he has sown
1797 more disinformation and discord in this regard since he has been Secretary of Health and
1798 Human Services. We have called for his resignation. I don't know a Democrat on Capitol
1799 Hill that hasn't called for his resignation. Public health a disaster because of RFK, Jr.

1800 We have the largest measles outbreak in this country in 20 years. We are very
1801 likely this year to lose our measles elimination status. He, you know, he has undermined
1802 confidence in the COVID vaccine and the measles vaccine and, of course, more -- let's take
1803 South Carolina. I mean, in the area of Greenville, South Carolina, where -- in that area,
1804 where measles has exploded. And, you know, RFK, Jr. hadn't stepped foot in South
1805 Carolina to address the measles epidemic there. He hadn't set foot in South Carolina and
1806 said, yes, you should get -- you know, you should get the vaccine. Yes, you know, there is
1807 no link between measles vaccine and, you know, and autism.

1808 So obviously, there that is going to have increased health care costs for people that
1809 have to be --

1810 *Ms. Chu. Yes.

1811 *Mr. Woodhouse. -- have to be cared for.

1812 *Ms. Chu. Well, let me ask -- just turning to another topic that is to me very
1813 essential, which is about private equity and how that is affecting hospitals, when hospitals
1814 are financially stable there are able to make decisions based on patient care. But
1815 Republicans' big ugly bill is pushing hundreds of hospitals to their breaking point.
1816 Hospitals are losing Medicaid revenue, facing more uninsured patients, and being forced to

1817 cut services just to survive. And when they become distressed, then private equity comes
1818 in. And often times the priority is not patient care, but investor return, and private equity
1819 is often the kiss of death for hospitals. In fact, it is hard to think of a business model less
1820 compatible with health care than private equity.

1821 So Mr. Woodhouse, does Republicans' big ugly bill make it more likely that
1822 struggling hospitals will be pushed into these kinds of arrangements?

1823 *Mr. Woodhouse. Well, let me say a couple of things here.

1824 One, we have 889 pins on our map of hospitals that are struggling. And I think
1825 there is no doubt that that creates a sense of desperation. And that is the very type of thing
1826 that can happen.

1827 I will say another thing. None of the data on our map is from 2019. None of the
1828 data on our map is what Congressman Smucker said it was from. The very first pin we put
1829 on our map was the day this bill passed, and it was sent to the President. It hadn't been
1830 signed yet. A hospital in -- forgive me -- I believe it was Oklahoma or Nebraska. But
1831 they looked at their financial situation. They looked at what they were likely to get cut
1832 from Medicaid in future years, and they closed. Before the bill was signed by the
1833 President they announced their closure. That was the first pin on our map. That was not
1834 in 2019.

1835 *Ms. Chu. Thank you for clarifying that.

1836 And I yield back.

1837 *Mr. Estes. Thank you. I now recognize Mr. Fitzpatrick from Pennsylvania for
1838 five minutes.

1839 *Mr. Fitzpatrick. Thank you, Mr. Chairman.

1840 Year after year my constituents in Bucks and Montgomery Counties are seeing
1841 rising health care costs, forcing many to make impossible decisions when it comes to

1842 necessary care. The consolidation of health care systems over the past several decades,
1843 among other factors, raises serious questions regarding the rising cost of care. I want to
1844 focus my questions on workforce challenges that have had a direct impact on rising costs,
1845 including a specific example from the SEIU in my home district.

1846 Mr. Donley, many labor unions provide health insurance from -- for their members
1847 and their families, including in Pennsylvania's 1st congressional district. Unions, like
1848 thousands of employers across the country, use price transparency data from the
1849 Administration's Price Transparency Initiative to garner information on their premiums.
1850 They found New York-Presbyterian charges much higher than Medicare for their care. To
1851 be precise, 358 percent more. After this union dropped New York-Presbyterian from their
1852 network, they reportedly saved substantial resources, allowing for more financial flexibility
1853 for their members.

1854 Mr. Donley, I assume, like most private health plans, you have built -- you have to
1855 build in some cost-shifting in order to help offset losses from the Medicare and Medicaid
1856 patients that you serve. So my question, Dr. Donley, does this situation that I mentioned
1857 cause any changes or considerations to the prices that are charged?

1858 *Dr. Donley. You know, as you note, pricing is very complex. There are many
1859 different variables. I would tell you New York-Presbyterian, as we look at pricing, what
1860 we look for our pricing to be based off of is the quality of care that we provide. We are
1861 very proud to be a five-star CMS hospital, recognized for our quality. Only 10 percent of
1862 the hospitals in America are recognized as five-star.

1863 The other thing we look at when we price is the complexity of the illness of the
1864 patients that we are treating.

1865 And the third variable is our underlying cost. And that is what we base our costs
1866 on when we price.

1867 *Mr. Fitzpatrick. I want to move on to discuss the workforce shortages impacting
1868 affordability and access to quality care for patients.

1869 The country is facing significant physician shortages that is impacting access to
1870 care for millions of Americans. And I, amongst many others, am concerned as recent
1871 commentary suggested that Congress should eliminate GME funding by formula and
1872 replace it with a discretionary grant program, problematically stating that the program
1873 supports revenues and not residents.

1874 I have partnered with Representative Terri Sewell on this committee to introduce a
1875 bipartisan legislation, the Resident Physician Shortage Reduction Act, which would invest
1876 in additional Medicare funding to train more residents. Specifically, this bill would add
1877 14,000 residency slots over 7 years, prioritizing distribution in rural and underserved areas,
1878 health professional shortage areas, states with new or expanding medical schools, as well as
1879 hospitals currently training their resident caps -- or training over the resident caps.

1880 Dr. Donley, a question for you again: Can you explain how this legislation would
1881 benefit patients' access to quality, affordable care, and how shifting GME to a grant
1882 program would be harmful to physician training programs at teaching hospitals
1883 specifically?

1884 *Dr. Donley. I strongly appreciate your support of GME. You know, in 10 years'
1885 time, we are going to be 86,000 physician shortage, and we are not going to solve that
1886 problem without increasing the GME spots that are available. And so I think it is really
1887 important, what you are doing and what you are leading around that.

1888 We train 2,500 residents, 500 over the cap. As you are well aware, that means
1889 those 500 we actually bear the cost ourselves. It is a part of our mission, and we are
1890 committed to doing that.

1891 *Mr. Fitzpatrick. Thank you, sir.

1892 I yield back, Mr. Chairman.

1893 *Mr. Estes. Thank you. I now recognize Mr. Kustoff from Tennessee for five
1894 minutes.

1895 *Mr. Kustoff. Thank you, Mr. Chairman. Thank you to the witnesses for
1896 appearing today.

1897 Dr. Donley, if someone presented themselves at your facility for a colonoscopy and
1898 they had commercial insurance, would you be able to tell them what the facility fee is
1899 within reason?

1900 *Dr. Donley. I personally don't know the facility fee, but our team would
1901 absolutely be able to get that information to --

1902 *Mr. Kustoff. In other words, a patient would be able to find out the facility fee if
1903 they had insurance.

1904 *Dr. Donley. I believe so, yes.

1905 *Mr. Kustoff. I mean, it is an important question because the patient is entitled to
1906 know, aren't they?

1907 *Dr. Donley. They are absolutely entitled to know, and our intent is that the
1908 patients absolutely know the transparency of the cost.

1909 *Mr. Kustoff. Would the patient know the facility fee if they were on Medicare?

1910 *Dr. Donley. I believe --

1911 *Mr. Kustoff. You don't know.

1912 *Dr. Donley. I believe they would.

1913 *Mr. Kustoff. Okay. That is not a yes, though. I mean, price --

1914 *Dr. Donley. Yes.

1915 *Mr. Kustoff. We talk about price transparency a lot. That is important to the
1916 President, it is important to every patient. And you are unsure whether they would know

1917 what the facility fee is before getting the colonoscopy at your facility.

1918 *Dr. Donley. Price transparency is extremely important to us. It is extremely
1919 important that patients know that.

1920 I will tell you in my first 12 weeks as CEO it might not be something that I
1921 specifically know, but I know our team would know the answer to that. And absolutely,
1922 we are committed to make sure patients know the price.

1923 *Mr. Kustoff. All right. Well, let's, if we can -- I am going to show you some
1924 data from CMS about a colonoscopy performed at an ambulatory surgical center and one at
1925 a hospital. And I know that when Chairman -- I believe it was Chairman Smith asked
1926 everybody to raise their hands about the disparity and cost at a procedure performed at a
1927 hospital versus a surgery center, you did raise your hand and you said that that was
1928 acceptable.

1929 [Chart.]

1930 *Mr. Kustoff. This shows the cost of a colonoscopy performed at a surgery center
1931 owned by a physician or group of physicians at \$656. That is CMS's fee that they pay.
1932 The facility fee at a hospital is almost double that, \$1,222.

1933 I am asking this and showing this to you because you raised your hand that you
1934 accepted the fact -- because you set the fees -- that the facility fee can be higher than the
1935 surgical center fee. My question to you is -- and I will concede that there are some
1936 services that you provide that the surgery center doesn't provide outside of the colonoscopy
1937 -- but is a 100 percent increase in the fee that you charge versus the surgical center, does
1938 that seem reasonable to you, to the American taxpayer?

1939 *Dr. Donley. I think there is absolutely opportunities as we look at site neutrality
1940 to look where things aren't reasonable.

1941 I do think it is important, though, that we recognize when things are done in

1942 hospitals that hospitals, compared to a place of not hospital, physician-owned, hospitals
1943 will take care of sicker patients. That is more risk and that is costlier. Hospitals also will
1944 take care of all patients that show up, regardless of what their payer is, and that is different
1945 than physician-owned places.

1946 The other thing is in a hospital place -- the third point -- there is a higher regulatory
1947 burden for a hospital place, opposed to a physician-owned place. Those are costs that we
1948 need to make sure, as we look at better options for site neutrality, that we remember that.

1949 *Mr. Kustoff. All right. This isn't private insurance, this is Medicare.

1950 *Dr. Donley. Yes.

1951 *Mr. Kustoff. CMS. Does all that justify a 100 percent increase in the fee that the
1952 facility charges versus the surgical center?

1953 *Dr. Donley. I think there is absolutely opportunities in site neutrality for us
1954 together, as we look at solutions for affordability, opportunities for it to be better.

1955 *Mr. Kustoff. Let me ask you. If you are a physician or a group of physicians
1956 and you own a surgery center and you see the disparity in what is reimbursed to them
1957 versus what is reimbursed to you, don't you look and say, how do I compete against the
1958 hospitals?

1959 *Dr. Donley. You know, I think, as a physician myself, what we see is the less
1960 regulatory burden that is in a physician-owned place as opposed to a hospital place.

1961 We also, I will tell you, I have personally experienced that in a hospital-owned
1962 place we will take care of much sicker patients compared to a physician place. There are
1963 definitely --

1964 *Mr. Kustoff. My time is expired. I yield back. Thank you.

1965 *Mr. Estes. Thank you. I now recognize Ms. Moore from Wisconsin for five
1966 minutes.

1967 *Ms. Moore of Wisconsin. Thank you so much, Mr. Chair.

1968 I want to know on the panel -- I like the raising hand thing -- how many of you just
1969 are really relieved to hear that we didn't cut \$1.2 trillion out of Medicaid, that all we did
1970 was sort of clean things up, and that there is, you know, 6 million able-bodied people,
1971 probably young people, who are not going to show up in your ERs because they are able-
1972 bodied and well, 1.4 illegals that we are going to deport, 3 million people who are
1973 ineligible and just don't know it yet, and the 5 million ACA Obamacare people who, you
1974 know, whatever?

1975 How many of you agree that we didn't really cut -- we have heard RFK, Jr. say this,
1976 we have heard our members on this panel say that that was not a real cut, we just cleaned
1977 up. How many of you believe that?

1978 None of you. Let the record reflect that nobody thinks that there was not a \$1.2
1979 trillion cut in Medicaid.

1980 I am going to come back to you, Mr. Woodhouse, to explain what that is. But I
1981 want to ask how many of you -- you heard Mr. Schweikert talk about obesity driving --
1982 being a health care cost driver. How many of you agree that GLP-1s would be very
1983 helpful if we allowed Medicaid and Medicare, both of these systems, to pay for GLP-1s for
1984 some of our patients, do you all agree?

1985 All right. Fantastic. I -- how many of you -- the -- disallowing the provider tax to
1986 help draw down more Medicaid, how many of you see that as a problem with regard to
1987 your bottom lines?

1988 All right. Wow. That is, like, most of you. All of you except one person.

1989 Mr. Lassiter, I have a specific question for you. I read through your testimony with
1990 great interest because you seemed really optimistic in terms of being able to navigate in this
1991 current environment because of the -- how large your system is. But I am wondering, are

1992 you depending on AI and telehealth to navigate these additional costs?

1993 You know, on a bipartisan basis people like telehealth, but I have always been
1994 skeptical of it, that it may displace care that people need in person.

1995 *Mr. Lassiter. Congresswoman, thank you for the question, and thank you for
1996 acknowledging a sense of optimism in some of my testimony.

1997 Yes, I do believe that telehealth is good for the health care field, and I do believe
1998 that technology and AI has its place. At CommonSpirit we are strongly investing in AI to
1999 support our caregivers in delivering safer care, higher quality care. We are using artificial
2000 intelligence to support reducing costs in our administrative areas. We believe strongly that
2001 there should always be a human being between AI and the patient, and so we are very
2002 focused there.

2003 We utilize things like virtual integrated care, virtual integrated nursing to provide
2004 support in rural communities where there may not be sufficient staffing to ensure that our
2005 nurses are relieved from some of the mundane administrative tasks.

2006 *Ms. Moore of Wisconsin. But you don't use AI in lieu of people coming into
2007 your facilities. That is what you are saying, right?

2008 *Mr. Lassiter. Not at this time. That is correct.

2009 *Ms. Moore of Wisconsin. Okay. Thank you very much.

2010 Mr. Woodhouse, there is really a big disagreement about whether or not we cut \$1.2
2011 trillion out of Medicaid. And you have heard all these people, every single one of them,
2012 say that it is going to disrupt their ability to care for patients. These people, the 15 million
2013 people, have been characterized as ne'er-do-wells, lazy people, illegals, people who are
2014 scamming the system. Can you tell us who these people are?

2015 *Mr. Woodhouse. Well, we have met with them all over the country. I mean,
2016 they are farmers, they are small business owners, they are people who are, you know, self-

2017 employed. They are gig workers, you know, they, you know, they deliver for DoorDash,
2018 they deliver for Uber. And like I said, there are many, many in the rural areas who are,
2019 you know, who are farmers.

2020 So look, we know -- we have seen in other states -- we saw in Arkansas, we have
2021 seen in Georgia -- we know what a lot of these provisions are about. They are paperwork
2022 provisions that are meant to trip people up, to keep them from accessing care and reduce
2023 that population to create money that can then be used for tax cuts for the rich. And that is
2024 what happened in H.R. 1.

2025 *Ms. Moore of Wisconsin. He is about to drop the gavel on you.

2026 So I would yield back, Mr. Chairman.

2027 *Mr. Estes. Thank you.

2028 Mr. Smucker, I will recognize you for a point.

2029 *Mr. Smucker. Thank you for recognizing me. I would just like to submit for the
2030 record a 990 Form from CommonSpirit Health relative to questions I had asked in regards
2031 to board meetings held outside of the U.S. This has a line item, Canada and Mexico,
2032 85,580 spent on board meetings there, and 78,123 spent on board meetings in Europe. So
2033 I would like to submit that for the record.

2034 *Mr. Estes. Without objection, so ordered.

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2023

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
COMMONSPIRIT HEALTH

Employer identification number

47-0617373

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

- For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.
- Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

| (a) Region | (b) Number of offices in the region | (c) Number of employees, agents, and independent contractors in the region | (d) Activities conducted in region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region) | (e) If activity listed in (d) is a program service, describe specific type of service(s) in the region | (f) Total expenditures for and investments in the region |
|---|-------------------------------------|--|--|--|--|
| CENTRAL AMERICA AND THE CARIBBEAN | 0 | 0 | GRANTMAKING | | 29,480 |
| SOUTH ASIA | 0 | 0 | GRANTMAKING | | 30,666 |
| SUB-SAHARAN AFRICA | 0 | 0 | GRANTMAKING | | 254,200 |
| CENTRAL AMERICA AND THE CARIBBEAN | 0 | 0 | INVESTMENTS | | 329,213,144 |
| EUROPE | 0 | 0 | INVESTMENTS | | 31,078,851 |
| EUROPE | 0 | 1 | PROGRAM SERVICES | INDEPENDENT CONTRACTORS | 15,268 |
| NORTH AMERICA (CANADA & MEXICO ONLY) | 0 | 13 | PROGRAM SERVICES | INDEPENDENT CONTRACTORS | 484,146 |
| SOUTH AMERICA | 0 | 1 | PROGRAM SERVICES | INDEPENDENT CONTRACTORS | 112,510 |
| SOUTH ASIA | 0 | 2 | PROGRAM SERVICES | INDEPENDENT CONTRACTORS | 94,802 |
| CENTRAL AMERICA AND THE CARIBBEAN | 0 | 1 | PROGRAM SERVICES | SELF-INSURANCE | 1,308,532 |
| NORTH AMERICA (CANADA & MEXICO ONLY) | 0 | 0 | BOARD MEETINGS | | 85,580 |
| EUROPE | 0 | 0 | BOARD MEETINGS | | 78,123 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 3a Sub-total | 0 | 15 | | | 361,218,265 |
| b Total from continuation sheets to Part I | 0 | 3 | | | 1,567,037 |
| c Totals (add lines 3a and 3b) | 0 | 18 | | | 362,785,302 |

2040 *Mr. Smucker. Thank you, Mr. Chairman.

2041 *Mr. Estes. Now I would like to call on Mr. Steube from Florida for five minutes.

2042 *Mr. Steube. Thank you, Mr. Chairman.

2043 In Florida rapid hospital consolidation and vertical integration have expanded the
2044 use of off-campus outpatient departments that bill the higher hospital rates, even when care
2045 is delivered in settings that look like independent physician offices. Congress recently
2046 took a step towards greater transparency by including provisions from the FAIR Act in the
2047 January appropriations package requiring distinct National Provider Identifiers, or NPIs,
2048 for on and off-campus facilities aimed at exposing site-of-care billing practices that drive
2049 up costs for patients and employers.

2050 Congress acted on a bipartisan basis to require separate NPIs so patients and payers
2051 can finally see where and how services are billed. Will your hospital systems fully comply
2052 in a timely manner, and will you commit to making the data easily accessible to patients?

2053 I will start with Mr. Hazen.

2054 *Mr. Hazen. Yes.

2055 *Mr. Lassiter. Yes.

2056 *Dr. Donley. Yes.

2057 *Dr. Waldrum. Yes.

2058 *Mr. Steube. Thank you. In Florida patients are often charged significantly more
2059 for the same service based solely on hospital ownership of a site, and basically I am just
2060 going to build on the questions from Mr. Kustoff.

2061 Mr. Donley, you already answered that, but how can you justify facility fees on
2062 outpatient facilities when there is no meaningful difference in the care delivered or the
2063 quality of the care?

2064 And I will start at the other end of the table, Mr. Hazen.

2065 *Mr. Hazen. I think there are aspects to hospitals that the reimbursement covers
2066 beyond just the procedure, and that is 24/7, 365. Readiness, it is hurricanes, as you know
2067 in Florida it is uncompensated care. And those components -- I do believe there are
2068 opportunities to rationalize some of those differences. As I mentioned --

2069 *Mr. Steube. So give me an example. What would that mean?

2070 *Mr. Hazen. Well, I think in the ambulatory surgery center discussion there could
2071 be certain procedures that are -- the separation between the prices are too significant, and
2072 they need to be less because they are not emergency-driven or something of that nature.
2073 That is just one example.

2074 *Mr. Steube. Is that something that HCA would look at in the next 30 to 60 days
2075 and then report back to the committee on --

2076 *Mr. Hazen. We would be --

2077 *Mr. Steube. -- any changes?

2078 *Mr. Hazen. We would be glad to work with the committee on that.

2079 *Mr. Steube. Mr. Lassiter, same question.

2080 *Mr. Lassiter. Thank you, Congressman, for the question.

2081 I would concur with my colleague to the right regarding why some of the
2082 differences exist between hospital-based activities and physician office activities.

2083 I would say to you also, sir, that at CommonSpirit we operate 2,300 care sites.
2084 Only 158 of those are hospitals. And so we work very hard to operate ambulatory surgery
2085 centers that would not have that site neutral adjustment.

2086 I would agree with the prior comment that we would acknowledge there might be
2087 opportunities for modifications in the current site neutral process. We support the fact that
2088 -- of hospitals having 24-hour coverage, emergency departments, et cetera, that that does
2089 drive some of the cost differential. But we also, frankly, we open more ambulatory, non-

2090 site-neutral facilities every year than we operate -- than we acquire new hospitals. So we
2091 are very focused on having multiple care sites to ensure that patients in the community
2092 have access to affordable services.

2093 *Mr. Steube. Mr. Waldrum.

2094 *Dr. Waldrum. Thank you. As you know, we have a Federal mandate to care for
2095 anyone who shows up to the hospital, and we have a moral obligation to do this. We are
2096 the only participants in the health care value chain that have that obligation. Doctors,
2097 nurses, insurance companies, drug companies do not share in that obligation.

2098 In order to provide rural -- access to rural care, HOPDs help us recruit physicians
2099 and support the workforce to maintain that critical access to --

2100 *Mr. Steube. So you are saying because of that requirement --

2101 *Dr. Waldrum. Important services --

2102 *Mr. Steube. -- it is going to cost more for you to provide the exact same service
2103 as it would at, say, an ASC?

2104 *Dr. Waldrum. We do not provide the exact same service. We care for more
2105 complex patients, and it is the only service.

2106 *Mr. Steube. Yes, but just like what Mr. --

2107 *Dr. Waldrum. So cancer --

2108 *Mr. Steube. Just like what Mr. Kustoff was showing --

2109 *Dr. Waldrum. We don't operate in New York City. We operate in rural North
2110 Carolina. And so in order to recruit and provide access for cancer care and other services -
2111 - as mentioned, we are willing to look at it. We would like to work on some rational
2112 reworking of how that works, but these payments are essential in providing access to care
2113 for rural Americans.

2114 *Mr. Steube. So you are saying in your hospital system, if somebody went to a

2115 private provider at an ASC for the same surgery that it would be the same price?

2116 *Dr. Waldrum. Or --

2117 *Mr. Steube. Or you are saying that it would be different, based on the Federal
2118 mandates that you have to treat everybody.

2119 *Dr. Waldrum. I am saying what we have talked about is that we have a problem
2120 with workforce and having doctors and access in rural environments. There is no
2121 alternative access points, and no one is coming to rural America to set up those practices.

2122 *Mr. Steube. My time has expired.

2123 *Mr. Estes. Thank you. I now recognize Ms. Tenney from New York for five
2124 minutes.

2125 *Ms. Tenney. Thank you, Mr. Chairman. Thank you for holding the meeting,
2126 and thank you to the witnesses for being here on this very important topic.

2127 I have heard the Democrats on this committee and their witness, Mr. Woodhouse,
2128 absurdly framing the affordability crisis as a result of H.R. 1. Well, as a New York
2129 resident and a New York business owner, I can tell you this health care affordability crisis
2130 has existed for years in my state, and it lies solely at the feet of Albany bureaucrats which
2131 for decades have saddled working-class families and small businesses with exorbitant taxes
2132 on private insurance.

2133 The truth is that Kathy Hochul and Albany Democrats -- and I served in the state
2134 legislature -- operate a health care financing system that extracts at least 6.6 billion in
2135 hidden taxes from working families for their health insurance, maximizes Federal cost
2136 shifting to cover their own budget failures, and insulates powerful institutions from
2137 accountability, all while calling itself a model of progressive governance. The result is the
2138 number-one highest employer-sponsored health insurance premiums in the country. Not
2139 second-highest, first: \$9,589 for single coverage, \$27,188 for family coverage.

2140 And I have a family business, and we are now paying in excess of \$30,000 for a
2141 family in rural upstate New York. They are 15 to 20 percent higher than the national
2142 averages, and just think of what our small family business does -- founded by my
2143 grandfather, who, by the way, founded a community hospital in the little hamlet of
2144 Hamilton, New York. And the state just approved premium increases from 7 to 13 percent
2145 for this coming year.

2146 Now, Mr. Woodhouse, I heard him, his -- a little bit of his testimony -- is not a
2147 physician, he is not trained in health care. He is a political operative and worked with
2148 President Obama to create what I think is one of the worst things that has happened to our
2149 country and our small business community, and that is the ACA, otherwise known as
2150 Obamacare.

2151 Mr. Woodhouse, you said in your testimony that there are 5 hospitals in my district,
2152 New York 24, that are at risk of closure because of H.R. 1. I have no idea where you got
2153 that idea, and I question the credibility of your source on that. But I can tell you every
2154 hospital in my district, and probably every hospital across the state, makes up the
2155 difference from commercial payers becoming fewer by the year because of the Albany
2156 Democrats and their disastrous policies and what has happened since the advent of the
2157 Obamacare system.

2158 So Mr. Woodhouse, you came here today to talk about working families being
2159 squeezed. So did those families know they were paying \$1,760 a year in hidden Albany
2160 taxes on top of their already skyrocketing premiums? Is your organization advocating to
2161 reduce those taxes? That is a rhetorical question.

2162 Do you believe that collecting 6.6 billion a year in hidden taxes on health insurance,
2163 including a covered lives assessment for the professional education pool, the state-run
2164 GME program that hasn't been funded since 2008, preceding Obamacare, lowers premiums

2165 for working families and small business owners and employees?

2166 These taxes hit a mechanic in Oswego, my home county, the exact same way they
2167 hit a Wall Street executive in Manhattan. So Albany built a public coverage program that
2168 was bankrolled off exorbitant subsidies for non-citizens, priced private insurance out of
2169 competition for nearly 10 percent of the state's population. Is it progressive to pull healthy
2170 people out of the private risk pool, concentrate the sickest and most expensive patients in
2171 what is left, and then call the result -- the resulting premium an explosion of a Federal
2172 problem? This is a New York State problem that is on top of a huge Federal problem
2173 created by Obamacare, not H.R. 1.

2174 Mr. Woodhouse came here to tell this committee that Washington is responsible for
2175 America's health care affordability crisis, but New York's story tells you different, and
2176 everything you need to know about where that framing breaks down. Albany created a tax
2177 in 1996 to fund doctor training, aside from the fact that our state is already one -- already
2178 the number-one beneficiary of Federal GME funding. They killed the program in 2008
2179 and kept the tax. They created a coverage mandate and diverted the revenue. They built
2180 a zero-premium public program on Federal dollars tied to a 30-year-old eligibility rule with
2181 no contingency for the day that that rule was reasserted and called it sustainable. They
2182 layer mandate after mandate onto private insurers every single session, and private
2183 employers. They run an indigent care program that sends more than -- more money to
2184 well-resourced hospitals than the safety net institutions in my communities that actually
2185 serve the poor. And they have been doing all of this for decades while presiding over the
2186 highest employer-sponsored health insurance premiums in the country that is bankrupting
2187 our employers across New York State.

2188 New York is not an outlier. This is a preview of where the Democrats' health care
2189 policies will lead us. And I agree with Dr. Murphy, the dream of Medicare for all is

2190 absurd. We have to stop this nonsense now. Affordability is because of the ACA and
2191 because of states like New York.

2192 I yield back my time.

2193 *Chairman Smith. [Presiding.] Mr. Beyer.

2194 *Mr. Beyer. Mr. Chairman, thank you, and thank you all very much for being
2195 here.

2196 I get to co-chair the Bipartisan Mental Health Caucus, and we are all deeply
2197 concerned about it. And just because of your important roles, I would like to dive deeper.

2198 I know we see emergency departments are -- an increased number of people with
2199 mental health -- I think of the teenagers in ERs waiting days for a bed. We have this
2200 challenge with boarding and trying to improve early intervention.

2201 I represent Inova, a large hospital chain here in northern Virginia. They
2202 established an EmPATH unit recently specifically designed to provide emergency care for
2203 adults experiencing a mental health crisis. Arlington County, right across the river,
2204 established a mobile crisis team. We funded it with special project funding, making a
2205 significant difference.

2206 But Dr. Donley, I am particularly interested in what New York-Presbyterian is
2207 doing to -- on mental health with early intervention, with improved access to care, and with
2208 support care coordination. What happens when they get out of the hospital?

2209 *Dr. Donley. Congressman, thank you very much for the question, and thanks for
2210 your support towards mental health. As you stated, it is a growing problem in America
2211 that we must face, and it is a big source of the cost of care.

2212 At New York-Presbyterian we are proud of our commitment to behavioral health.
2213 We have 500 inpatient beds. We are one of the largest providers of behavioral health
2214 services in New York.

2215 You know, one program that recently we found very beneficial is we work with a
2216 non-profit government organization to do patient navigation. And so when patients come
2217 into our emergency rooms we screen them for housing insecurity, we pair them with our
2218 partner and are able to find housing for them. This is not only great for the patients
2219 themselves, it is obviously great for their families. But it also is great for taking out the
2220 cost of care because otherwise these people across the country are frequently using the
2221 emergency room. We have already found -- we have already been able to help 200
2222 patients like that using that program.

2223 *Mr. Beyer. Great, thank you very much.

2224 Using Mr. Lassiter's statistics, Dr. Waldrum, he talked about 141,000 physicians
2225 short, 70,000 primary care physicians; the shortage of psychiatrists, especially child
2226 psychiatrists around here. When you look at the cost of college like a Virginia public
2227 school -- you know, like James Madison, UVA is going to be pushing \$30,000 a year, you
2228 talk about medical school, especially with the loan cut-off now at \$50,000, how do we
2229 address this long-term physician and nurse shortage, especially with the extraordinary cost
2230 it is to move them through?

2231 And let me throw out my favorite thing. Why do we insist on a four-year college
2232 education for physicians here when they don't throughout Europe, where the medicine is
2233 very good?

2234 *Dr. Waldrum. So thank you for the -- highlighting a very important issue. As
2235 we have mentioned and I have mentioned, workforce is a major driver of health care costs,
2236 and we have to increase the pipeline and make the pipeline more efficient. So cutting off -
2237 - and we built pathways to decrease the level of education, so a year of college off and then
2238 we are looking at three-year programs. And then for GME and specifically for behavioral
2239 health, to graduate medical education and looking at how we can be more efficient at -- for

2240 the pipeline because, as you mentioned, it takes 10 years to create a physician. And so the
2241 glide path of that is long.

2242 And importantly, this expansion of GME, as we all cover an extreme amount of that
2243 workforce development in Graduate Medical Education, I am very proud of the school at
2244 Brody School of Medicine at VCU. We have one of the lowest debt rates coming out.
2245 We have structured our pipeline to increase the yield for primary care and for rural
2246 environments. We have had investment in rural residency training programs, and we can
2247 show a direct return to those communities with over 70 percent retention. So that is built
2248 into the way we recruit and then train our doctors for the specific environments that we
2249 serve.

2250 *Mr. Beyer. Great, thank you very much.

2251 Mr. Hazen -- run a big system. We know that administrative costs -- like, NIH
2252 administrative costs are 17 percent of total hospital costs. You got to fight over payment
2253 recovery requests, all kinds of things. What do we do about payment friction? What can
2254 we do to reduce the administrative costs in hospitals?

2255 *Mr. Hazen. Thank you, Congressman. That is one of the areas where we see
2256 opportunities, opportunities for the patient, opportunities for providers, and really for the
2257 system as a whole.

2258 I think digital integration between payers and providers is a very significant
2259 opportunity. We, in fact, are working with some of the major payers on that very effort,
2260 and I think we are, as I mentioned in my opening comments, making progress.

2261 The idea of regulations and regulation overlap and conflicts also complicates the
2262 whole administrative processing of claims. I think there are opportunities there. We have
2263 discussed a few of those today. Those are areas.

2264 And then I think using best practices, innovation, new technologies like AI to

2265 improve administrative activities is going to be helpful.

2266 *Mr. Beyer. Thank you very much.

2267 I yield back, sir.

2268 *Chairman Smith. Thank you.

2269 Ms. Van Duyne.

2270 *Ms. Van Duyne. Thank you very much, Mr. Chairman.

2271 As we examine health care affordability today, American families are getting
2272 squeezed from every direction. Premiums keep rising, but so do the underlying costs,
2273 especially hospital prices which now account for the largest share of health care spending.

2274 Just a few months ago we were having this same conversation when this committee
2275 brought in the CEOs of the largest health insurance companies. A lot of commitments
2276 were made in that hearing about lowering costs and working with Congress on solutions,
2277 and it has been interesting to see what has happened ever since. Of the five CEOs who
2278 testified, only one has continued to actively engage with my office to follow up on these
2279 commitments.

2280 So that gap between what is said in a hearing and what actually happens afterward
2281 is part of the problem. And until accountability matters, it is going to -- you are going to
2282 see this problem grow rampant across the entire system. That is why I have been leading
2283 legislation to repeal the Federal restrictions on physician-owned hospitals. And right now
2284 Washington is effectively blocking the expansion of facilities that often deliver high-
2285 quality care at lower costs, and these restrictions protect incumbent systems and limit
2286 patient choice.

2287 We should not be protecting consolidation. We should be encouraging
2288 competition, and physician-owned hospitals can help bring real market pressure into highly
2289 concentrated areas, lower costs, and expand access. But today they are essentially frozen

2290 in place by outdated Federal policies. That needs to change.

2291 And this issue goes beyond providers. I hear constantly from constituents who are
2292 trying to buy coverage on their own that they only have one or two options. All of them
2293 are expensive, and no meaningful ability to shop for anything that actually fits their needs
2294 and their budget. So affordability is not just about the cost of care, it is also about the
2295 people, whether or not the people have access to coverage options that work for them.

2296 So Dr. -- is it Hazen or Hazen? I want to make sure --

2297 *Mr. Hazen. Hazen, no doctor.

2298 *Ms. Van Duyne. Hazen, okay. I want to make sure that we are saying your
2299 name correctly.

2300 Physician-owned hospitals expand access, they lower costs, and they serve a broad
2301 patient population. What are your specific concerns with that model?

2302 *Mr. Hazen. Congresswoman, I am glad you raised that. I have had 43 years in
2303 this industry. I have seen physician-owned hospitals operate, I have seen them close.
2304 And so I think we are all for competition, we are all for competition with physician-owned
2305 hospitals.

2306 However, it has to be a level playing field. In my experiences in the past, that is
2307 just not the case. They don't have functioning emergency rooms, they don't take care of
2308 uninsured Medicaid patients, and so forth. And so you have a difference in competition in
2309 that it is not level and balanced and there are conflicts.

2310 And so I think, if we can harmonize those factors and make sure that all aspects of
2311 the system are competing on a level playing field, that could be productive.

2312 *Ms. Van Duyne. Don't you see that some of the hospitals also cherry-pick their
2313 patients? I have got -- you know, I have got an article here that shows that babies will no
2314 longer be delivered at Research Medical Center. This is an HCA Midwest Research

2315 Medical Center in Kansas City that actually stopped seeing labor and delivery patients.

2316 Don't hospitals do that too?

2317 *Mr. Hazen. Well, Congresswoman, we have 33,000 patients in a bed today, 90
2318 percent of them presented to our emergency room first. So 30,000 of them came through
2319 our emergency room. We are not cherry-picking patients when 30,000 of the 33 come to
2320 our hospitals.

2321 *Ms. Van Duyne. All right, thank you.

2322 Mr. Lassiter -- and really, all of you -- this is kind of an open question. There has
2323 been a lot of discussion about how the administrative burden is driving up costs. We have
2324 all seen the charts where you see the growth in physicians. The people who actually touch
2325 the patients are pretty much level, but the administration has gone up, like, multitudes.
2326 That is contributing to burnout and it is not improving patient care or the patient
2327 experience. It is really only increasing costs.

2328 From your perspective -- and I want you to be as specific as possible -- what
2329 Federal requirements should we be targeting to meaningfully reduce that burden?

2330 *Mr. Lassiter. Thank you for the question, Congresswoman. I would say a few
2331 things.

2332 First and foremost, the quality reporting is one area that I would specifically focus
2333 on. There is significant overlap in the requirements to report, which creates significant
2334 issues. At CommonSpirit we are working on trying to reduce some of that burnout that
2335 you described by investing in, for instance, ambient scribing, which allows --

2336 *Ms. Van Duyne. I am not asking what the hospitals could do. I am asking what
2337 federally -- what requirements that we should be looking at that we can scrap that would
2338 help reduce the costs.

2339 *Mr. Lassiter. Thank you for the clarification. So I would say that I do believe

2340 that our administrative burden is tied very much to what we have to report on, what we are
2341 regulated on, the agencies that have overlapping jurisdictions that require that kind of
2342 multiple reporting on similar issues. Those are the kinds of things that I would point to.

2343 *Ms. Van Duyne. And I see everybody wants to jump in, but I am already over my
2344 time.

2345 *Dr. Donley. Yes, I would love to see supportive policy to protect the safety of
2346 health care workers. You mentioned burnout. There is an alarming increase of violence
2347 against health care workers. And so policy to protect those workers -- we spend \$120
2348 million on physical and cybersecurity every year.

2349 *Ms. Van Duyne. Excellent.

2350 *Dr. Waldrum. I think it is --

2351 *Ms. Van Duyne. Thank you very much, and I yield -- oh.

2352 *Dr. Waldrum. I think it is important to just put this in context. For MA alone,
2353 our -- there is 3,700 MA Advantage plans with -- our beneficiaries can choose 42 different
2354 plans, and they all have -- with 9 different carriers, and they all have different reporting
2355 rules, they all have different prior auth rules, they all have all these administrative burdens.
2356 So in the clinics in rural America, that is what we have to train our staff on and that is what
2357 we have to submit the data on. That is an extreme expense that we have to incur.

2358 *Chairman Smith. Mr. Feenstra.

2359 *Mr. Feenstra. Thank you, Chairman Smith and Ranker, thank you for holding
2360 this hearing.

2361 We have talked a lot about affordability. I am from rural Iowa. I sat on an
2362 executive board of a small rural hospital. And it is different than urban centers. You
2363 know, I know we all talk about the hub-and-spoke model. I get it, you know, I mean, we
2364 are a spoke to one of the big hubs in Sioux Falls, South Dakota or Des Moines or Sioux

2365 City. But I want to talk a little bit about how we can maybe look at affordability different.

2366 Mr. Hazen, you noted that affordability is a barrier to care -- we all get that -- and
2367 the starting point is insurance coverage. So I want to ask you, what happens if somebody
2368 doesn't have insurance coverage but wants to pay straight cash? What is their discount?
2369 And the reason I am asking -- well, let me ask you that question first. What is their
2370 discount if they want to pay straight cash?

2371 *Mr. Hazen. Congressman, I can't give you a specific percentage because it varies
2372 by hospital, it varies by service.

2373 *Mr. Feenstra. But 10 percent, 5 percent, 20 percent?

2374 *Mr. Hazen. Oh, no. It is way more than that.

2375 *Mr. Feenstra. Say it again. It is way more than what?

2376 *Mr. Hazen. Ten or twenty percent.

2377 *Mr. Feenstra. Yes, it is way more than 20 percent.

2378 *Mr. Hazen. Right.

2379 *Mr. Feenstra. All right. I just want to think about this. So the average hospital
2380 charges commercial insurers about 250 percent of Medicare rates. Okay? So you really
2381 have the insurance people, all right -- people that are carrying the insurance are really
2382 covering for those that are using Medicare. Is that a fair statement, Mr. Hazen?

2383 *Mr. Hazen. There is cost shifting that occurs.

2384 *Mr. Feenstra. Cost shifting, yes, yes, yes, yes. So this is the problem with just
2385 the common family, right? They their child breaks a leg, they have an HSA. HSA, also
2386 they got a \$10,000 deductible, and that broken leg cost 8,000. All right? So they pay
2387 8,000 out of pocket.

2388 But here is the problem. They don't get the cash discount because they are going
2389 through the insurance company, and the HSA still has to go through the insurance

2390 company. So the insurance company has to do all the pre-authorization, all this other
2391 stuff. Why can't we get rid of the insurance company and say let's just do cash based and
2392 create an account for somebody that can grow tax free, like an HSA, and not having all this
2393 other red tape involved?

2394 Dr. Donley, what is your thoughts? How do you handle your cost accounting when
2395 it comes to somebody that wants to private pay and pay cash?

2396 *Dr. Donley. You know, we have a process in our finance department for patients
2397 that would want to pay cash, and they do receive a discount off the listed price.

2398 *Mr. Feenstra. How much?

2399 *Dr. Donley. I don't know the exact amount, but it --

2400 *Mr. Feenstra. But it should be significant, right?

2401 *Dr. Donley. Yes.

2402 *Mr. Feenstra. Okay. What I am trying to get at is the cost of having health
2403 insurance and you using health insurance -- and you just noted it, Dr. Waldrum, about Med
2404 Advantage plans and all this stuff. I mean, there is bureaucracy that is incredible. So
2405 when you move the bureaucracy off to the side and say, hey, I am just going to pay cash,
2406 you can dramatically lower your cost of affordability.

2407 And I just look at the government saying if this is what we want to do, then you just
2408 do it tax free and say you put this in a tax-free account -- not an HSA, because an HSA is,
2409 again, tied to a health insurance company. It would work a lot better. All right, I will get
2410 off my high horse. To me it is sort of important.

2411 I want to talk to you, Mr. Waldrum. Thank you, by the way, for what you wrote in
2412 your testimony. Maternity units are closing at an alarming rate. I did my doctorate in this
2413 very vein, showing that maternity units are closing at this crazy rate and we are seeing a
2414 dramatic increase in infant mortality. And the problem is, as you noted, is we have less

2415 births and the cost in med malpractice, and there is a lot of other things.

2416 So in the hub-and-spoke model you noted that we are also seeing -- you know, you
2417 can give early care, but you still need a main hospital to have maternity care. How do we
2418 change the system where we get more -- these spokes to have maternal care and maternity
2419 unit care?

2420 *Dr. Waldrum. So I think it is important to understand the hub-and-spoke model.
2421 We operate all of our hospitals as one conglomerate whole, and we understand our
2422 population and we match the needs of the patient to the care locations and keep it as close
2423 to home.

2424 I have five hospitals, five hospitals in very remote, rural organizations that we
2425 maintain maternity units. And AI will not deliver a baby. And so I pay doctors and
2426 nurses and drug companies to catch one baby or maybe two babies a day. They don't
2427 come that way. They may come five a day.

2428 *Mr. Feenstra. Yes.

2429 *Dr. Waldrum. And we know that if we close those units, that more moms and
2430 babies die in rural America so we take the profit --

2431 *Mr. Feenstra. Yes, and I --

2432 *Dr. Waldrum. -- from the academic medical center that is in a rural community
2433 called Greenville, North Carolina, and we cross-subsidize it because that is what a mission-
2434 based --

2435 *Mr. Feenstra. My time is up. I yield back.

2436 *Dr. Waldrum. -- delivery organization --

2437 *Mr. Feenstra. But you nailed it. You absolutely nailed it, that we are having
2438 higher infant mortality rates and mom mortality rates. It is sad. Thank you.

2439 I yield back.

2440 *Chairman Smith. Mr. Evans.

2441 *Mr. Evans. Thank you, Mr. Chairman.

2442 Congress is not addressing the priorities right now. Premiums in Philadelphia have
2443 drastically risen over the last year an increase of 116 percent, causing severe financial
2444 stress on many of the residents of the city.

2445 One of my constituents is a musician and an independent contractor. He says when
2446 the ACA subsidy went away, his monthly premium went up by over \$600. He is now
2447 paying over \$180 a month. That is one fifth of the income on the health insurance. He is
2448 not counting on copayment and prescription. The ACA is not perfect system, but making
2449 people who are financially struggling to bear the burden of health cost is unfair.

2450 Mr. Woodhouse, what would you say that people experience what my constituents
2451 describe, especially when they have to choose between health care, food, and housing?

2452 *Mr. Woodhouse. Well, I think it is something that, in the stories that we have
2453 been collecting, that we are seeing. And there are lots of really tough choices. We have a
2454 woman who -- Teresa Acosta in Georgia, who had her own business and then had these
2455 exorbitant health care premium increases as a result of the ACA tax credits going away.
2456 And it is similar to another story that I recounted earlier, where she has now got to go find
2457 a job that has insurance. She cannot afford the -- her own premiums on, you know, on the
2458 marketplace. And we are seeing this with farmers, we are seeing this -- small business
2459 owners, we are seeing a lot of really tough decisions with the Medicaid cuts coming with
2460 caregivers who are thinking about what is the access that they are going to have to nursing
2461 homes.

2462 By the way, these people are not just facing affordability crisis in health care. Let's
2463 talk about, you know, let's talk about eating. You know, let's talk about the cuts that were
2464 made in H.R. 1 to SNAP and that were made to food assistance. And then we talk about a

2465 healthy diet. Vegetables are more expensive today because of tariffs and because of all of
2466 the inflation that we have seen since Donald Trump came into office, and so you can't --
2467 they can't eat healthy, they are having a hard time accessing health care, having a hard time
2468 accessing their premiums. It is a lot of things coalescing on an affordability crisis on
2469 Americans all at once.

2470 *Mr. Evans. Dr. Donley, how is your hospital committed to offering low-cost
2471 health insurance plans for consumers and employees?

2472 Dr. -- yes.

2473 *Dr. Donley. You know, we are -- I am sorry?

2474 *Mr. Evans. Good, yes, how is your hospital committed to offering low-cost
2475 health insurance plans for consumers and employees?

2476 *Dr. Donley. You know, we have a strong focus on our employees. We have
2477 45,000 employees who are dedicated to taking care of our patients every single day. And
2478 in order for them to be great for our patients, we realize our priority is that -- make sure that
2479 we put a priority on them. And so it is around their insurance, it is around healthy food, it
2480 is around mental health. We have a lot of support programs for them.

2481 *Mr. Evans. Let me go back to Mr. Woodson real -- Woodhouse.

2482 How does a growing number of uninsured and underinsured patients impact our
2483 strained health care system?

2484 *Mr. Woodhouse. Well, I think these gentleman might be more qualified to
2485 answer that than I am. But I think one of the things you have heard here is about, you
2486 know, uncompensated care.

2487 I mean, we -- you know, I think there was a member over here blowing off 15
2488 million people losing access to health care, but as those people lose access to health care I
2489 think what you have heard is there are a lot of emergency room visits. Those emergency

2490 room visits are not paid for. That -- you know, those costs are borne by other people on
2491 employer insurance, by other parts of, you know, the system, not to mention the fact that
2492 we are seeing states and localities that are really struggling with what are they going to --
2493 are they going to allow this calamity to happen?

2494 We have seen, you know, people are raising property taxes. I mean, I don't think
2495 the people in those counties -- I don't think those county commissioners want to raise
2496 property taxes, but they don't want to see their hospitals close. So it does cascade.

2497 *Mr. Evans. Chairman, I yield back -- past my time.

2498 *Chairman Smith. Thank you.

2499 Mr. Hern.

2500 *Mr. Hern. Thank you, Mr. Chairman, for holding this very important meeting.
2501 Thank you all for being here today. It is obviously a very hot topic among all of our
2502 constituents no matter what side of the aisle you are on.

2503 Just yes-or-no question, just so we have you guys on the record. As we go across -
2504 - starting with you, Mr. Hazen -- are you for Medicare for all? Just so all of our colleagues
2505 here know that.

2506 *Mr. Hazen. No.

2507 *Mr. Hern. Okay. Mr. Lassiter?

2508 *Mr. Lassiter. No, sir.

2509 *Mr. Hern. Donley?

2510 *Dr. Donley. No.

2511 *Mr. Hern. Waldrum?

2512 *Dr. Waldrum. No.

2513 *Mr. Hern. Woodhouse?

2514 *Mr. Woodhouse. It is not a yes-or-no question.

2515 *Mr. Hern. Nice answer. The -- you know, every one of us here today have heard
2516 from our constituents expressing their concern over rising health care costs. Since 2000,
2517 hospital prices have grown nearly 300 percent, vastly outpacing inflation and wages. In
2518 fact, hospital prices have grown more than any other part of our economy, and no one
2519 really knows how these prices are calculated.

2520 While most individuals are not directly exposed to true hospital prices, these are not
2521 just abstract costs in the ether. These costs are passed directly onto patients, whether it is
2522 in the form of cash prices or higher premiums or out-of-pocket costs. I would like to
2523 follow up on some of my colleagues' comments regarding site neutrality or the lack thereof.

2524 The reality is that Federal payment policies and billing practices such as site-of-
2525 service pricing have enabled wide variation in prices that often bear little relationship to the
2526 actual cost or quality of care. Hospital systems being allowed to charge more for the same
2527 services has led to consolidation in the system, with hospital systems steadily acquiring
2528 more independent physician offices and outpatient facilities, reducing competition. Data
2529 has shown that when hospitals acquire physician offices, patients pay up to four times more
2530 than the same exact service done in the same exact place by the same exact doctor. I had
2531 one CEO say, "I can't explain why that is allowed, but that is just the way the system
2532 works."

2533 And again, this is not just a data game. I have heard from patients directly in my
2534 district that have seen this happen and want answers. Their doctor hasn't changed, their
2535 health status hasn't changed, the building hasn't changed, just the ownership changed and
2536 the price.

2537 For all of the witnesses here today, if you all won't commit to supporting site
2538 neutral payment policies, how will you ensure patients will not be subject to price increases
2539 at their physician offices after they are brought up -- bought up by your hospital systems?

2540 Any thought, Mr. Donley, Dr. Donley?

2541 *Dr. Donley. I was just going to say as a strategy we do not purchase physician
2542 practices and turn them into hospital sites. That is not a part of our strategy.

2543 *Dr. Waldrum. I would say the same thing.

2544 *Mr. Lassiter. I would concur with that, Congressman, that we do not buy
2545 practices to convert them to site neutral.

2546 *Mr. Hern. Mr. Hazen?

2547 *Mr. Hazen. We don't do that at all.

2548 *Mr. Hern. Okay. So continuing on the disparities between independent
2549 physician offices and hospital systems, I want to talk about tax status. Many large health
2550 systems operate as tax-exempt entities and are subject to the same requirements to maintain
2551 their tax-exempt status as independent providers. Given the differences between these
2552 large corporate health systems and smaller independent providers, I imagine that the IRS
2553 reporting varies as well.

2554 Dr. Donley, solo providers report their community benefit spending based on its
2555 individual facility. Do large systems like New York-Presbyterian report community
2556 benefits spending on a facility-by-facility basis, or does the hospital report all of the
2557 community benefit spending across all the facilities on one Form 990?

2558 *Dr. Donley. We report following the Federal guidelines as one facility.

2559 *Mr. Hern. Okay. So how can the IRS determine if an individual facility is
2560 satisfying the community benefit standard if no information is reported about the
2561 community benefit spending by the individual facility?

2562 *Dr. Donley. You know, I think that would be a discussion we would be happy to
2563 have. As I said, right now the Federal guidelines have us reported as one facility.

2564 *Mr. Hern. So you would have no problem then being able -- a very large system -

2565 - if you are in a rural community or outlying community, you would have no problem
2566 reporting a different 990 for that particular area as you are looking at how your community
2567 benefits compare to some other independent provider.

2568 *Dr. Donley. You know, I think it would take a lot of work. We would have to
2569 work through that to see what the process is.

2570 *Mr. Hern. But it would probably be well worth it for a tax-exempt status, right?

2571 *Dr. Donley. I think the tax-exempt status is very important. You know, we have
2572 a \$2.4 billion community benefit. Our tax-exempt status is a benefit of 622 million. So
2573 our community benefit right now is four times what the tax-exempt status is for us.

2574 *Mr. Hern. You would -- obviously, I haven't looked at your financials, and I will
2575 take you at your word since you are you are testifying here, but that is not the case for all.
2576 When you look at the tax-exempt benefit for many hospitals across the country, where their
2577 tax benefit, whether it is local, state, or Federal, doesn't meet that same community
2578 standard which is, by and large, one of the reasons the tax-exempt status is questioned from
2579 time to time -- or quite often, actually.

2580 So again, maybe you are the model for the rest of the country or for maybe
2581 everybody else that is up here, but it is certainly a real problem for many communities
2582 across America, and that is why they get questioned. And, you know, so I think that, as
2583 we go through this process, we appreciate you being here, we appreciate all of you all in
2584 bringing forth your information, and it will help us make better policies in the future.

2585 *Dr. Donley. Thank you.

2586 *Mr. Hern. Thank you, Mr. Chairman. I yield back.

2587 *Chairman Smith. Thank you.

2588 Mrs. Miller.

2589 *Mrs. Miller of West Virginia. Thank you, Mr. Chairman, and thank you all for

2590 being here today. It has been quite an interesting discussion.

2591 Mr. Woodhouse, in your written testimony you mentioned my district and the
2592 decision of Greenbrier Valley Medical Center to close their labor and delivery unit. You
2593 specifically cite this closure as being caused by H.R. 1, which -- you make it sound like it is
2594 the boogeyman. But that is false. It is a false statement. Vandalia Health, the owner of
2595 the hospital, has said themselves that the closure is a recruitment issue, and that the hospital
2596 had tried for over two years to -- unsuccessfully to recruit a physician for their delivery
2597 room. How can this possibly be an issue caused by H.R. 1, when the hospital has been
2598 unable to recruit physicians to staff its labor and delivery unit for over two years, well
2599 before this legislation was ever under consideration? Recruiting and maintaining
2600 physicians is only one of the many challenges of rural hospitals. I am from West Virginia.
2601 I understand this issue.

2602 Another issue impacting tax-exempt health systems involves the classification of
2603 the hospital itself. I am disturbed at the trend of rural hospitals getting taken advantage of.
2604 As we know, hospitals classified as urban receive higher Medicare payments, whereas
2605 hospitals classified as rural benefit from other things like easier access to 340B program
2606 and 30 percent more graduate medical education funding.

2607 That said, an increasing issue in recent years has been the dual classification of
2608 some tax-exempt hospitals as both rural and urban, seemingly taking advantage of a
2609 Medicare loophole in order to receive lucrative financial benefits. That is why I joined
2610 with my colleague, Congressman Taylor, in introducing the Defend Rural Health Act. My
2611 bill safeguards Federal resources intended for rural hospitals and the communities that they
2612 serve. It closes the longstanding loophole that has allowed large urban hospitals to
2613 simultaneously classify as both urban and rural, enabling them to improperly access
2614 benefits reserved for rural providers.

2615 Dr. Donley, I understand that eight of New York-Presbyterian Hospital campuses
2616 are classified as rural, despite the proximity to New York City. Can you explain this to
2617 me? I mean, do you think New York-Presbyterian is a rural hospital?

2618 *Dr. Donley. Yes, first of all, thank you very much for your advocacy of rural
2619 health care.

2620 As a physician myself, rural health care is critical to the health care of this country,
2621 and we all need to focus on making sure that rural health care remains strong. At New
2622 York-Presbyterian, we do not consider ourselves a geographic -- a geographically rural
2623 hospital. But under CMS we are designated as a rural referral center, and we are proud of
2624 the thousands of patients from rural America that come to us when there is nowhere to turn
2625 for a problem that they have.

2626 We are also proud of the 2,500 residents that we train, 65 percent of which leave
2627 after their training to go across America, including rural America.

2628 *Mrs. Miller of West Virginia. I would love to know that percentage of how many
2629 of them really do go to rural America after being in a big city.

2630 I understand that reports have also surfaced that New York-Presbyterian provides
2631 Chanel gift bags as its maternity hospital. Is New York-Presbyterian using the lucrative
2632 financial benefits received due to its dual classification to buy luxury handbags instead of
2633 lowering costs for their patient care?

2634 *Dr. Donley. We absolutely are not. Those are donated, and they are donated by
2635 the company's foundation in addition to further philanthropic support that that company
2636 and their foundation gives us to support a fourth trimester program to take care of mother --
2637 all mothers and all children in the first 12 weeks after being born, which, as we all know, is
2638 a critical time.

2639 *Mrs. Miller of West Virginia. That is really good news. I thank you.

2640 Do you want any more time?

2641 I yield back my time. Thank you.

2642 *Chairman Smith. Mr. Panetta.

2643 *Mr. Panetta. Thank you, Mr. Chairman.

2644 Gentleman, thank you for being here. I appreciate your time to discuss, obviously,
2645 the many issues in our health care system that are deeply important not just to all of us up
2646 here, but to our constituents back home. And I think that is the main point as to why we
2647 are here and these issues that we are talking about.

2648 Look, for me in the 19th congressional district, I got a lot of senior citizens. And
2649 the number-one health care issue for them is not coverage, it is access. It is the delay they
2650 constantly face when accessing care through their Medicare benefits.

2651 When I talk to doctors, as well, I hear similar concerns. Medicare Part B is not
2652 keeping up with the cost of providing care. When I talk to these physicians they tell me
2653 they are struggling to hire and retain staff as demand grows, and they tell me that they
2654 spend as much time in one in five working days fighting Medicare Advantage prior
2655 authorization denials, time that should be spent caring for their patients. That is why when
2656 it comes to health care there are a number of issues, but in California's 19th congressional
2657 district fixing the payment system is a priority.

2658 Reimbursements have to reflect inflation and the real cost of keeping a practice
2659 open. That is why I have introduced legislation with my colleagues on this committee to
2660 address this shortfall. More recently I partnered with some of you to pass legislation
2661 which cracks down on Medicare Advantage ghost networks. Last week we built on that
2662 success by introducing the Medicare Advantage Improvement Act, a common-sense bill
2663 that directly addresses the challenges that my constituents face by speeding up Medicare
2664 Advantage approvals, bringing transparency to the prior authorization process, requiring

2665 timely payment to providers, and it is -- and limits post-authorization denials that lead to
2666 surprise coverage losses.

2667 As you have heard today, there is a lot to discuss about the health care system
2668 overall. But selfishly, as a representative of the 19th congressional district, I want to focus
2669 squarely on issues that affect my constituents that they live with every single day and what
2670 together we can possibly do to fix them. I represent the central coast of California, 19th
2671 congressional district, San Jose, Santa Cruz, Monterey down the northern San Luis Obispo,
2672 a pretty big, diverse, dynamic district. We got a lot of beauty and bounty and, as I said, we
2673 got a lot of senior citizens who like to retire there.

2674 In Santa Cruz, though, we got one hospital, Dominican, part of CommonSpirit
2675 which, Mr. Lassiter, you know well. It is a lifeline for that community with an aging
2676 population, more than 52,000 Medicare beneficiaries. Mr. Lassiter, I am going to tell you
2677 -- and gentlemen, I am going to focus mainly on him, and I am not going to ask you any
2678 questions, especially in my limited time, so you can kind of zone out after the hours that
2679 you have been here.

2680 But Mr. Lassiter, you are up. Government payer rates, how do they impact
2681 Dominican in particular?

2682 *Mr. Lassiter. Congressman Panetta, thank you for the question, and also thank
2683 you for representing the district where we offer one of our facilities.

2684 Generally speaking, the answer to your question is this: Medicare reimburses us
2685 below our costs to provide care to patients in your community. On average, it is about 80
2686 percent of our costs. The Medicaid program also reimburses us below our costs and, as a
2687 result, that challenges the sustainability and profitability of organizations like Dominican in
2688 your district.

2689 *Mr. Panetta. And what are your contingencies, if any?

2690 *Mr. Lassiter. Well, I think we have talked a bit today about the issue of cost
2691 shifting, frankly, and that for CommonSpirit more than two-thirds of our patients are
2692 Medicare and Medicaid. And so we rely on reimbursement from commercial insurance to
2693 make up for the lack of reimbursement that we receive from governmental payers.

2694 *Mr. Panetta. Now, the bill I am working on to reform Medicare reimbursements,
2695 including indexing Medicare Part B to inflation and requiring Medicare Advantage plans to
2696 pay 100 percent of previously authorized services, speed up authorization approvals, and
2697 ban retroactive denials, can you give us a sense of how those policies would impact seniors'
2698 access to services via Medicare?

2699 *Mr. Lassiter. Thank you for the question, sir. I would say a couple things.

2700 For senior citizens, one of the bigger challenges are senior citizens who are the
2701 recipients of Medicare Advantage coverage. When you talk about issues related to pre-
2702 authorization, denials after a positive authorization, and then, frankly, payment by hospitals
2703 and systems like CommonSpirit for services we have delivered to your constituents, we
2704 don't get paid regularly or timely.

2705 I mentioned earlier today, sir, before you came in, that we have about \$4.3 billion of
2706 unpaid Medicare Advantage claims that we are fighting to receive for care that we have
2707 delivered to constituents like yours. I shared with the committee that more than \$1 billion
2708 of those unpaid claims are more than 150 days old.

2709 *Mr. Panetta. Great, thank you. And I have run out of time. We have more to
2710 talk about and we can do that later.

2711 Thanks to all of you gentleman for being here.

2712 Thank you, Mr. Chairman.

2713 *Chairman Smith. Mr. Carey.

2714 *Mr. Carey. Thank you, Mr. Chairman, for bringing this very -- the attention to

2715 this very important issue, and I want to thank all of you for being here today.

2716 I am going to start my remarks today talking about the ACA. In January I, with
2717 my colleagues, many of my colleagues, voted to extend the enhanced ACA subsidies to
2718 help keep more Ohioans insured. Now, while I wish that our Congress would have been
2719 able to reach a bipartisan agreement on this issue, ultimately we were unable to do that.

2720 Now, I support President Trump's great health care plan to reduce insurance
2721 premiums and to maximize price transparency.

2722 Mr. Hazen, yesterday HCA Healthcare released its 2026 Q1 financial reports.
2723 Now within that -- and I may need to put on my glasses because we were looking at this
2724 today -- I read that the expiration of the ACA enhanced subsidies cost HCA about \$150
2725 million. However, HCA still brought in a net income of 1.6 billion, or 8.5 percent of the
2726 revenue. So I am going to ask you this question: Can you speak to the impact of the
2727 expiration of the enhanced ACA subsidies on the prices that HCA facilities charge or
2728 negotiate with payers? Have they increased as a result? You are up.

2729 *Mr. Hazen. Thank you, Congress, for -- Congressman, for bringing up the idea of
2730 coverage. I think coverage is fundamental, as we have indicated here today.

2731 For us in the first quarter, speaking to that, we did see a decline in covered lives in
2732 our facilities. Overall, we saw a 15 percent increase in uninsured patients across our
2733 system as a whole.

2734 As it relates to pricing, I would submit that there has been no effect on pricing as a
2735 result of that change in --

2736 *Mr. Carey. Okay, so no effect on the pricing. So I am going to continue with
2737 you. In your written testimony you referenced that HCA Healthcare provided
2738 approximately 4.5 billion in uncompensated care, okay, including charity care and financial
2739 assistance for uninsured patients. And this is just last year.

2740 A topic that I am also interested in is the chargemaster pricing. So although these
2741 are not the prices, obviously the patients tend to see -- uninsured patients or those whose
2742 lost coverage after the ACA enhanced subsidies expired and those to whom you are
2743 providing this uncompensated care are the patients most likely to see these prices. Do
2744 uninsured patients, the most financially vulnerable, receive these chargemaster prices, the
2745 highest possible, and then receive financial assistance to bring down their costs?

2746 *Mr. Hazen. The -- Congressman, the 4.5 billion that we referred to is actually the
2747 cost that we incur to take care of those patients who are uninsured or charity. We have a
2748 very robust financial assistance program, including our charity policies for patients who
2749 don't have insurance. And for those who are completely uninsured, we have a very
2750 significant discount, uninsured discount, for those patients.

2751 *Mr. Carey. Okay. And the next question is going to be a yes and no. So when I
2752 make the statement, you can think about this. These chargemaster prices are not directly
2753 connected to the cost of care. They are inflated to raise the bottom line. Am I correct,
2754 yes or no?

2755 *Mr. Hazen. No.

2756 *Mr. Carey. So how do you calculate the chargemaster price in total then?

2757 *Mr. Hazen. Well, the chargemaster connected to the point I made in my opening
2758 comments about regulatory modernization is an artifact from 50 years ago. And so the
2759 requirements that we have as hospitals is to maintain a listing of charges. So that listing is
2760 not entirely connected to the reimbursement.

2761 *Mr. Carey. So --

2762 *Mr. Hazen. Eighty percent of our patients are determined by either Medicare,
2763 Medicaid, or some other government programs in our company, and the balance is largely
2764 commercial contracts with large payers.

2765 There are --

2766 *Mr. Carey. Real quick, so if the answer is no, so what really is the point in having
2767 these inflated prices if the patients don't even see them? And you got 13 seconds.

2768 *Mr. Hazen. As I said, it is an artifact from a 50-year-old regulation.

2769 *Mr. Carey. Okay. I want to thank the chairman, and I want to thank the
2770 witnesses again, and with that I yield back.

2771 *Chairman Smith. Ms. Malliotakis.

2772 *Ms. Malliotakis. Thank you, Mr. Chairman. I want to thank you all for being
2773 here today.

2774 Look, this is obviously a very important issue because we are talking about the
2775 affordability of health care and making sure that our hospitals stay viable, that they are able
2776 to provide the care that is necessary in our communities.

2777 Over the past two decades the cost of health care premiums, prescription drugs, and
2778 hospital services has risen significantly, and these increases are driven by a range of factors
2779 including reduced competition, growing consolidation across the health care market,
2780 misaligned or overly burdensome government policies such as the unaffordable care act,
2781 and bad actors who exploit the system to maximize payments from these Federal programs.
2782 Since 2000, hospital prices have increased by more than 280 percent, and today roughly
2783 one-third of U.S. health care spending goes to hospital care, totaling approximately 1.6
2784 trillion in 2024.

2785 And as leaders in some of the largest hospital systems in our country, you all play
2786 an important role in helping shape the health care costs and we must work together to
2787 identify these solutions that can make things more affordable for patients while also
2788 ensuring that taxpayer dollars are spent responsibly.

2789 Hospitals are essential institutions. They provide lifesaving care. They serve as

2790 major drivers of economic activity and employment in communities across the country,
2791 including in my own district.

2792 My district, which is Staten Island and Brooklyn in New York City, has three
2793 hospitals in very different circumstances. One is an independently-owned safety net
2794 hospital that serves a large low-income population and often faces financial challenges.
2795 Another is part of a larger New York-based health system and operates a robust medical
2796 educational program. And then there is a third hospital that serves my district, and it is in
2797 the process of being acquired by New York City's public hospital system. So each of these
2798 facilities provides quality care to my constituents, and all are top of mind as we consider
2799 legislative reforms. And as we work to bring more affordable services, it is critical that
2800 our policy decisions do not create unintended consequences that could undermine the
2801 ability -- your ability to serve patients.

2802 So first I want to start off with tax-exempt status reforms. Non-profit hospitals
2803 receive a significant tax benefit, and in return we expect them to meet certain obligations.
2804 However, those requirements are relatively broad and fall under the community benefit
2805 standard which includes operating an emergency department, maintaining a governing
2806 board, and investing in facilities or private care among other standards.

2807 But Dr. Donley, first of all I want to say you are a top-tier hospital. We appreciate
2808 the work that you do in New York City. You have been recognized by many publications
2809 and accredited organizations. And, you know, when we are examining ways to strengthen
2810 these non-profit requirements such as setting minimum levels of charity care or patient care
2811 investments, can you explain how your hospital system meets the community benefit
2812 standard particularly in improving patient care and helping lower costs for patients?

2813 *Dr. Donley. Yes, thank you, Congresswoman, and thank you, actually, for your
2814 thoughtful support of hospitals and balancing the different issues to make sure hospitals

2815 continue to be strong for your constituents, and certainly for our patients.

2816 You know, for a community benefit we have a \$2.4 billion community benefit.
2817 The tax-exempt status benefit that we receive is -- \$622 million is what we estimate. A
2818 bulk of that community benefit is our commitment to take care of patients who are insured
2819 by Medicaid. We are the largest provider of Medicaid services in the State of New York
2820 for transplant services and pediatric services, and we are the second largest provider in the
2821 entire state for emergency room services. In order to provide that care it is at a shortfall of
2822 nearly \$1 billion over the year, and that is a big part of our community benefit. It is core
2823 to who we are as an organization, and it has been core for 250 years that we have been in
2824 existence.

2825 *Ms. Malliotakis. But if this committee was going to establish a minimum for
2826 charity care or patient investment, how could we design those policies so we avoid
2827 unintended consequences, especially for safety net hospitals that we represent that are
2828 already struggling financially?

2829 *Dr. Donley. I certainly can speak for New York, where Medicaid was expanded.
2830 In New York there is only five percent of people that don't have insurance. So I think, as
2831 we look at making sure hospitals do live up to the community benefit that they should, it is
2832 important to look at not just the charity care but also the care provided to patients who are
2833 insured by Medicaid.

2834 *Ms. Malliotakis. Okay. And then, when we look at site neutrality policy, your
2835 hospital as well as some in my district, they operate outpatient facilities. Is there a way to
2836 tailor site neutrality payments so that patients benefit from lower costs while still
2837 preserving access to specialized care close to home?

2838 *Dr. Donley. I think it is important to look at what the options are around site
2839 neutrality, but we must always recognize that a hospital is a place to take care of a higher

2840 acuity of patients. You also take care of all patients, regardless of what their insurer is at
2841 hospital sites compared to physician-owned sites. And there is also a higher regulatory
2842 burden for hospital sites.

2843 *Ms. Malliotakis. So those things should all be considered --

2844 *Dr. Donley. Yes.

2845 *Ms. Malliotakis. -- as we move forward in deciding what type of facilities have
2846 the site neutrality payments.

2847 *Dr. Donley. Yes.

2848 *Ms. Malliotakis. Okay. And I want to just say you have only been the president
2849 and CEO for three months. You have already come before a congressional hearing, and
2850 you have done a good job today. So thank you and congratulations.

2851 *Dr. Donley. Thank you very much.

2852 *Chairman Smith. Mr. Gomez.

2853 *Mr. Gomez. Thank you, Mr. Chairman.

2854 If you talk to any family or American in this country they know that health care
2855 costs are out of control because they see it every single month when they pay their medical
2856 bills or their premiums. They have seen it for years. But they also know that the system
2857 doesn't work, and so do a lot of elected officials. For far too long you had a system that
2858 was trying to pass the cost, minimize coverage, and passing it from each -- fighting
2859 amongst themselves. PBMs versus big pharma, health insurance companies, hospitals,
2860 physicians, everybody kind of jockeying to pass the dollar or the buck or the cost to
2861 somebody else, and at the same time making that fall onto the American taxpayer and to
2862 the consumer. We recognize that.

2863 In my district, in the -- in urban Los Angeles, I had 11 hospitals when I first started
2864 in 2017. Two of them closed for a variety of reasons, and then we have other ones that are

2865 teetering. But I also have LA County General Hospital, I also have Good Samaritan. I
2866 have a lot of hospitals, and hospitals that do good work, that are trying to take care of their
2867 patients. So I recognize that pressure.

2868 But I recognize that things weren't perfect. The costs were still increasing. And
2869 we didn't have a -- Congress didn't necessarily have a plan to deal with it. So when the
2870 Republicans take over, what is their plan? What is -- the first thing they do is they pass the
2871 One Big, Beautiful Bill that cuts almost \$1 trillion out of Medicaid. That really impacts
2872 every individual in this country, if they know it or not. It also hurts hospitals that have a
2873 lot of patients that are on Medicaid. And then they let the ACA subsidies expire.

2874 Just if we look at it, who is getting hurt? Seniors when it comes to accessing home
2875 care, children with disabilities, women who won't get reproductive health care coverage
2876 that they need. And in this country 40 percent of all births are covered by Medicare, and
2877 the highest maternal mortality rates are -- 9 out of the 10 top states are Republican who
2878 never expanded Medicaid. And then they go and they cut the ACA, or let the ACA expire.

2879 So you have a situation where the health care crisis in this country is getting worse.
2880 But what did the Republicans do? Their first priority was not to take care of the cost, the
2881 affordability cost. Their first priority was to pass a One Big, Beautiful Bill that would jack
2882 up the deficit and debt by \$4 trillion, cut \$1 trillion from Medicaid, 200 billion from SNAP,
2883 and they made it worse.

2884 So if they -- now they have a priority. Their priority is now trying to make excuses
2885 of what kind of plan that they have to address the crisis that they made worse. There was a
2886 -- if there was a fire when it came to the health care affordability in this country, they put
2887 gasoline on it. And now they are saying that they are the firefighters to help deal with the
2888 problem, and I think that is completely wrong.

2889 We know that because the ACA subsidies expired 24 million Americans are paying

2890 higher premiums; 15 million people are going to lose their health care; people are seeing
2891 premium increases as high as 280 percent. And here is the thing. It is also on top of
2892 every other affordability issue: housing, energy, child care.

2893 And as somebody who grew up without health insurance, I know what parents do
2894 when their kid gets sick or injured. They want to wait to see if that -- their child or their
2895 family member gets worse or they get better. When I was about seven years old, because
2896 my parents wanted to see if I got better, I ended up getting pneumonia so severe I had to
2897 spend a week in the hospital. When I broke my leg in ninth grade or my ankle in ninth
2898 grade, my parents had me ice it for -- not for four to five hours, for four to five days before
2899 I had to go and get it checked out because it was not getting better.

2900 So that delayed care is going to only make people go to the emergency room, where
2901 it is the uncompensated cost. So this is a -- we are in a crisis, but the priorities for my
2902 Republican colleagues were never to address this crisis. And even now it is really as a
2903 political stunt to have something to show for the mid-terms that they actually care. And
2904 they are -- the way they are talking is a little confusing because they have no concept of a
2905 plan, no plan, and they don't even know if they believe in private care, public care, if they
2906 believe in non-profits. They are all over the place because they are not being truthful on
2907 what they actually believe, and they believe that the American taxpayer should not be
2908 involved in the delivery of care or involved in health care at all, and that every American
2909 should be on their own. And if when they say that, they will have more credibility in the
2910 eyes of the American public.

2911 With that I yield back.

2912 *Chairman Smith. Mr. Yakym.

2913 *Mr. Yakym. Thank you, Mr. Chairman, for holding this important hearing, and
2914 thank you to our witnesses for being here and testifying today.

2915 Cost, quality, and access to health care is constantly top of mind for the Hoosiers
2916 that I serve. My district faces regulations in health care services, provider shortages. In
2917 addition to that we also face constantly rising health care costs. Hospitals account for
2918 about a third of health care costs, and hospital prices have risen faster than any other part of
2919 the economy over the past two decades. Hospital prices are not exclusively responsible
2920 for the high cost of health care in the Hoosier State and across the country, but they
2921 definitely play a significant role. High hospital prices lead to higher health insurance
2922 premiums, placing financial stress on patients and employers that provide those benefits.

2923 Dr. Donley, New York-Presbyterian Health System is a tax-exempt system with 11
2924 hospitals located across the New York metropolitan area, including multiple facilities in
2925 Manhattan, Brooklyn, and Westchester. Despite operating in a densely urban area, the
2926 New York-Presbyterian reclassified, meaning your urban hospitals are counted as being
2927 rural under Federal health care programs. Being reclassified allows you to take advantage
2928 of programs designed to support our vulnerable rural hospitals. Do you think it is justified
2929 that hospitals in New York City are reclassifying as rural providers in order to utilize
2930 programs designed to support vulnerable rural providers?

2931 *Dr. Donley. Yes, thank you, Congressman, for your question, and thank you for
2932 your advocacy of rural hospitals.

2933 Rural hospitals are critical to the health in this country, and it is critical that all of us
2934 focus on making sure they remain strong.

2935 We do not in New York consider ourselves geographically a rural hospital. But
2936 under CMS we are designated as a rural referral center, and we are proud of the role we
2937 play in supporting rural health care as a rural referral center. We treat thousands of
2938 patients from rural America each year when there is nowhere to turn for that patient or for
2939 the doctor that is taking care of that patient. We also train 2,500 residents each year; 65

2940 percent of those leave NYP, go across the country in places such as rural health care and
2941 help support rural health care.

2942 *Mr. Yakym. Would you support Congress closing the rural designation loophole?

2943 *Dr. Donley. I would be happy to work with you and have our team talk to you.

2944 I think it is important that we also, as we look at strengthening rural hospitals, we
2945 also maintain strength in urban hospitals. There is a shortage of 86,000 physicians that we
2946 will see over the next 10 years, and I think in regards to GME slots the answer is urban
2947 versus rural, the answer is more GME slots.

2948 *Mr. Yakym. Yes, thank you. And large parts of my district are heavily rural,
2949 and our rural providers certainly do work tirelessly. They work every day to serve their
2950 communities and ensure access to Hoosiers that live in rural communities.

2951 Estimates show that administrative costs in our health care system account for
2952 between 15 and 25 percent of health care spending. Mr. Hazen, are there specific Federal
2953 regulations that you see as drivers behind the high administrative costs facing hospitals
2954 today?

2955 *Mr. Hazen. Thank you for referring to administrative costs, a very important
2956 issue, and one that we believe there is opportunity to lower the cost of the system which
2957 should translate downstream to lowering costs of purchasing health care.

2958 So regulation modernization, as we spoke to earlier, is an opportunity. There are
2959 huge numbers of regulations that get layered upon layers of regulation. We have
2960 conflicting regulations across different states which produce administrative difficulties, as
2961 well. And then I think in the commercial market there are opportunities administratively,
2962 as well, that may be enhanced by certain regulation standards that the Federal Government
2963 imposes. So yes, thank you.

2964 *Mr. Yakym. And Mr. Hazen, just as a follow-up, in your opening statement you

2965 talked about how there are conflicting Federal regulations for hospitals. Can you give
2966 some examples, and maybe expound a little bit on the conflicting Federal regulations you
2967 see?

2968 *Mr. Hazen. If I understood you correct -- question correctly, Congressman, the
2969 conflicts exist between certain state requirements and Federal requirements, and so we have
2970 to balance both. There could be opportunities to harmonize some of those. We
2971 understand that states have the rights to do regulatory things, but nonetheless there are
2972 opportunities, we think, in common areas to consolidate certain regulations and create a
2973 little bit more efficiency for the system.

2974 *Mr. Yakym. Great. And do you have any specific sets of regulations that you
2975 would like to see us roll back or modernize?

2976 *Mr. Hazen. Well, these are state-based, and we mentioned this --

2977 *Mr. Yakym. Are there any Federal regulations?

2978 And for any of you, are there any Federal regulations that you think that we should
2979 modernize or do some work on that would help lower your cost of health care delivery?

2980 *Mr. Hazen. We would be glad to bring some ideas forward. Thank you.

2981 *Mr. Yakym. Thank you.

2982 Mr. Donley?

2983 *Dr. Donley. We spend \$120 million on physical and cybersecurity. I think
2984 regulations helping to keep our workforce safe would be -- go a long way. These people,
2985 as has been mentioned many times by the people -- committee members here, are critical to
2986 providing the care across this country, and I would appreciate the support of helping keep
2987 our workforce safe.

2988 *Mr. Yakym. Great, thank you.

2989 And Mr. Chairman, I yield back.

2990 *Chairman Smith. Thank you.

2991 Mr. Bean.

2992 *Mr. Bean. Thank you very much, Mr. Chairman. Good afternoon to you and
2993 good afternoon, Ways and Means. To our all-star panelists, welcome.

2994 We can all agree that housing prices have risen significantly. We can agree that
2995 child care costs a lot more than it used to. And I think everybody knows that college
2996 tuition is -- has risen so much, it is just unfathomable how much it has risen.

2997 But wait, hold the phone, shut the front door. There is a new heavyweight
2998 champion of rising prices. It is the hospital industry. And I got the tape right now. Let's
2999 show the screen.

3000 [Chart.]

3001 *Mr. Bean. It is not from Bean, this is from the Bureau of Labor Statistics that has
3002 charted all industries, how have you risen your prices. And this top line is not the outline
3003 of Mount Everest, it is the outline of the price curve for hospitals, how much you have
3004 risen. In fact, I think the person that invented the phrase "this is off the charts" probably
3005 was looking at the prices that hospitals charge.

3006 Now, all that said, all that being said, we need you healthy. We want your industry
3007 to be healthy. There is 330-million-plus Americans that depend on you to provide the
3008 quality of care that they expect. The Federal Government, we pay most of the bills and so
3009 we want you healthy. So we have tried to work with you.

3010 And you said, give us tax exempt status, give us rural designation, and what did you
3011 do? We got less charity care and you raised your prices.

3012 We said -- you said, pay us more money because when we do procedures in the
3013 hospital -- because you said, we have to support an ER, an emergency room that loses
3014 money. So we helped to support that. What did you do? You now build freestanding

3015 ERs on every street corner, at least in the free State of Florida, and you raised your prices.

3016 You said, let us consolidate, let us share overhead, and we can be a healthy
3017 industry. What did you do? You invented something called a facility fee that, when you
3018 buy a physician practice you charge more and you raise prices.

3019 So what do we do? What do we -- where do we go? How do we believe anything
3020 you said? How do we restore trust in an industry that we have given you every chance
3021 there is, yet this Mount Everest is where we are headed. Any thoughts? How do we build
3022 trust?

3023 [No response.]

3024 *Mr. Bean. As you are thinking about it, maybe you will say -- and I have heard it
3025 here today a couple of times -- the ACA, we want everybody to have coverage. Funny
3026 you mention that, because right around here, right around here, 2010, we passed the ACA.
3027 Everybody gets coverage. And that surely would make the difference. That is when
3028 rocket fuel was added to that price line of where everything shot up. It seems the more
3029 money we put into hospitals and in that industry, the more you raised prices.

3030 Where did we go wrong? Where did we go wrong with the ACA? And why
3031 didn't that honor the promise of bending the cost curve down? We thought this thing
3032 would peak right there, yet it still goes up and there is no stopping it. Anybody want to
3033 jump in with what did we do wrong with ACA and why didn't it bend the price curve?

3034 Dr. Waldrum, welcome. Jump in, my friend.

3035 *Dr. Waldrum. Well, I think that we do have a math problem, and I wouldn't say
3036 that anybody did anything wrong. I think you have heard from us that we need to have
3037 people have coverage so we can not cross-subsidize and have cost shifting.

3038 *Mr. Bean. Got you. We just can't --

3039 *Dr. Waldrum. And the hospital is --

3040 *Mr. Bean. Yes.

3041 *Dr. Waldrum. -- is not what it was last year or the year before. It is full of
3042 sicker, more costly people that we --

3043 *Mr. Bean. Dr. Waldrum, hold on one second because it is funny. There is sicker
3044 people? We fell for that already because built into Medicare we pay you extra when you
3045 see sick people. We have already figured that out. And again, that also is read to
3046 everything else.

3047 Last year -- you are not going to believe this -- I got my knee done. I had a new
3048 knee put in, and -- show our next slide, our knee done -- and I still don't really know what it
3049 cost. But if there was a way that you could walk in to the hospital and know what things
3050 cost, maybe it would look like this. At the Chick-fil-A you know exactly what everything
3051 costs.

3052 [Slide.]

3053 *Mr. Bean. Here is what I kind of mocked up of what it should look like.

3054 The only thing that I think is going to save us -- and if you look at other industries,
3055 it is competition. And I want to salute Mr. Hazen. He understands competition. He
3056 says, get out of our way, we will compete. But how do we have a competitive marketplace
3057 when the public doesn't know? How do we get you guys to be transparent? We have
3058 passed bills in the State of Florida, we have passed bills here. How do we get hospitals to
3059 be more transparent?

3060 And I am out of time. I just -- there is lots of questions. So here is our homework.
3061 How do we restore trust with the American people? And trust me, I am open. I would
3062 love to solve, and I think everybody does. I look at my colleagues on the left and the right.
3063 We want to solve the problem. We have to solve the problem. But it can't be the answer
3064 -- Mr. Chairman, thank you for my extra time -- it can't be we need more money, we need

3065 more subsidies. We are out. The American taxpayer is out. We can't do it anymore.
3066 So what can we do? I look forward to meeting with you later.

3067 And Mr. Chairman, thank you. I yield back.

3068 *Chairman Smith. Thank you.

3069 Mr. Schneider.

3070 *Mr. Schneider. Thank you, Mr. Chairman. I want to thank the witnesses for
3071 appearing before us today and your patience and endurance for a long hearing. But we
3072 appreciate your perspectives.

3073 Across the community in communities large and small, rural towns, and major
3074 metropolitan centers, health care and, in particular, hospitals are fundamental to the
3075 vibrancy and prosperity of our communities. Local hospitals are often the largest
3076 employer in their community, and everyone, everyone at some point in their lives, are
3077 going to depend on quality hospital care.

3078 Just reflecting on my own lifetime, I know how blessed I am to live in a city, the
3079 Chicago area, with many wonderful hospitals. Our children were born in Northwestern'
3080 Prentice Women's Hospital. I can't tell you how grateful we were for the quality of care
3081 when my wife had a serious medical complication during her delivery of our oldest son.
3082 Twenty-five years ago I had surgery to address severe spinal stenosis threatening to leave
3083 me paralyzed at Lutheran General Hospital, now part of Advocate. Seventeen years ago I
3084 had lifesaving surgery at Highland Park Hospital, now part of Endeavor Health, to address
3085 a staph infection that had risen to critical levels. Last year my wife had successful hip
3086 replacement surgery at Endeavor Health Skokie Hospital. And just four weeks ago, as you
3087 saw me limping in, I had major foot reconstruction surgery at Rush Hospital.

3088 Now, I have to recognize how lucky I am to live in a community with so many
3089 wonderful hospital and hospital choices, including several safety net hospitals. Having

3090 access to these facilities during such crucial times is a privilege I do not take for granted.
3091 But here is the thing. Everyone in this country should have access to quality, affordable
3092 care from providers they know and trust when and where they need it. And I know our
3093 witnesses, and I am sure all my colleagues on both sides of the dais, can agree with that.

3094 What troubles me most, however, is that my Republican colleagues have had no
3095 problem accelerating the Administration's attempt at weakening the American health care
3096 system while hospitals are already under severe strain.

3097 It is also noteworthy that the hospitals I mentioned have the names Advocate,
3098 Endeavor, and Northwestern, all examples of the consolidation we are seeing across the
3099 country. As the witnesses noted, consolidation is driven in part by necessity, necessity to
3100 survive. Access to quality hospital care is becoming more difficult and more expensive,
3101 irrespective of where we live.

3102 And again, as the witnesses have said, in rural parts of the country hospitals are
3103 closing, but also in urban centers as well. That means too many expecting mothers are
3104 having to travel more than 30 minutes or even an hour to deliver their babies. Too many
3105 patients are waiting an average of 31 days to see a specialist, nearly a 20 percent increase
3106 from just 4 years ago. Too many ER departments have turned into overrun triage units,
3107 with patients waiting for hours on end to receive care and be discharged. For example,
3108 Northwestern's Lake Forest Hospital in my district opened a brand new facility in 2018
3109 with a beautiful ER. It was immediately overwhelmed. Last year Northwestern doubled
3110 the ER capacity, and already demand exceeds that new capacity.

3111 So I appreciate the witnesses, that the witnesses have emphasized three things we
3112 need to be focusing on: stable and affordable health insurance for all Americans, fair
3113 competition, and reduced administrative complexity. So with the little bit of time I have
3114 left I want to ask a few quick questions for everyone on the panel.

3115 When a patient comes to your hospital, do you ever discriminate based on the type
3116 of insurance a patient has or doesn't have?

3117 Mr. Hazen.

3118 *Mr. Hazen. We do not.

3119 *Mr. Lassiter. No.

3120 *Dr. Donley. Absolutely not.

3121 *Dr. Waldrum. Absolutely not.

3122 *Mr. Schneider. That is what I expected.

3123 Next question: When an uninsured patient comes to your ER, does that uninsured
3124 patient put a burden on the hospital, yes or no?

3125 *Mr. Hazen. They don't put a human burden; they put a cost burden.

3126 *Mr. Schneider. Cost burden, I meant cost burden, so thank you. Does it put a
3127 cost burden on your hospital?

3128 *Mr. Lassiter. Yes.

3129 *Dr. Donley. A cost burden, yes.

3130 *Dr. Waldrum. Yes.

3131 *Mr. Schneider. All right. So Mr. Hazen, I will ask you, have you seen an
3132 increase in the uninsured population showing up at your hospital? And at the same time
3133 have you seen a decrease of the population that was previously covered by ACA insurance?

3134 *Mr. Hazen. Congressman, we just recently reported our first quarter earnings.
3135 And yes, we did see an increase in uninsured patients, 15 percent. And we saw an equal
3136 decline in patients who were insured in the health insurance exchanges, yes.

3137 *Mr. Schneider. And there is a difference between coincidence and causality, but
3138 it is fair to assume that the fact that so few -- so many people are losing their insurance,
3139 whether it is because the Republicans took away Medicaid or because the ACA subsidies

3140 were allowed to expire, a 15 percent decline in those who have insurance and a 15 percent
3141 increase of those without insurance seems to be consistent.

3142 And I will ask the last question. Well, I am out of time, so I am going to skip that.

3143 Let me just again say thank you. I know this is a hard challenge. We need to
3144 work together, both sides of the aisle, Democrats and Republicans, to make sure that
3145 Americans in the richest country in the world, everyone in this country, no matter where
3146 they live, no matter what income they have, have the greatest health care in the world.

3147 And with that I yield back.

3148 *Chairman Smith. Mr. Moore.

3149 *Mr. Moore of Utah. Thank you, Chairman. I appreciate everybody, the
3150 witnesses, questions from across the dais up here.

3151 I want to reiterate I think something that our chairman was pointing out that, you
3152 know, we have -- in this committee in particular, but across Congress, across the country
3153 and the Administration, as well, this -- having several discussions on health care
3154 affordability. I think it is front and center to every American, and particularly over the last
3155 year. We have looked at it from an insurance angle, different providers today, hospital
3156 systems, pharmaceuticals are always in a focus. What is clear to me is that if we are
3157 actually going to reduce health care for patients, it is going to take some give-and-take
3158 from all sides of the equation. And everyone here has a role to play in that. The constant
3159 -- as the chairman said earlier -- it is your fault, it is our fault, it is their fault, like, the
3160 American people are getting sick and tired of it. They are sick and tired of the blame
3161 game, and they want to see results.

3162 One of the things that we like to talk about is competitiveness. This is a unique
3163 world because when you are obviously in the back of an ambulance and you have had a
3164 major, you know, accident happen, you are not in the ability to make a decision on, oh, take

3165 me to here, or here, or here.

3166 You are going to go where that ambulance is going to take you, right? The call is made
3167 and everything. We get that. There is a different element to health care that doesn't exist
3168 in other markets.

3169 But it is still a very uncompetitive market. Even the dichotomy of New York-
3170 Presbyterian, right? You are talking about in New York we have an extremely
3171 competitive health care market, but also now under -- you know, there is an investigation
3172 from the DoJ on New York-Presbyterian for anti-competitive practices. There is no
3173 question there. I am just highlighting there is this, like, well, we do have some
3174 competition, but then there is accusations of it being completely anti-competitive, and we
3175 have got to figure out a way outside of that. It is one fundamental aspect to making sure
3176 that our health care can be affordable for the citizens of this country.

3177 Mr. Hazen, Mr. Lassiter, your companies operate a number of hospitals in
3178 competitive and non-competitive markets. I have had a chance to visit many, and know
3179 the system well. Speaking broadly, would you say that hospitals in smaller markets,
3180 maybe your competitors who have fewer hospital systems, use insurance contracts to lock
3181 patients into one provider system, preventing them from shopping around? Is that a tactic
3182 that is often used, Mr. Hazen?

3183 *Mr. Hazen. Thank you, Congressman. We do promote a competitive
3184 marketplace. Most of the states we operate in are non-certificate of need. We do have
3185 some certificate of need within our contracting strategies. We do not use that tactic.

3186 *Mr. Moore of Utah. Mr. Lassiter?

3187 *Mr. Lassiter. I would say the same answer, sir. Thank you for the question.

3188 We operate in varied environments across the country, 24 states. Again, some
3189 states have certificate of need, some do not. We operate in states where there is great

3190 competition, and we operate in states where there are organizations that have market
3191 power. We do not use the practice that you indicated as part of our contracting strategy.

3192 *Mr. Moore of Utah. Would you admit that insurer contracts are used to lock in
3193 patients to a one-provider system? I mean, that is anti-competitive. How much worse is
3194 this going to get?

3195 I mean, that practice is happening. Maybe you are claiming that there isn't among
3196 your systems, but how do we get out ahead of that? How do we stop that from getting
3197 worse?

3198 *Mr. Hazen. Congressman, I would say more competition creates opportunities to
3199 deal with that. Supply, if supply is constrained in a particular market, it creates
3200 opportunities for choice, it creates opportunities for lower cost, convenience. All those
3201 factors can contribute to dealing with that particular issue.

3202 *Mr. Moore of Utah. Thank you.

3203 Mr. Lassiter, I will just finish with one last question. Health systems invested over
3204 \$1.3 billion last year in AI tools for clinical documentation and coding, tools that often
3205 don't change the care that a patient receives but instead increases coding intensity and
3206 reimbursement. When you evaluate ROI on those AI investments, are you measuring
3207 success based on improvements in patient outcomes and efficiency, or an increase in
3208 revenues?

3209 *Mr. Lassiter. When we evaluate investments in AI, we are evaluating it based
3210 upon a number of factors, and we are first and foremost looking at does it help us increase
3211 the quality and safety of the care we deliver to our patients. That is first.

3212 The second thing we look at is does it improve the working environment for our
3213 caregivers who are burned out and are focusing on helping them increase their resilience.
3214 We do not look at AI tools specifically to drive -- I think you didn't use this term, but I

3215 would say upcoding and things of that -- that is not our explicit goal. Our goal is always to
3216 code the clinical record accurately and appropriately.

3217 *Mr. Moore of Utah. Thank you.

3218 Thank you, Chairman.

3219 *Chairman Smith. Mr. Horsford.

3220 *Mr. Horsford. Thank you, Mr. Chairman.

3221 I think it is important for us to remember how we ended up here, and how we have
3222 arrived at this moment. It was a choice. It was a choice to pass a bill last July that some
3223 call the One Big, Beautiful Bill. I call it a betrayal of a bill. It was a choice to give tax
3224 breaks to billionaires and to big corporations at the expense of hard-working Americans.
3225 It was a choice to cut \$168 billion from nutrition assistance programs for people all across
3226 this country.

3227 And yes, access to food is health care.

3228 It was a choice to take \$1 trillion out of the health care system. It was a choice.
3229 And now there are consequences to that choice. The consequence is evident in the lives of
3230 patients all across this country and in communities that we serve. It is the consequences in
3231 emergency rooms happening right now, where someone's life is at risk. It is consequences
3232 that are showing up in hospital budgets.

3233 And Nevada leaders have warned that residents will "feel the ultimate pinch," and
3234 that the fallout from these cuts will be pretty horrific. In Las Vegas, University Medical
3235 Center is bracing for \$45.4 million in annual losses, while Mountain View Hospital, owned
3236 by HCA Healthcare, is projecting an \$18 million shortfall. Boulder City Hospital has
3237 already begun laying off about 70 workers, ending inpatient care and transferring patients
3238 elsewhere due to changes in the provider fee program.

3239 Make no mistake, these are likely just the first reported hospital job losses in my

3240 state alone tied to this One Big, Beautiful Bill.

3241 Nationwide, Public Citizen recently found that 446 hospitals are at a heightened risk
3242 of closure or service reductions. That represents 69,000 beds, 6.6 million patients, and
3243 275,000 health care workers that we depend on to provide this essential care. In Nevada
3244 alone four hospitals have been identified as at-risk, including Saint Rose Dominican de
3245 Lima in Henderson, part of the CommonSpirit health system.

3246 Mr. Lassiter, I understand you may not be able to speak to the specific projections,
3247 but can you broadly speak to how the One Big, Beautiful Bill impacts services that your
3248 hospitals provide? Briefly, please.

3249 *Mr. Lassiter. Thank you, Congressman Horsford.

3250 I would just say simply the impact of the bill for CommonSpirit is approximately \$5
3251 billion in lost reimbursement over the next 10 years. At its highest point, beginning about
3252 2031, CommonSpirit will lose \$1 billion in reimbursement that we currently receive.

3253 *Mr. Horsford. Thank you.

3254 Mr. Woodhouse, will \$50 billion in temporary rural funding make up for nearly \$1
3255 trillion in permanent health care cuts? Yes or no?

3256 *Mr. Woodhouse. Well, I -- no.

3257 *Mr. Horsford. Thank you. Investing in the health and vitality of rural America
3258 is necessary and long overdue. I agree with the chairman and his passionate plea at the
3259 beginning of the hearing. But the reality is this. This fund, this Rural Health
3260 Transformation Fund, was not designed to replace or meaningfully offset the lost health
3261 care funding. If it were, we would see far greater flexibility to invest in workforce and
3262 direct patient care. Instead, much of the funding is geared towards building digital
3263 infrastructure. And while that has value, I have yet to see any technology that can replace
3264 doctors, nurses, and frontline providers, especially in rural communities like the ones I

3265 represent. And while rural hospitals are grateful for any support, they are also deeply
3266 concerned. They worry that program restrictions combined with limited state capacity will
3267 only make it more difficult.

3268 So Mr. Woodhouse, will the Rural Health Transformation program meaningfully
3269 help rural hospitals in my state?

3270 And how should families in these rural communities react when there are
3271 comparable or even greater resources being directed to high-profile presidential pet
3272 projects, international ventures abroad, and now a vanity project to build a ballroom at the
3273 White House?

3274 *Mr. Woodhouse. Well, I think your constituents and constituents in rural
3275 America should be concerned. I mean, this -- I was not a math major, but \$1 trillion in
3276 cuts to Medicaid and a \$50 billion Rural Transformation Fund, the two are not comparable
3277 to one another.

3278 The Kaiser Family Foundation said they didn't believe a single state would gain
3279 more from the Rural Transformation Fund than they will lose from the Medicaid cuts.

3280 *Mr. Horsford. Thank you.

3281 Just in closing, Mr. Hazen, I know you work closely with SEIU 1107, which
3282 represents nearly 2,000 health care workers and public service workers across Nevada.
3283 They recently -- after 13 months of negotiation, more than 300 employees secured their
3284 first contract, one that strengthens recruitment and retention and delivers average raises of
3285 more than 12 percent. So I want to ask you, can you commit to engaging in fair, good
3286 faith contract negotiations in Nevada?

3287 And can you commit to ensuring that equitable wage growth for your staff across
3288 the health care system, including at Sunrise?

3289 *Mr. Hazen. We -- thank you, Congressman. Sunrise is a great hospital. We do

3290 approach our contracting with that attitude.

3291 *Mr. Horsford. Thank you.

3292 *Chairman Smith. Mr. Moran.

3293 *Mr. Moran. Thank you, Mr. Chairman. Before I get into my questions, I want to
3294 play a little bit of a cleanup here on a couple issues.

3295 First, Mr. Woodhouse, I want to come to you because I was concerned that Mr.
3296 Bean -- when he was giving his statements and using his five minutes, I was watching you
3297 closely. And I was shocked and surprised by the fact that you were rolling your eyes
3298 during his commentary, and I clearly viewed you doing that. And I have to say I was
3299 disturbed by that. He was talking about rebuilding trust in the health care industry, and
3300 here one of our five witnesses was here rolling his eyes at the very things he was trying to
3301 engage in on a bona fide reasonable dispute on differences between your position and ours.
3302 And I would just say I don't think that is helpful to your position, to the things you are
3303 trying to advocate for here today. We want to have an honest discussion, and I certainly
3304 don't think that Protect Our Care hired you to come to Congress to roll your eyes at a
3305 colleague of mine when he is giving you statistics from the Bureau of Labor Statistics that
3306 are honest statistics engaged in an honest conversation. So I would say next time watch
3307 your behavior when you show up in front of Congress.

3308 *Mr. Woodhouse. I don't think I was rolling my eyes.

3309 *Mr. Moran. You were, indeed.

3310 *Mr. Woodhouse. I was not rolling my eyes at that. You are way more
3311 perceptive than I am, if that is what you think. He was talking about increasing hospital
3312 prices. That is not my --

3313 *Mr. Moran. I am talking about your reaction --

3314 *Mr. Woodhouse. That is not my issue.

3315 *Mr. Moran. And you probably --

3316 *Mr. Woodhouse. And so I would --

3317 *Mr. Moran. You probably didn't --

3318 *Mr. Woodhouse. So I would beg to differ with your perception --

3319 *Mr. Moran. -- preparation like Mr. Donley --

3320 *Mr. Woodhouse. Maybe you should be the one to watch your behavior.

3321 *Mr. Moran. Pardon me, sir, but you are here to answer questions from the United
3322 States Congress about how to fix the very problem that you continue to advocate for. You
3323 want us to double down on the failed policies of the ACA, and I am amazed that my
3324 colleague over here -- I am not asking you a question, you can just hold your tongue for a
3325 second -- I am amazed that my colleague would talk about the difference between the 1
3326 trillion and the 50 billion, when the 1 trillion is waste, fraud, and abuse. We are talking
3327 about people that were not even supposed to be on Medicaid, and you are saying we want
3328 to keep them on the rolls, we want to put more people on the rolls, we want to throw more
3329 money at it when only what we are seeing is the prices going up, as my colleague so aptly
3330 pointed out.

3331 I came here with a set of questions that now I am going to have a hard time getting
3332 to because I can't believe that you are wanting to double down on the very failed policies
3333 that the Democrats have been leaning into for years, that even Hakeem Jeffries said a few
3334 months ago was a broken health care system. And that is what I used with the health
3335 insurance companies when they came here a few months ago, as well, because it is amazing
3336 to me that we want to keep doubling down on the failed policies.

3337 I also want to clarify this because -- before I get into my questions -- I noticed that
3338 whenever members of the committee have asked the witnesses here today about why they
3339 deserve to be paid more than independent doctors for the exact same service, you all keep

3340 saying "it is because we care for sicker patients," but let's make the record clear and
3341 accurate. Medicare already adjusts payments based on how sick a patient is, whether they
3342 are sick in a hospital or sick in a doctor's office. So that argument does not hold any
3343 water.

3344 And we are talking about why hospitals get paid more for the same service for the
3345 same sick patients just because their name is on the door, and that is what this committee
3346 will work to fix to lower costs for all patients across the country. I can tell you -- I can
3347 attest to this in particular. And again, I probably won't even get to my questions today. It
3348 is amazing to me. I understand the issue of site neutrality. I am from a rural district. I
3349 get that there is -- there are outlying entities that need to be supported, and a lot of those
3350 payments go to help support that at the end of the day.

3351 But I also understand that from one year to the next -- I went to the same
3352 pulmonologist, got the same service in the same location, and from one year to the next
3353 they were acquired by a hospital system and all of a sudden I had an enhanced patient fee, a
3354 facility fee that I had to pay. Now, I can afford it, but many others cannot. And there is
3355 no reason. There is no added expense for that except the law provides for that. And so
3356 that does need to be fixed.

3357 And I will also say in my remaining time in the last minute here that this pain point
3358 is not just on you guys.

3359 We get it. It is PBMs, it is Medicare Advantage, it is health insurance companies, it is
3360 hospitals, it is the whole system, and it is working against the patient in every instance.
3361 And I don't get that. Actually, I do get that because it is all about profitability not just for
3362 the hospital systems, but also for the insurance companies which we hit a few months ago
3363 as well. That has to end.

3364 The self-serving nature of what we are doing in this industry absolutely must end.

3365 You have to do what is right by the patient and not try to exercise strict construction of a
3366 statute to go against the spirit of the statute like we are seeing in non-rural medical facilities
3367 in the middle of New York City that are -- claim to be rural hospitals. It might meet the
3368 letter of the law, but it is not the spirit of the law, and the person that loses on that is the
3369 patient. And our patience is waning on that.

3370 And, Mr. Chairman, I would suggest that this committee take a holistic view and
3371 rewrite this entire scenario so that we can let the free market determine what is going to
3372 happen, we can let patients have more access, more quality care, lower prices, and all of
3373 you and all the insurance companies and all the PBMs and all the other entities out there
3374 that are gouging profits to the detriment of the patients, you begin to lose and the patients
3375 begin to win.

3376 With that I yield back.

3377 *Chairman Smith. Mr. Suozzi.

3378 *Mr. Suozzi. Okay. Thank you, Mr. Chairman. I appreciated your remarks
3379 earlier today when you talked about we need to work together, Democrats and Republicans.
3380 I think we need to do a lot more of that to try and find answers to these very complicated
3381 problems.

3382 This is a really complicated topic. I mean, there is just so many different factors.
3383 I hate the blame game stuff. I really think it is so inappropriate because it is so many
3384 different factors that are involved here, from urban versus rural. I looked it up just a few
3385 minutes ago. There are 1,800 rural hospitals, 3,300 urban hospitals, according to the
3386 American Hospital Association. There are 3,000 not-for-profits, 1,200 for-profits, 900
3387 state and local, 200 Federal, and 656 psychiatric hospitals. So it is a very complex, diverse
3388 environment that we are living in.

3389 I had some friends here from 32BJ. They are kind of -- act like insurance

3390 companies because they are self-insured, so they are upset about increased prices that they
3391 have to pay as a union because of self-insured. But affordability is a problem for
3392 everybody. It is the number-one issue in America right now.

3393 Affordability is the biggest issue in the country, and hospital costs and health
3394 insurance costs are a big part of that affordability crisis in our country, increasing costs
3395 because a bunch of people got whacked when they lost their premium tax credits in January
3396 of this year. When people lose Medicaid it is going to hurt a lot of people. It is going to
3397 hurt your hospitals, it is going to hurt the health care system, and there is going to be less
3398 people insured. When there is less people insured, less people in the risk pool, then
3399 everybody's insurance rates go up.

3400 Okay. So I want to ask a couple -- I want to just ask some basic questions, and I
3401 want to offer to meet with you and bring in experts from insurance companies, from
3402 pharmaceutical companies, from PBMs, from doctors. I want to get -- we got to get --
3403 come up with some real answers here, not these one-off things. We need something
3404 comprehensive and not finger pointing. So quick questions.

3405 Mr. Hazen, you represent a hospital, a for-profit hospital. Do you make money or
3406 lose money on Medicaid?

3407 *Mr. Hazen. Congressman, did you say Medicaid? I didn't hear you --

3408 *Mr. Suozzi. On Medicaid, do you make money or lose money?

3409 *Mr. Hazen. We lose money.

3410 *Mr. Suozzi. Mr. Lassiter, do you make money or lose money on Medicaid?

3411 *Mr. Lassiter. We lose money, Congressman.

3412 *Mr. Suozzi. Mr. Donley, do you make money or lose money on Medicaid?

3413 *Dr. Donley. Medicaid does not cover the cost of care.

3414 *Mr. Suozzi. Dr. Waldrum, make money or lose money on Medicaid?

3415 *Dr. Waldrum. Lose money.

3416 *Mr. Suozzi. Okay, so you three not-for-profit, you are one for-profit.

3417 What about Medicare? You make or lose?

3418 *Mr. Hazen. We are -- we like to refer to ourselves, Congressman, as taxpaying.

3419 But nonetheless, we make a little bit.

3420 *Mr. Suozzi. Okay. How about you, Mr. Lassiter? Do you make money or lose
3421 money on Medicare?

3422 *Mr. Lassiter. Medicare generally does not cover the full cost of care provided to
3423 CommonSpirit.

3424 *Mr. Suozzi. Dr. Donley, do you make money or lose money on Medicare?

3425 *Dr. Donley. Medicare does not cover the cost, full cost, of care.

3426 *Mr. Suozzi. Dr. Waldrum?

3427 *Dr. Waldrum. We are price takers, and we lose money on Medicare.

3428 *Mr. Suozzi. So when people show up and they have no insurance at all, do you
3429 lose money on that or you make money on that?

3430 *Dr. Waldrum. Lose money.

3431 *Mr. Suozzi. Dr. Donley?

3432 *Dr. Donley. We lose money.

3433 *Mr. Suozzi. Dr. Lassiter?

3434 *Mr. Lassiter. We lose money.

3435 *Mr. Suozzi. Mr. Lassiter.

3436 Mr. Hazen?

3437 *Mr. Hazen. Lose money.

3438 *Mr. Suozzi. Okay, so you are going to lose a lot of money from Medicare,
3439 Medicaid, and people coming in with no insurance. So how do you make up for the

3440 money that you lose from Medicare, Medicaid, and people not having insurance?

3441 You make it up by getting more money from the private insurers, which upsets the
3442 insurance companies so they go after you. It upsets the unions that are self-insured and
3443 other self-insured businesses because they have got to pay it. But that is understandable
3444 that you also make it up by doing philanthropy. Do you have, like, charity dinners and
3445 things like that, Dr. Waldrum?

3446 *Dr. Waldrum. Yes, we do. Seventy-five percent of our patients are Medicare,
3447 Medicaid, or uninsured, and so the only way that we can make it is through commercial.

3448 *Mr. Suozzi. Do you do philanthropy, though?

3449 *Dr. Waldrum. Yes.

3450 *Mr. Suozzi. Do you get philanthropy, Dr. Donley?

3451 *Dr. Donley. Yes, Congressman.

3452 *Mr. Suozzi. Mr. Lassiter, do you do philanthropy?

3453 *Mr. Lassiter. Yes, we do.

3454 *Mr. Suozzi. How about you, Hazen? Do you get philanthropy in the tax-paying
3455 hospital?

3456 *Mr. Hazen. We provide charity care, yes.

3457 *Mr. Suozzi. But do you get philanthropy from the private sector?

3458 *Mr. Hazen. Oh, no, no, no, Congressman, we do not.

3459 *Mr. Suozzi. Okay. Do you have an endowment, Mr. Lassiter?

3460 *Mr. Lassiter. We have reserves, so I guess the answer would be yes.

3461 *Mr. Suozzi. You can invest that money and make some money off of that.

3462 *Mr. Lassiter. Correct.

3463 *Mr. Suozzi. Dr. Donley?

3464 *Dr. Donley. We do.

3465 *Mr. Suozzi. Dr. Waldrum?

3466 *Dr. Waldrum. Correct.

3467 *Mr. Suozzi. Okay, so you have to figure out how to make up for the losses you
3468 have in the other area by doing these other things. And some of the things that you do, I
3469 would suspect, are what has been referred to as gaming the system. It is all perfectly legal,
3470 but you are trying to use the existing laws that are incredibly complicated. You do
3471 something over here and it pops out over there, and then you do something over here and it
3472 pops out over there. And so you are trying to figure out, how can I use the law in order to
3473 bring more revenues into my hospital, either for-profit or not-for-profit, to make up for the
3474 losses I have from my Medicare, Medicaid, and non-insurance patients. So it is very
3475 complicated.

3476 So I do want to ask each of you if you will commit to work with me, and I am going
3477 to ask the chairman if he will help me with this, as well, and get me some Republicans and
3478 sit down and let's figure out -- let's bring in a bunch of experts and talk instead of, like,
3479 yelling at each other, and say what can we do to make the world a better place to live in by
3480 improving our health care for the people that are suffering from these burdensome costs
3481 and have better health for them. Would you help with that, Dr. Waldrum?

3482 *Dr. Waldrum. Yes, we look forward to that.

3483 *Mr. Suozzi. Dr. Donley, would you help with that?

3484 *Dr. Donley. Yes, I would.

3485 *Mr. Suozzi. Mr. Lassiter, would you help with that?

3486 *Mr. Lassiter. We look forward to it, sir.

3487 *Mr. Suozzi. Mr. Hazen?

3488 *Mr. Hazen. Yes.

3489 *Mr. Suozzi. And Mr. Woodhouse, I need your help on this too. I didn't ask you

3490 questions because you don't run a hospital, but I know you are an expert in this area.

3491 *Mr. Woodhouse. Absolutely.

3492 *Mr. Suozzi. We would love to have your help.

3493 *Mr. Woodhouse. I am there for you.

3494 *Mr. Suozzi. Mr. Chairman, thank you very much, and I yield back.

3495 *Chairman Smith. Thank you, sir.

3496 Before I adjourn the hearing I want to enter into the record some information. We
3497 have heard a lot of comments in testimony in regards to 15 million people that was thrown
3498 off of health care because of the big, beautiful bill. We have also heard the trillion dollars
3499 that is being cut to health care.

3500 And so I just want to give the exact facts from CBO, the Congressional Budget
3501 Office, which is being cited: 6 million of the people of the 15 million are able-bodied
3502 adults without dependents who choose not to meet the modest Medicaid work
3503 requirements, so they just choose not to work for Medicaid, so that is 6 million people
3504 which adds up to 325 billion; 1.4 million are illegal immigrants; and 3 million are people
3505 already ineligible for Medicaid and simply haven't been removed from the program. That
3506 adds up to \$200 billion.

3507 And then there is \$350 billion worth of provider tax loopholes that states were using
3508 that was cleaned up.

3509 And then the remaining five million people are supposedly due to the expiration of
3510 the expanded Obamacare tax credits which -- the Democrats set the expiration date.

3511 With that I would like to thank our witnesses for being here today for 4.5 hours, so
3512 we appreciate that.

3513 Please be advised that members have two weeks to submit written questions to be
3514 answered later in writing. Those questions and your answers will be made part of the

3515 formal hearing record.

3516 With that the committee stands adjourned.

3517 [Whereupon, at 2:29 p.m., the committee was adjourned.]



June 24, 2025

Honorable Jodey Arrington
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Honorable Brett Guthrie
Chairman
Committee on Energy and
Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Information Concerning Medicaid-Related Provisions in Title IV of H.R. 1

Dear Chairman Arrington and Chairman Guthrie:

You have asked the Congressional Budget Office for information concerning changes to insurance coverage that would occur under H.R. 1, the One Big Beautiful Bill Act, as passed by the House of Representatives on May 22, 2025. You asked specifically about changes related to Medicaid under title IV, Energy and Commerce.

CBO estimates that enacting the Medicaid provisions in title IV would increase the number of people without health insurance by 7.8 million in 2034 relative to baseline projections under current law.¹ Of that number:

- About 4.8 million would be able-bodied adults between the ages of 19 and 64 who have no dependents and who do not meet the community engagement requirement in section 44141 for participating in work-related activities at least 80 hours a month.
- About 1.4 million would be people who do not meet citizenship and immigration status requirements for Medicaid enrollment but who would be covered under current law in programs funded by the states.
- About 2.2 million would become uninsured because of other provisions in H.R. 1, including provisions increasing the frequency of verification of eligibility to enroll in Medicaid or those that would lead states to

1. Congressional Budget Office, estimated budgetary effects of H.R. 1, the One Big Beautiful Bill Act (June 4, 2025), www.cbo.gov/publication/61461.

Honorable Jodey Arrington

Honorable Brett Guthrie

Page 2

change their Medicaid enrollment requirements in response to federal policy changes.

- CBO estimates that the interactions among the policies would, on net, reduce the number of people without health insurance by 600,000 in 2034 relative to the sum of the estimated effects of the individual policies because some people would become uninsured under more than one policy.

You asked several questions about the number of people who would be enrolled in Medicaid under the legislation and about the number of people who would not have health insurance under H.R. 1. You also asked about the effects on state Medicaid spending under H.R. 1.

For the number of individuals estimated to be without health insurance in 2034 as a result of the Medicaid policies in H.R. 1, what share would be eligible for other health insurance subsidies but would be estimated to not participate?

CBO estimates that of the projected increase of 7.8 million people without health insurance in 2034, 1.6 million would have access to, but would not take up, other forms of subsidized coverage, such as premium tax credits for insurance purchased through the marketplaces established by the Affordable Care Act or employment-based coverage; that number also includes people who would remain eligible for Medicaid but would not enroll.

For which provisions in H.R. 1 does CBO estimate that there would be an increase in the number of people without health insurance resulting from state discretion in the management of enrollment within their own Medicaid programs? What does CBO estimate would be the effect on the number of people without health insurance under those policies?

CBO estimates that enacting several sections would reduce resources available to states to fund their Medicaid programs or state-funded insurance programs:

- Section 44107 would eliminate the authority of the Centers for Medicare & Medicaid Services to waive penalties for payment errors and would reduce federal funding to states for errors in eligibility determinations.
- Section 44111 would reduce the federal matching rate for people enrolled in Medicaid under the expansion of the program provided in the Affordable Care Act from 90 percent to 80 percent for any state that

Honorable Jodey Arrington

Honorable Brett Guthrie

Page 3

uses its own funds to provide coverage to certain immigrants through state programs.

- Section 44132 would prevent states from increasing current tax rates on providers and bar them from creating new tax arrangements for providers.
- Section 44134 would make additional changes to what constitutes a permissible provider tax and would effectively limit collections of those taxes in certain states.

CBO expects that in response to those provisions, states would modify their Medicaid or state-funded insurance programs to curtail their spending by reducing provider payment rates, reducing the scope or amount of optional services, and reducing Medicaid enrollment.²

CBO estimates that state responses to those provisions would increase the number of people without health insurance by a total of 2.0 million in 2034.

Does CBO estimate that the Medicaid provisions in H.R. 1 would result in a net decrease in state spending on the Medicaid program, before accounting for how states respond to the federal policy changes, and if so by how much?

CBO estimates that, if combined, enacting all of the Medicaid provisions in H.R. 1 would reduce the states' total share of spending on Medicaid by \$13.1 billion, on net, over the 2025–2034 period. Some provisions would reduce state spending, and some would increase it. CBO estimates that over the 2025–2034 period, provisions that make changes to program eligibility and enrollment processes, as well as some payment changes, would cause states' spending to decline by \$214.4 billion. Reductions in federal or other resources available to state programs would cause states' spending to rise by \$201.3 billion.

What is the number of individuals whose citizenship, nationality, or satisfactory immigration status is not verified, but would be covered under current law in programs funded by states?

CBO estimates that enacting section 44111 would increase the number of people without health insurance by 1.4 million in 2034 because, in order to

2. See Congressional Budget Office, letter to the honorable Ron Wyden and the Honorable Frank Pallone, Jr., concerning estimates for Medicaid policy options and state responses (May 7, 2025), www.cbo.gov/publication/61377.

Honorable Jodey Arrington

Honorable Brett Guthrie

Page 4

maintain the 90 percent federal matching rate, most states would stop using state-only funds to provide health insurance coverage to people who do not meet citizenship and immigration status requirements for Medicaid enrollment.

What are the changes in the number of uninsured people that would be associated with provisions aimed at verifying eligibility for the Medicaid program, specifically sections 44102 and 44108 of H.R. 1?

Section 44102 would prevent one part of what is termed the Eligibility and Enrollment final rule from being implemented, administered, or enforced through the end of 2034. That part of the rule changes the way that states process applications and renewals for coverage under Medicaid and the Children's Health Insurance Program. For example, the rule specifies that states can only conduct eligibility determinations for people who are aged, blind, and disabled once a year—less frequently than under some states' prior practices. The rule also specifies that states cannot require in-person interviews during eligibility redeterminations for that group of enrollees. CBO expects that enacting section 44102 of H.R. 1 would reduce enrollment as states returned to earlier administrative practices.

CBO estimates that enacting section 44102 would increase the number of people without health insurance by 600,000 in 2034.

Section 44108 would require states to redetermine Medicaid eligibility every six months, instead of once a year, for some enrollees. CBO expects that enacting the section would result in some people being removed from the program sooner than would occur under current law.

CBO estimates that enacting section 44108 would increase the number of people without health insurance by 700,000 in 2034.

In CBO's baseline, how many individuals are enrolled in Medicaid in 2025 and how many are enrolled in 2034? How many would be enrolled in 2034 under H.R. 1?

In CBO's January 2025 baseline projections, 85.0 million people will be enrolled in Medicaid this year, rising to 90.0 million in 2034. CBO estimates that under H.R. 1, 79.5 million people would be enrolled in Medicaid in

Honorable Jodey Arrington

Honorable Brett Guthrie

Page 5

2034—10.5 million fewer than under current-law projections.³

In CBO's baseline, what is total federal Medicaid spending in 2025 and in 2034? What would total federal Medicaid spending be in each of those years accounting for the effects of H.R. 1?

In CBO's January 2025 baseline, the agency estimates \$655.9 billion in Medicaid spending in 2025, increasing to \$985.7 billion by 2034. CBO estimates that enacting the Medicaid provisions of H.R. 1 would reduce Medicaid spending by \$125.2 billion in 2034, to total \$860.5 billion that year.

I hope this information is useful to you. Please contact me if you have further questions.

Sincerely,



Phillip L. Swagel
Director

cc: Honorable Brendan F. Boyle
Ranking Member
House Committee on the Budget

Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

3. The decline in enrollment under H.R. 1 incorporates 1.3 million people who would be eligible for Medicaid and Medicare but would lose Medicaid coverage. They would retain Medicare coverage and not become uninsured. That 10.5 million figure also reflects a reduction of 1.6 million people enrolled in Medicaid in more than one state; those enrollees would maintain Medicaid coverage in their home state.



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

August 25, 2025

Honorable Jodey Arrington
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Honorable Brett Guthrie
Chairman
Committee on Energy and
Commerce
U.S. House of Representatives
Washington, DC 20515

Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

*Re: Clarifications of Marketplace Coverage and Eligibility
Under Public Law 119-21 (H.R. 1) and the 2025 Marketplace Integrity
and Affordability Rule*

Dear Chairman Arrington, Chairman Guthrie, and Chairman Smith:

You have asked the Congressional Budget Office for additional information concerning the ways that Public Law 119-21, also referred to in this letter as H.R. 1 and as the 2025 reconciliation act, will affect the ability of certain groups of people to obtain health insurance coverage through the marketplaces established by the Affordable Care Act and the extent to which enrollees are improperly receiving the premium tax credit for that coverage. You also have asked for CBO's assessment of the effects of a final rule published by the Department of Health and Human Services in June 2025.¹ That rule takes effect on August 25, 2025. Your questions are given below along with CBO's answers.

1. Department of Health and Human Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," final rule, 90 *Fed. Reg.* 27074 (June 25, 2025), <https://tinyurl.com/fyzyp6sb>.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 2

Several provisions in the 2025 reconciliation act that apply to the marketplaces will begin to take effect in 2026. CBO estimates that those provisions will increase the number of people without health insurance, in total, by 2.1 million in 2034. In its answers to your questions, CBO provides the separately estimated effect of each provision; those estimates sum to 2.4 million people. In CBO's estimation, interactions among the provisions would reduce that number by 300,000 in 2034.

CBO formulated the estimates relative to the agency's January 2025 baseline budgetary projections, adjusted to account for judicial decisions and administrative actions through April 10, 2025, and to account for the estimated effects of the version of the June 2025 rule not as made final but as proposed in March 2025.²

Questions About Citizenship or Immigration Status Criteria

How many individuals does CBO project will no longer be eligible for premium tax credits (PTCs) and no longer have health insurance because they do not meet the citizenship or immigration status criteria outlined in section 71301 of H.R. 1?

Beginning in 2027, the 2025 reconciliation act restricts noncitizens' eligibility to claim the premium tax credit by making the credit no longer available to noncitizens other than legal permanent residents, Cuban and Haitian entrants, and people physically present under the terms of the Compacts of Free Association between the United States and the freely associated states. CBO estimates that under that provision the number of people without coverage will increase by 900,000 in 2034.

How many non-citizens with incomes below 100 percent of the federal poverty level does CBO project will no longer be eligible for PTCs and no longer have health insurance under section 71302 of H.R. 1?

Beginning in 2026, certain immigrants whose income is below 100 percent of the federal poverty level (FPL) will no longer be eligible for the tax credit under the act. Until 2026, people whose income falls below that threshold at the time they apply for marketplace coverage are ineligible to claim the

2. As it does in similar cases, CBO incorporated half of the full effect of implementing the rule. See Congressional Budget Office, *CBO Explains How It Incorporates Administrative and Judicial Actions When Updating Its Baseline Projections and Preparing Cost Estimates* (December 2024), www.cbo.gov/publication/60846.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 3

premium tax credit, with one area of exception. Certain immigrants whose income is below the FPL may claim the credit if their immigration status makes them ineligible to enroll in Medicaid; they must also meet other eligibility criteria.³

Beginning in 2026, the act removes eligibility for the credit from anyone whose income is below 100 percent of the FPL. CBO estimates that under that provision, the number of people without insurance will increase by 300,000 in 2034.⁴ Because the provision applies to people who are not eligible for Medicaid, CBO does not expect anyone in that group to gain Medicaid coverage.

A Question About Verification Requirements

How many individuals does CBO project will no longer receive PTCs and not have subsidized health insurance because they are not completing the verification requirements under section 71303 of H.R. 1?

Beginning in 2028, the 2025 reconciliation act requires people to actively affirm their eligibility to enroll in marketplace coverage and to claim the premium tax credit when they apply for that insurance. CBO estimates that under that provision the number of people without health insurance will increase by 700,000 in 2034. The agency estimates that most of that change will stem from a decrease in passive reenrollment, which the act precludes.

Some people may not be able to complete the verification process before their enrollment is scheduled to begin. The act does not specify whether people would be required to pay their entire gross premium while completing the verification process or, alternatively, whether their enrollment could be put on hold without requiring payments until the process is complete. Applicants are not now required to pay the entire gross premium while they await verification of eligibility for a special enrollment period. Drawing on that precedent, CBO

3. As defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, qualified aliens' eligibility for Medicaid is limited, with most becoming eligible only after a five-year waiting period. By contrast, the premium tax credit is available to any applicant who is lawfully present if they meet other eligibility criteria. Thus, people who are ineligible for Medicaid because of their immigration status may still be eligible for the premium tax credit if they are lawfully present in the country.

4. See Congressional Budget Office, letter to the Honorable Brendan F. Boyle, the Honorable Hakeem Jeffries, the Honorable Jeff Merkley, and the Honorable Chuck Schumer concerning the distributional effects of Public Law 119-21 (August 11, 2025), www.cbo.gov/publication/61367.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 4

finds it unlikely that people will be required to pay their gross premiums while completing the verification process under the 2025 reconciliation act and expects the Administration to issue guidance or regulations to that effect.

Questions About a Change to the Special Enrollment Period

How many individuals does CBO project will no longer receive PTCs and not have subsidized health insurance due to the changes to the special enrollment period for individuals with certain incomes under section 71304 of H.R. 1? Are these individuals otherwise eligible for enrollment and, if applicable, PTCs during the standard open enrollment period?

CBO estimates that the act's changes to the special enrollment period for people whose income is at or below 150 percent of the FPL will increase the number of people without health insurance by 400,000 in 2034. People in that group will still be eligible to enroll in marketplace coverage during the open enrollment period and, if eligible, to claim the premium tax credit.

A Question About the Reconciliation of the Advance Premium Tax Credit

Does the removal of the limitation on repayment of excess advanced PTCs under section 71305 of H.R. 1 change individuals' eligibility for PTCs?

The act's removal of the limitation on the repayment of an excess advance premium tax credit does not affect enrollees' eligibility to claim the premium tax credit.

Questions About Access to Other Subsidized Health Care Coverage

Could those who lose eligibility for advanced PTCs due to provisions in H.R. 1 still choose to enroll in a marketplace plan without advanced PTCs? How many of these individuals have access to other subsidized health care coverage, including employer-sponsored health insurance?

In CBO's estimation, the act's provisions will result in some people losing eligibility for the advance premium tax credit. Under the 2025 reconciliation act, applicants who cannot meet the law's citizenship or immigration criteria must pay the full premium and cannot claim a tax credit. People who cannot verify their eligibility or tax-filing status also are ineligible to receive an advance credit until they complete verification.

People who lose eligibility for the advance premium tax credit under the act can still enroll in a marketplace plan without the advance premium tax credit; some who lose eligibility will become uninsured. CBO estimates, after

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 5

accounting for interactions among all provisions in the act, that about 1.8 million people in 2034 will fall into that category. By statute, eligibility for the advance credit is limited to people who are ineligible for affordable employment-based insurance or for minimum essential coverage like Medicaid, so the agency anticipates that most people who lose eligibility for an advance premium tax credit under the provision will not have access to other subsidized coverage. However, about 400,000 (or 22 percent) of the 1.8 million people will have access to employment-based coverage that, although subsidized, is considered unaffordable for the purpose of determining eligibility for the premium tax credit.

A Question About Premiums

By what percentage will H.R. 1 lower gross benchmark premiums, on average, in marketplace plans established by the Affordable Care Act in 2034?

CBO estimates that the act will reduce gross benchmark premiums by 0.6 percent in 2034.

Questions About Improper Receipt of Marketplace Subsidies

What analysis has CBO done regarding the extent to which individuals are improperly receiving PTCs for marketplace coverage under current law? Do any of the provisions in H.R. 1 or the June 2025 final rule titled “Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability” reduce improper receipt of PTCs?

Recent work at CBO and elsewhere indicates that many enrollees are improperly claiming the premium tax credit and receiving cost-sharing reductions for marketplace coverage.⁵ In CBO’s estimation, several provisions in the 2025 reconciliation act and in the final rule published by the Department of Health and Human Services in June 2025 will reduce the number of people who improperly claim the tax credit.

Eligibility for marketplace coverage and subsidies is determined on the basis of information that enrollees report on their applications. That information

5. Brian Blase and others, *The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025* (Paragon Health Institute, June 2025), <https://tinyurl.com/bdhfn6xj>; and Benjamin Hopkins, Jessica Banthin, and Alexandra Minicozzi, “How Did Take-Up of Marketplace Plans Vary With Price, Income, and Gender?” *American Journal of Health Economics*, vol. 11, no. 1 (Winter 2025), pp. 63–90, www.journals.uchicago.edu/doi/10.1086/727785.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 6

includes the income enrollees expect to earn for the year in which they will be covered. There are incentives for enrollees to report incorrect information in order to obtain larger subsidies and for agents, brokers, or others to do so on their behalf in order to obtain larger commissions. CBO considers an enrollee to have improperly received an advance premium tax credit if they, or someone acting on their behalf, intentionally provides incorrect information or does not attempt to provide accurate information. CBO does not consider an enrollee to have improperly received an advance premium tax credit if their expected income differs from their actual income as a result of the inherent difficulty of projecting income.

Ways Enrollees Can Misrepresent Eligibility for Subsidies. In CBO's estimation, enrollees can misrepresent their eligibility in various ways: by overstating or understating their income, for example, or by improperly claiming eligibility for a special enrollment period. Misrepresentations also can be unintentional.

Overstating Income. With the exception of certain immigrants, before 2026, most people who expect to earn income below the FPL are ineligible for marketplace subsidies. People who are also ineligible for Medicaid have an incentive to report income above the FPL when they apply for coverage so that they can receive an advance premium tax credit and cost-sharing reductions. Such overstatements occur predominantly in states that have not expanded Medicaid.

Understating Income. People who are eligible for marketplace subsidies may understate their income to claim a larger advance premium tax credit and gain access to reductions in cost sharing.

Misrepresenting Eligibility. People who do not enroll in marketplace coverage during open enrollment may misstate their income to gain access to a special enrollment period for people whose income is at or below 150 percent of the FPL.

Other and Unintentional Misrepresentation. Misrepresentations can occur in other ways, some of which may be unintentional. For example, some enrollees may not update their income when they are automatically reenrolled in a marketplace plan under current reenrollment procedures.

Rather than being made personally by an enrollee, misrepresentation also may be made by an agent, broker, or others acting on the enrollee's behalf.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 7

Estimates of Improper Enrollment. CBO has no direct knowledge of the intentions of enrollees or others acting on their behalf, so estimating the number of people who have improperly received subsidies for marketplace coverage is difficult. The agency has, however, specifically estimated that 1.3 million marketplace enrollees improperly claimed the premium tax credit via intentional overstatement of income for 2023; 2.3 million enrollees did so for 2025. CBO is able to estimate the extent of such misrepresentation because it appears in enrollment data as an unusual concentration of enrollees reporting income just above the FPL.

CBO's estimates are informed by statistics from several sources:

- A disproportionate number of enrollees reported income just above the FPL in 2023. Enrollment data from HealthCare.gov analyzed by CBO showed that 1.7 million people reported income between 100 percent and 105 percent of the FPL in states that had not expanded Medicaid in 2023. That group is 2.6 times larger than the group reporting income between 105 percent and 110 percent of the FPL. CBO's analysis of data from the American Community Survey also indicates that there were more enrollees with income between 100 percent and 105 percent of the FPL in states that did not expand Medicaid than there were people with income in that same range who were not enrolled in employment-based coverage or Medicaid and, as such, may have been eligible for the tax credit.⁶
- Using data from the Centers for Medicare & Medicaid Services, CBO estimates that the number of marketplace plan selections for people who reported income between 100 percent and 138 percent of the FPL increased from 4.3 million to 7.1 million between the 2023 and 2025 open enrollment periods.⁷ In CBO's estimates, the number of people reporting income just above the FPL increased proportionally.
- Estimates from the staff of the Joint Committee on Taxation indicate that 1.6 million (39 percent) of the 4.2 million enrollees who initially

6. Census Bureau, "American Community Survey Data" (last updated July 31, 2024), www.census.gov/programs-surveys/acs/data.html.

7. Centers for Medicare & Medicaid Services, "2025 Marketplace Open Enrollment Period Public Use Files" (last updated May 12, 2025), <https://tinyurl.com/4wjp3sck>, and "2023 Marketplace Open Enrollment Period Public Use Files" (last updated March 3, 2025), <https://tinyurl.com/2p3vt6mw>.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 8

reported income below 150 percent of the FPL and received an advance premium tax credit in 2023 ultimately had income below the FPL.

Those estimates confirm that a large share of enrollees who reported income below 150 percent of the FPL eventually earned income that was below the FPL. The estimates do not identify how many enrollees initially overreported their income.

CBO's baseline projections account for the expiration of the expanded premium tax credit at the end of calendar year 2025. That expansion initially was authorized by the American Rescue Plan Act of 2021 and extended under the 2022 reconciliation act. Because the expiration of the expanded credit will increase enrollees' out-of-pocket costs for premiums, the incentive to enroll in marketplace coverage is expected to abate and, in CBO's January 2025 baseline projections, the number of people who overstate their income declines.

Effects of the 2025 Reconciliation Act. By CBO's estimation, several provisions in the law will reduce the improper receipt of marketplace subsidies.

Beginning in 2028, people must verify their household income, family size, health coverage status, and other information before enrolling in marketplace coverage and becoming eligible for an advance premium tax credit. That requirement will reduce improper receipt of marketplace subsidies among enrollees who, under current reenrollment procedures, would have been automatically reenrolled without updating their information and who, had they done so, would have received a smaller subsidy or none at all.

That provision also makes it less likely that a Medicaid enrollee will simultaneously enroll in subsidized marketplace coverage and makes it more difficult for brokers, agents, or others to enroll people in marketplace coverage without their knowledge.

Beginning in 2026, the act disallows the premium tax credit for people who enroll in marketplace coverage during a special enrollment period for people whose income is at or below 150 percent of the FPL. That provision reduces the incentive for people who do not enroll during open enrollment to misstate their income to gain access to a special enrollment period. It also may reduce the total commissions brokers, agents, or others expect to earn by enrolling people during a special enrollment period without their knowledge.

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 9

Another provision eliminates the limitation on repayment of the advance premium tax credit, which reduces the incentive for people who are eligible for marketplace subsidies to understate their income in order to claim a larger credit. It does not reduce the incentive to understate income in order to receive subsidies that reduce cost sharing.

Effect of the June 2025 Final Rule for Marketplace Enrollments. Several provisions of the final rule published by the Department of Health and Human Services in June 2025 will reduce improper receipt of marketplace subsidies by requiring enrollees to take specific actions to verify their eligibility. As a result, the number of people improperly receiving subsidies is expected to decline.

One provision of the rule, which applies only in 2026, requires enrollees to provide additional income verification when the income they report is above the FPL but other information shows that their income is below that threshold. A similar policy instituted for the 2019 plan year was declared invalid by a March 2021 judicial decision.⁸

In CBO's assessment, if the income verification provision had been in place in 2025, the number of people receiving marketplace subsidies would have been reduced by 500,000. The agency used enrollment under the 2019 income verification requirements as a guide for that estimate.

Additional income verification will not eliminate all improper enrollment in 2026 among people who report income near the FPL, for several reasons:

- Verifying enrollees' future income is difficult.
- Many enrollees who report income near that threshold will not be identified for additional verification because their income was higher in the recent past.
- The documentation requirements of the income verification process do not completely eliminate the ability to overstate income. In some instances, if an enrollee cannot provide other verification of income, for example, a marketplace could accept a signed letter of explanation.

8. *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 761–763 (D. Md. 2021).

Honorable Jodey Arrington

Honorable Brett Guthrie

Honorable Jason Smith

Page 10

CBO expects that the income verification processes under the 2025 final rule will lead some otherwise eligible people to forgo claiming the premium tax credit. Specifically, CBO anticipates that people would be identified to provide additional income verification if they expect their future income to be above the FPL but their recent income is below that threshold. In such cases, CBO estimates, fewer than 100,000 people either would be unable to or would choose not to verify their income in order to claim the premium tax credit.

I hope this information is useful to you. Please contact me if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Phillip L. Swagel", with a long, sweeping flourish extending to the right.

Phillip L. Swagel
Director

cc: Honorable Brendan F. Boyle
Ranking Member
House Committee on the Budget

Honorable Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

Honorable Richard E. Neal
Ranking Member
House Committee on Ways and Means



Summary

Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline

As enacted on July 4, 2025

| | By Fiscal Year, Millions of Dollars | | | | | | | | | | 2025-2029 | 2025-2034 | |
|--|-------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------|------------|--|
| | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 | | | |
| Increases or Decreases (-) in Direct Spending Outlays, Revenues, and Deficits | | | | | | | | | | | | | |
| Title I. Committee on Agriculture, Nutrition and Forestry | | | | | | | | | | | | | |
| Estimated Outlays | 300 | -7,901 | -10,424 | -14,734 | -15,013 | -14,467 | -13,244 | -14,897 | -15,319 | -15,261 | -47,772 | -120,960 | |
| Estimated Revenues | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Net Effect on the Deficit | 300 | -7,901 | -10,424 | -14,734 | -15,013 | -14,467 | -13,244 | -14,897 | -15,319 | -15,261 | -47,772 | -120,960 | |
| Title II. Committee on Armed Services | | | | | | | | | | | | | |
| Estimated Outlays | 2,020 | 41,864 | 44,677 | 24,923 | 17,175 | 9,426 | 4,720 | 2,767 | 1,347 | 623 | 130,659 | 149,542 | |
| Estimated Revenues | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Net Effect on the Deficit | 2,020 | 41,864 | 44,677 | 24,923 | 17,175 | 9,426 | 4,720 | 2,767 | 1,347 | 623 | 130,659 | 149,542 | |
| Title III. Committee on Banking, Housing, and Urban Affairs | | | | | | | | | | | | | |
| Estimated Outlays | -15 | -132 | -80 | -25 | -72 | -122 | -188 | -313 | -347 | -374 | -324 | -1,668 | |
| Estimated Revenues | 0 | -202 | -182 | -164 | -178 | 726 | 0 | 0 | 0 | 0 | -726 | 0 | |
| Net Effect on the Deficit | -15 | 70 | 102 | 139 | 106 | -848 | -188 | -313 | -347 | -374 | 402 | -1,668 | |
| Title IV. Committee on Commerce, Science, and Transportation | | | | | | | | | | | | | |
| Estimated Outlays | -65 | 2,825 | 4,896 | 5,437 | 2,151 | -6,708 | -15,329 | -18,556 | -12,658 | -4,377 | 15,244 | -42,384 | |
| Estimated Revenues | -1 | -20 | 94 | 173 | 249 | 288 | 337 | 385 | 127 | 21 | 495 | 1,653 | |
| Net Effect on the Deficit | -64 | 2,845 | 4,802 | 5,264 | 1,902 | -6,996 | -15,666 | -18,941 | -12,785 | -4,398 | 14,749 | -44,037 | |
| Title V. Committee on Energy and Natural Resources | | | | | | | | | | | | | |
| Estimated Outlays | -156 | -178 | -1,183 | -2,383 | -2,099 | -2,804 | -2,900 | -2,846 | -3,149 | -3,641 | -5,999 | -21,339 | |
| Estimated Revenues | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Net Effect on the Deficit | -156 | -178 | -1,183 | -2,383 | -2,099 | -2,804 | -2,900 | -2,846 | -3,149 | -3,641 | -5,999 | -21,339 | |
| Title VI. Committee on Environment and Public Works | | | | | | | | | | | | | |
| Estimated Outlays | -857 | -936 | -1,237 | -887 | -570 | -360 | -112 | * | * | * | -4,487 | -4,959 | |
| Estimated Revenues | * | * | * | * | * | -375 | -300 | -275 | -275 | -275 | * | -1,500 | |
| Net Effect on the Deficit | -857 | -936 | -1,237 | -887 | -570 | 15 | 188 | 275 | 275 | 275 | -4,487 | -3,459 | |
| Title VII. Committee on Finance | | | | | | | | | | | | | |
| Estimated Outlays | 783 | -11,710 | -34,780 | -58,518 | -98,023 | -118,581 | -138,504 | -157,122 | -153,211 | -172,058 | -202,248 | -941,720 | |
| Estimated Revenues | -130,903 | -461,569 | -585,848 | -585,287 | -529,328 | -450,023 | -416,941 | -425,102 | -452,408 | -483,910 | -2,292,936 | -4,521,327 | |
| Net Effect on the Deficit | 131,686 | 449,859 | 551,068 | 526,769 | 431,305 | 331,442 | 278,437 | 267,980 | 299,197 | 311,852 | 2,090,688 | 3,579,607 | |
| On-Budget Effects | 131,684 | 449,639 | 550,402 | 525,847 | 430,052 | 330,001 | 276,783 | 266,190 | 297,300 | 309,774 | 2,087,625 | 3,567,684 | |
| Off-Budget Effects | 2 | 220 | 666 | 922 | 1,253 | 1,441 | 1,654 | 1,790 | 1,897 | 2,078 | 3,063 | 11,923 | |
| Title VIII. Committee on Health, Education, Labor and Pensions | | | | | | | | | | | | | |
| Estimated Outlays | -154,029 | -10,584 | -6,316 | -14,880 | -15,639 | -16,039 | -16,281 | -16,521 | -16,741 | -16,992 | -201,448 | -284,022 | |
| Estimated Revenues | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Net Effect on the Deficit | -154,029 | -10,584 | -6,316 | -14,880 | -15,639 | -16,039 | -16,281 | -16,521 | -16,741 | -16,992 | -201,448 | -284,022 | |
| Title IX. Committee on Homeland Security and Governmental Affairs | | | | | | | | | | | | | |
| Estimated Outlays | 5 | 9,511 | 18,265 | 25,317 | 25,414 | 20,262 | 14,787 | 9,351 | 4,194 | 1,805 | 78,512 | 128,911 | |
| Estimated Revenues | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Net Effect on the Deficit | 5 | 9,511 | 18,265 | 25,317 | 25,414 | 20,262 | 14,787 | 9,351 | 4,194 | 1,805 | 78,512 | 128,911 | |
| On-Budget Effects | 5 | 9,512 | 18,264 | 25,317 | 25,414 | 20,262 | 14,787 | 9,351 | 4,194 | 1,805 | 78,512 | 128,911 | |
| Off-Budget Effects | 0 | -1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Title X. Committee on the Judiciary | | | | | | | | | | | | | |
| Estimated Outlays | * | 3,579 | 6,256 | 9,479 | 11,415 | 9,154 | 4,677 | 2,702 | -544 | -662 | 30,729 | 46,056 | |
| Estimated Revenues | 0 | 1,290 | 3,747 | 3,868 | 3,963 | 4,501 | 4,726 | 4,859 | 4,992 | 5,216 | 12,868 | 37,162 | |
| Net Effect on the Deficit | * | 2,289 | 2,509 | 5,611 | 7,452 | 4,653 | -49 | -2,157 | -5,536 | -5,878 | 17,861 | 8,894 | |
| Interactions Among Titles | | | | | | | | | | | | | |
| Estimated Outlays | 0 | 0 | 54 | 103 | 153 | 198 | 251 | 326 | 113 | 0 | 310 | 1,198 | |
| Estimated Revenues | 0 | 0 | -124 | -218 | -275 | -309 | -354 | -381 | -116 | 0 | -617 | -1,777 | |
| Net Effect on the Deficit | 0 | 0 | 178 | 321 | 428 | 507 | 605 | 707 | 229 | 0 | 927 | 2,975 | |
| Total Changes | | | | | | | | | | | | | |
| Estimated Outlays | -152,014 | 26,338 | 20,128 | -26,168 | -75,108 | -120,041 | -162,123 | -195,109 | -196,315 | -210,937 | -206,824 | -1,091,345 | |
| Estimated Revenues | -130,904 | -460,501 | -582,313 | -581,628 | -525,569 | -445,192 | -412,532 | -420,514 | -447,680 | -478,948 | -2,280,916 | -4,485,789 | |
| Net Effect on the Deficit | -21,110 | 486,839 | 602,441 | 555,460 | 450,461 | 325,151 | 250,409 | 225,405 | 251,365 | 268,011 | 2,074,092 | 3,394,444 | |
| On-Budget Deficit | -21,112 | 486,620 | 601,774 | 554,538 | 449,208 | 323,710 | 248,755 | 223,615 | 249,468 | 265,933 | 2,071,029 | 3,382,521 | |
| Off-Budget Deficit | 2 | 219 | 667 | 922 | 1,253 | 1,441 | 1,654 | 1,790 | 1,897 | 2,078 | 3,063 | 11,923 | |

Components may not sum to totals because of rounding.

* = between zero and \$500,000.

See notes on the next page.



Summary

Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline

As enacted on July 4, 2025

The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) will be the official estimates for all tax legislation considered by the Congress. As such, CBO incorporates those estimates into its cost estimates of the effects of legislation. The estimates for the revenue provisions of P.L. 119-21 were provided by JCT.

This estimate is relative to CBO's January 2025 baseline projections, updated to reflect enacted legislation. It includes budgetary effects through fiscal year 2034 and it incorporates interactions among provisions within each title and among titles.

Under an agreement between CBO and the House and Senate Committees on the Budget to focus analytical resources on reconciliation, this estimate accounts for judicial decisions and administrative actions through April 10, 2025. That agreement supplements a long-standing agreement between CBO and the Budget Committees. See Congressional Budget Office, *CBO Explains How It Incorporates Administrative and Judicial Actions When Updating Its Baseline Projections and Preparing Cost Estimates* (December 2024), www.cbo.gov/publication/60846.

The revenues and outlays of the Social Security trust funds and the net cash flows of the Postal Service are classified as off-budget.

The Budget Control Act of 2011, as amended, requires annual sequestration of mandatory spending for certain programs. The Office of Management and Budget determines which accounts are subject to reductions under that act. In CBO's estimation, some of the accounts affected by P.L. 119-21 will be subject to sequestration. This estimate accounts for those effects.

CBO estimates that P.L. 119-21 will increase by 10 million the number of people without health insurance in 2034.

CBO estimates that P.L. 119-21 will lower gross benchmark premiums, on average, in marketplace plans established by the Affordable Care Act by an estimated 0.6 percent in 2034. (That is, the premiums for the plans used to determine premium tax credits, before those credits are accounted for.)

CBO estimates that P.L. 119-21 will increase on-budget deficits after 2034 relative to CBO's January 2025 baseline budget projections updated to reflect enacted legislation.

Mandates

CBO has determined that the non-tax provisions of P.L. 119-21 will impose intergovernmental and private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) with costs that exceed the annual intergovernmental and private-sector thresholds established in UMRA (\$103 million and \$206 million in 2025, respectively, adjusted annually for inflation). The provision in title I that requires states to contribute matching funds for Supplemental Nutrition Assistance Program benefits and the provision that increases the state share of administrative costs for that program will impose the largest intergovernmental mandates. Provisions in title VII that require importers to remit duties on goods that otherwise could be imported duty-free under the de minimis exemption and in title X that impose new or modified fees on aliens seeking benefits under the Immigration and Nationality Act will impose the largest private-sector mandates.

PUBLIC SUBMISSIONS FOR THE RECORD



U.S. House Ways and Means Subcommittee Hearing

Full Committee Hearing with Health System CEOs

Tuesday, April 28, 2026

Comments for the Congressional Record

The National Association for Behavioral Healthcare (NABH) represents the full continuum of behavioral healthcare services, including not-for-profit and for-profit systems that treat children, adolescents, adults, and older adults with mental and substance use disorders. NABH members provide care across inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, opioid treatment programs, specialty outpatient services, and recovery support services in 49 states and Washington, D.C. We are pleased to submit the following statement for the record.

Behavioral health providers are a critical part of the healthcare infrastructure, often serving as the pressure release valve for a strained system. NABH members respond to emergency departments, crisis responders, and other healthcare units by treating the most high-need, complex patients. Due to historic stigma, underinvestment, lack of parity, Medicaid's IMD Exclusion, Medicare's 190-Day rule, and chronic claim denials, behavioral healthcare providers struggle to provide timely access to evidence-based care.

Despite their critical importance, behavioral healthcare systems are paid less and are subject to more stringent conditions than other specialties. Investment in behavioral healthcare, early intervention, treatment, and recovery supports yields near- and long-term benefits to the entire healthcare system.

PAI: An Example of Federal Policy that Creates Healthcare Waste

The proposed Fiscal Year 2027 Inpatient Psychiatric Facilities Prospective Payment System rule (CMS-1847-P) includes a new quality measure called the patient assessment instrument (PAI) measure. This measure, which takes effect in October 2027, is an ideal example of the type of "waste in healthcare" the committee seeks to eliminate. It has six parts and will require psychiatric hospitals and units to report more than 100 million data points to the Centers for Medicare & Medicaid Services (CMS) in the first year alone. Of those data metrics, an estimated 32 million will need to be manually entered due to a lack of available technology to meet the demands of the measure. Given that scope, this statement will focus only on two of the six components of the measure: the "functional status" and the "impairments" elements.

The PAI (1) is not clinically relevant to psychiatric care; (2) does not improve the outcomes for psychiatric patients; and (3) is an enormous burden for psychiatric hospitals and units. Yet, CMS is requiring these two elements of the PAI to be collected and submitted, along with the rest of the PAI "for all patients age 18 years and older, regardless of payor, beginning October 1, 2027." This measure is a case study of waste in the healthcare system.

This measure will increase healthcare costs by requiring providers to do unnecessary tests that have no clinical relevance. However, the real problem for the fiscal solvency of the Medicare program is that CMS intends to consider the results of this measure in how they calculate payments for psychiatric hospitals and units during future rule makings.



CMS has operationalized the statutorily required “impairments” element of the PAI measure as a “Hearing, Speech Clarity, and Vision assessment,” which requires IPFs at intake to measure and report to CMS each “patient’s ability to hear,” provide a “description of their speech pattern,” and determine “their ability to see in adequate light.” The “detailed instructions for administration” of this assessment can be found in the 50-page draft manual for the PAI measure. Critically, this measure has no clinical relevance to inpatient psychiatric care. CMS notes in its proposal that eyesight, hearing, and speech clarity are “unlikely to change during the IPF stay, which is typically brief (about seven days, on average).” Consequently, the CMS proposal will dramatically increase the requirements for psychiatric hospitals and units for every patient they treat with no benefit to the patient.

The CMS proposal under “functional status” element of the PAI measure is no better than the “impairments” element. CMS has interpreted the statutory functional status category as “Mobility: Chair/Bed-to-Chair Transfer,” providing a cumbersome decision tree for the measure with six possible responses. Clinicians will test every patient aged 18 and older who visits a psychiatric hospital or unit for mental health or substance use disorder treatment on the prospective patient’s ability to move to a bed from a chair and from a chair into a bed. The results of that test, which will occur twice during every stay (once at intake and once at discharge), will be administered and reported to CMS, even though there is no connection between the ability of a psychiatric patient to complete this task and the quality of psychiatric care the patient receives. Nor is there a connection between this task and outcomes for psychiatric patients. The CMS proposal significantly increases the requirements for every psychiatric hospital and unit without any corresponding benefit to psychiatric patients.

Implementing the PAI as proposed is a prime example of healthcare waste, burdening an already strained workforce wishing to provide quality treatment to some of their communities’ most vulnerable members. This entirely unfunded mandate with no benefit adds burden, interrupts workflow, and diverts healthcare workers to irrelevant tasks instead of providing treatment to patients experiencing a psychiatric crisis. We encourage the committee to address this issue with CMS and take legislative action to prevent this policy from becoming a reality.

Unmet Treatment Needs Have Dire Consequences

We urge the committee to address the burden and waste of CMS’ proposed patient assessment requirements and instead support logical investments in behavioral healthcare to meet the needs of individuals who require evidence-based treatment to thrive. Individuals with untreated mental illness incur two to four times higher total medical costs than those without such conditions.

While timely access to behavioral healthcare can improve outcomes and mitigate costs to the system, the total overall healthcare cost of not treating behavioral health disorders to the healthcare system exceeds \$290 billion annually in the United States alone.¹ Behavioral health conditions are associated with up to a threefold increase in spending among individuals with otherwise similar physical disease burden. The impact is greatest among patients with high-cost physical health conditions. More than half of patients with high-cost medical conditions also have a behavioral health condition,² and these conditions are linked to increased medical spending for chronic pain, cardiovascular disease, and diabetes.

¹ Melek SP, Norris DT, Paulus J. (2018). Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman. <https://www.counseling.org/docs/default-source/default-document-library/milliman-report-integrated-medical-and-behavioral-healthcare-2018.pdf>

² Hayes, SL, McCarthy, D., Radley, DC. (2016). The Impact of a Behavioral Health Condition on High-Need Adults. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2016/impact-behavioral-health-condition-high-need-adults>



Untreated behavioral health conditions are also associated with societal costs and outcomes outside the healthcare system, including reduced educational outcomes, criminal legal system involvement, and homelessness. Mental illness and substance use disorder (SUD) significantly decrease ability to successfully maintain employment and contribute to the economy and tax base. However, a key challenge is that behavioral health generates “diffuse savings,” meaning the financial benefits often accrue outside the system making the initial investment.

Behavioral Health Treatment Reduces Healthcare and Societal Costs

A robust body of evidence demonstrates that investment in timely access to quality behavioral healthcare improves outcomes in both the short and long term while reducing broader healthcare and societal costs.

Expanding timely access to specialty behavioral health treatment is a cost-effective strategy to improve both behavioral and physical health outcomes. Effective behavioral health treatment reduces high-cost utilization across the healthcare system, including emergency department visits, inpatient admissions, rehospitalizations, and long-term disability. Importantly, behavioral health treatment alters long-term risk trajectories by stabilizing co-occurring physical conditions and improving adherence to medical care.

While employer-based and Medicare plans cover behavioral health treatment, Medicaid covers a disproportionate share of individuals with SMI and SUD, especially those with chronic medical comorbidities, housing instability, and justice system involvement. The current system often perpetuates a high-cost cycle: behavioral crisis, emergency department utilization, short-term hospitalization, discharge without stabilization, medication non-adherence, and housing instability. These individuals frequently cycle across multiple public systems.

Access to effective behavioral health treatment reduces costs for taxpayer-funded systems, including child welfare, law enforcement, and crisis response. Behavioral health funding should therefore be viewed as a fiscal policy lever, not solely a healthcare investment. When behavioral health conditions go untreated, costs compound across multiple agencies; when effectively treated, expenditures decline across those same systems. Strategic investment converts recurring emergency spending into more predictable, lower long-term expenditures.

Behavioral Health System Funding and Policy Options

Despite behavioral healthcare’s demonstrated return on investment to the overall health system and societal costs, the segment’s providers are generally paid less and subject to more stringent conditions than other healthcare specialties. Cutting behavioral health services as a result of fiscal constraints would be short-sighted. Medicaid programs can achieve savings through fewer crises, lower inpatient admissions, reduced readmissions, and decreased reliance on long-term services and supports.

Despite this, existing insurance payment rates for behavioral healthcare services are inadequate. Substantial disparities exist between behavioral healthcare providers and the rest of the healthcare system: an analysis found that, compared with psychiatrists and psychologists, benchmarked commercial insurance reimbursement for office visits with specialist medical/surgical physicians was 25% and 29% higher, respectively.³

³ Mark, T.L. & Parrish, W. (2024). Behavioral health parity – pervasive disparities in access to in-network care continue. RTI International. <https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf>



Meanwhile, Medicaid payment is typically much lower than payment in other insurance programs, with average Medicaid reimbursement for physician office visits being 38% less than employer-sponsored insurance and 26% less than Medicare.⁴ In addition, Medicaid rates do not necessarily cover provider costs; in 2018, Medicaid payments for community hospital services amounted to only 89% of the cost to deliver those services.⁵

Recent changes to Medicaid and the health insurance marketplaces will add to the financial and operational challenges of behavioral healthcare providers by widening existing payment gaps and increasing the number of uninsured patients.

Meanwhile, increasingly problematic insurer practices result in inappropriate delays and denials that harm patients. These issues are pervasive in the managed care sector, including increased administrative denials, use of coverage guidelines that do not reflect generally accepted standards of care, excessive use of prior authorization and treatment audits, parity violations, degrading customer service quality, and insurers shifting more costs to patients. These practices threaten the access to and affordability of behavioral healthcare services. Congress should pass the *Improving Seniors' Timely Access to Care Act* (S. 1816/H.R. 3514) to streamline the prior authorization process for seniors enrolled in Medicare Advantage (MA) plans. Congress should also pass the *REAL Health Providers Act* (H.R. 5281) to improve the accuracy of MA provider directories to combat ghost networks.

At no cost to federal or state governments, Congress can direct CMS to reduce inpatient mental health provider burden by removing special conditions of participation (CoP) requirements specific to psychiatric facilities. Psychiatric hospitals must satisfy the CoP for Medicare certification and ultimately payment that apply to all general hospitals but are also subject to special conditions that are not applied to other specialty hospitals. These special conditions require psychiatric hospitals to adhere to certain staffing, documentation, treatment, and physical environment standards that are more stringent than the CoP all hospitals adhere to for Medicare participation. We see the differences in these standards as an absence of parity issue, as CMS has imposed these requirements on psychiatric hospitals without comparable requirements for other specialties.

To help reduce the burden for mental health providers, NABH recommends amending staffing conditions related to nursing administrator positions and Advanced Practice Registered Nurses (APRNs) and amending the medical records conditions to simplify treatment planning and individualized patient record documentation to align with current practice and allow appropriately trained and credentialed APRNs to conduct psychiatric evaluations.

Conclusion

Expanding access to high-quality behavioral healthcare is essential to stabilizing overall healthcare costs and improving outcomes for all Americans. Access to medically necessary behavioral healthcare enables individuals to achieve better health, maintain employment, and participate fully in their communities.

Behavioral healthcare is not simply another medical specialty. This form of care functions as a system stabilizer, with benefits extending across healthcare, employment, insurance markets, and public

⁴ Biener AI, Selden TM. (2017). Public and private payments for physician office visits. *Health Affairs*, 36(12), 2160-2164. doi: 10.1377/hlthaff.2017.0749.

⁵ Appendix 1: supplementary data tables. (2025). Trends in the overall health care market. American Hospital Association. <https://www.aha.org/system/files/media/file/2020/10/TrendwatchChartbook-2020-Appendix.pdf>

National Association for Behavioral Healthcare



Access. Care. Recovery.

systems. Recent developments, including value-based care models, integrated delivery systems, and improved outcomes measurement, create new opportunities to capture and sustain this return on investment.

Behavioral healthcare care providers deliver the strongest returns on investment in healthcare. We urge Congress to support access to behavioral healthcare by working with NABH to maintain funding, address insurance barriers, and reduce provider burden.

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org



VIA EMAIL

April 27, 2026

House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Committee Members,

Thank you for convening the April 28 hearing with health system CEOs to examine how providers can contribute to reducing health care costs for patients. I am writing on behalf of the International Foundation for **Autoimmune and Autoinflammatory** Arthritis (**AiArthritis**) to urge your committee to focus on one provider cost driver that Congress has long-identified as in need of reform, namely the abuse of the 340B Drug Pricing Program by many large, tax-exempt hospitals.

In order to increase access to outpatient drugs for low-income and uninsured patients, the 340B program requires substantial drug discounts be provided to “safety net” providers. Since it was created in 1992, the intent of the program has always been for eligible providers to use the discounted savings to increase staff, services, charity care, etc. for low-income and uninsured patients.

AiArthritis commissioned a recent [Milliman study](#) that presented new data demonstrating how the opposite continues to occur in 340B. This research shows that large-tax-exempt hospital mark-ups for autoimmune drugs under 340B are far greater than non-340B hospitals—consistent with previous studies for oncology and other disease groups.

The central findings from the Milliman study confirmed that:

Tax-exempt hospitals charge patients, employers and insurers more for the same drug than for-profit hospitals.

Hospital reimbursement often far exceeds what hospitals pay for medicines, creating large margins that hospitals can pocket as profits. When hospitals charge employers and insurers more, those costs frequently flow through to patients in the form of higher premiums and cost sharing.



Tax-exempt hospitals have been reported to increase the prices of certain medications by over 10,000%.

According to the study, 340B hospitals raised the prices of the four highest-spending analyzed autoimmune drugs by more than 350% on average, and more than 10,000% for certain medications.

The lack of transparency and oversight in 340B allows large hospital systems to profit from the program.

The 340B Drug Pricing Program has become an \$81 billion source of revenue for major hospitals (by 2024) without requirements that patients benefit. According to the Congressional Budget Office's [2025 report](#) on 340B, there's no evidence that the program is currently meeting its goal of improving patient access or reducing patient out-of-pocket costs. The program enables hospitals to increase medicine prices, boosting profits rather than increasing staff, services, or charity care for low-income and uninsured patients.

AiArthritis maintains that comprehensive federal reform of the 340B program is necessary to ensure benefits reach patients rather than primarily supporting hospital finances, ultimately leading to reduced healthcare costs for all Americans.

Please feel free to contact me with any questions about how 340B reform can benefit patients.

Sincerely,

Mark Hobraczek, JD, MPA

Director of Public Policy

Person living with ankylosing spondylitis (an AiArthritis disease)

mark@aiarthritis.org

**Statement
of the
American Hospital Association
for the
United States House of Representatives
Committee on Ways and Means
“Hearing with Health System CEOs”**

April 28, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well as our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — the American Hospital Association (AHA) appreciates the opportunity to share the hospital field’s perspective on how to make health care more affordable for Americans.

America’s hospitals and health systems take great pride in our service in this country, providing constant, round-the-clock care, and we remain unwavering in our commitment to delivering safe, quality care to patients in every community.

We understand the importance of making sure high-quality care is affordable and accessible. As such, hospitals have long been leaders in advancing meaningful solutions to complex health care challenges, including the issue of affordability. That spirit continues today as hospitals across the country work to reduce the cost of care by improving efficiency, embracing innovative technologies and redesigning how services are delivered. Many are investing in preventive care and care coordination programs that help patients manage chronic conditions, avoid unnecessary hospital visits and stay healthier at home. These efforts not only improve patient outcomes but also lower overall costs for patients, families and the health care system.



CURRENT LANDSCAPE FACING HOSPITALS

Hospitals and health systems share Congress' commitment to improving health care affordability, lowering costs and maintaining access to health care services. As we discuss ways to accomplish these goals, it is important to recognize the environment in which hospitals operate.

Hospital care today is more advanced, more effective and more resource-intensive than ever before. It is powered by the skill of the nation's clinical caregivers, breakthroughs in medical technology and sustained investments in the infrastructure needed to deliver modern care. The result is that patients are living longer, recovering faster and benefiting from treatments that would have been unimaginable just a generation ago.

At the same time, hospitals are balancing significant cost pressures as they treat a sicker and more medically complex, aging patient population, all while operating with persistent misalignments in how care is financed and reimbursed.

Investing in Our Nation's Care Teams. Hospitals and health systems exist and function because of the doctors, nurses, technologists, facilities management specialists and many other professionals who dedicate their lives to helping others. We cannot take care of patients without these caregivers and team members who are always there to care. We are committed to supporting the workforce, including by expanding training and education programs, reimagining workforce models, investing in upskilling and providing non-traditional supports for health care workers.

At the same time, labor costs are the most significant driver of hospital operating costs. Labor and workforce expenses account for roughly 60% of total hospital costs. Over the past five years, labor costs have risen sharply. This growth, initially driven by the extraordinary strain of the pandemic, is increasingly shaped by persistent workforce shortages. Many experienced clinicians have left the workforce, burnout remains high, and the pipeline of new physicians, nurses and other health care providers has not kept pace with demand.

To address these issues, hospitals have ramped up recruitment investments and retention efforts while maintaining essential community services, even as many have operated at or below breakeven financial levels. Hospitals also have leveraged artificial intelligence (AI) technologies to reduce administrative burden. While hospitals have been proactive in leveraging these tools, additional investment is needed to address infrastructure barriers, like workforce training and digital literacy.

Sharp Increases in Costs of Medical Supplies and Drugs. Hospitals also have faced faster growth in the cost of goods and services required to care for patients. Spending on medical supplies, equipment and technology has increased significantly as hospitals, like others in the broader community, have had to contend with inflation and global supply chain pressures. Hospitals' total spending on supplies increased 9.9% in 2025, reflecting higher prices for everything from disposable medical gloves to pacemakers,

ventilators and other technology that clinicians rely on every day, as well as lifesaving medical innovations, like advanced imaging systems, implants and new surgical devices.¹

In addition, as with patients, prescription drugs represent another significant, direct expense for hospitals. Hospital drug expenses increased 13.6% in 2025.² Hospital spending on drugs has grown faster than inflation, driven by both price increases on existing medications and the rapid adoption of new, high-cost therapies. Breakthrough treatments, particularly in oncology and other specialty areas, can be clinically transformative but often cost tens or hundreds of thousands of dollars per patient, with some costing in the millions.

Caring for More Patients Who Are Sicker, Leading to Increased Spending. Another important trend to recognize is that hospitals increasingly care for older, sicker patients who have more complex medical needs. Recent analyses show that Americans are spending more years of their lives in poor health, reflecting a growing occurrence of chronic disease across the population. This is occurring along with significant demographic shifts, including an aging population with more persistent and complex medical needs, who then require hospital treatment.³ Those two factors — higher complexity of care and more volume — have been the primary drivers of costs in recent years.

The latest data from the federal government’s own actuaries reinforce those findings. Analysis from the Centers for Medicare & Medicaid Services (CMS) shows that recent increases in health care spending are overwhelmingly driven by higher use and intensity of services, not necessarily higher prices. In 2023 and 2024, medical inflation stayed roughly in line with overall inflation, indicating that the rise in spending reflects more patients getting care rather than rising prices.⁴ Hospital prices are certainly a component, but they are not the only driver. While the entire system, including the government, employers and patients, has seen increased spending, we must look at the deeper structural issues that are truly driving health care costs.

Commercial Insurer Policies Adding Patient Costs, Increasing Provider Burden and Burnout. One factor that has increasingly affected both costs and patient and provider access is the growing administrative burdens placed on them by large commercial health insurers. These include payment denials and delays, as well as skyrocketing prior authorization requirements. These burdens have been felt acutely in the Medicare Advantage program, and the program’s patients as enrollment has grown.

¹ [Costs of Caring | AHA](#)

² [Costs of Caring | AHA](#)

³ [2025 Trends Shaping the Health Economy Report | Trilliant Health.pdf](#)

⁴ [Growth In National Health Expenditures: It's Not The Prices, Stupid | Health Affairs](#)

In the most recent CMS-reported year, Medicare Advantage plans made nearly 53 million prior authorization requests.⁵ Hospitals must devote substantial staff time and resources to prior authorization, claims denials, delayed payments and repeated documentation requirements. These activities can increase costs without improving patient outcomes. They also pull clinicians away from direct patient care and create tremendous stress for patients, families and caregivers. The AHA estimates that in 2025, hospitals spent over \$43 billion trying to collect payments that insurers owe for care already delivered.⁶ To make matters worse, commercial insurers' use of AI to determine disposition of claims and prior authorization has exacerbated inappropriate denials. The AHA has advocated for administrative and congressional action to ensure that clinicians — not just AI tools — are included in denial decision-making.

These harmful administrative practices also have very real consequences for health care providers. It is no surprise that administrative burden is one of the top contributors to clinician burnout.⁷ Nearly 90% of physicians report that prior authorization somewhat or significantly increases physician burnout, which adds to the workforce shortages facing hospitals across the country.⁸

Underpayment for Care Services. These rising costs come at a time when public programs continue to underpay for care services. Medicare and Medicaid payments generally do not cover the full cost of providing care. In 2024, Medicare underpayments to hospitals totaled more than \$100 billion.⁹ According to a recent report from the Medicare Payment Advisory Commission, Medicare margins for hospitals have dropped to -12%.¹⁰ At the same time, many of the essential services that communities depend on the most, such as behavioral health, obstetrics, trauma care and burn services, operate at low or negative margins. These growing Medicare underpayments are threatening many hospitals' ability to continue providing these services.

Excessive Malpractice Costs. Many physicians will face a medical malpractice suit over the course of their career, and the overwhelming majority of those litigated are dropped, denied or dismissed. The data suggest that the rise in these lawsuits stems not from an increase in actual malpractice but rather a legal environment that incentivizes and enables these suits, and the costs are borne by the entire U.S. health care system. The last comprehensive analysis of malpractice-associated costs pegged it at 2.4% of all U.S. health care spending.¹¹ Using the National Health Expenditure's estimate of 2025 spending, this would amount to \$135 billion in 2025.

⁵ [Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024 | KFF](#)

⁶ [Costs of Caring | AHA](#)

⁷ [Addressing Health Worker Burnout](#)

⁸ [AMA prior authorization \(PA\) physician survey | AMA](#)

⁹ [Costs of Caring | AHA](#)

¹⁰ [MedPAC March 2025 report to the Congress--Chapter 3: Hospital inpatient and outpatient services](#)

¹¹ [Medical Liability Costs Estimated at \\$55.6 Billion Annually | Commonwealth Fund](#)

Medical malpractice lawsuits divert time from patient care, limit access and encourage defensive medicine. Rising lawsuit frequency and high payouts have driven malpractice insurance costs higher, forcing providers to raise prices or reduce high-risk services.

Navigating Challenges and Responding. Taken together, these dynamics highlight the incredibly challenging environment that hospitals must manage. These pressures have mounted even while hospital prices have increased moderately in the aggregate.

Looking ahead, recent changes to Medicaid and the health insurance marketplaces will further add to the financial and operational challenges already facing hospitals and health systems and the communities they serve. Reducing federal Medicaid funding and limiting key state financing mechanisms will widen existing payment gaps and increase the number of uninsured patients. Together with the expiration of the enhanced premium tax credits, these policy shifts will lead to higher levels of hospital uncompensated care and bad debt. Those costs will make it harder for hospitals to sustain services and preserve access to care in their communities. In addition, as more uninsured individuals rely on emergency departments for routine primary and preventive care, communities can expect longer waiting times and added strain on the entire health care system, affecting all patients.

Access to Care in Rural and Underserved Communities Threatened. Rural and other safety net providers are committed to working with Congress to find solutions to make health care more affordable for their patients, but also need long-term stability to maintain access to essential services in their communities. Many rural hospitals are delivering care for which they are getting reimbursed significantly below the cost of providing services, making it financially challenging to remain viable. Some of these rural hospitals are facing risks of closure or service line reductions due to low patient volumes, high fixed costs, outdated infrastructure and workforce shortages. For example, nearly 40% of rural hospitals operated at a financial loss in 2024, and over 90 have closed or converted since 2016. As proven time and again, when rural hospitals close, it threatens the health and economic vitality of the entire community.

Most rural hospitals lose money when providing critical medical services such as behavioral health, pulmonology, obstetrics and wound care. They also rely more heavily on public payers — Medicare and Medicaid — and have a corresponding lower share of private coverage. Consistent and appropriate financing for rural hospitals and health systems is imperative to maintain access to care. The AHA thanks Congress for its support for vulnerable hospitals and health systems in rural and underserved communities, including extending key Medicare payments such as the Low-volume Adjustment, Medicare-dependent Hospital designation and telehealth extenders, along with additional legislation to support flexible payment models to help struggling rural hospitals.

Rural hospitals often act as the center of health care activity for their communities and patients. However, there are times when higher levels of care or unique service lines that cannot be sustained in less populous areas are required. The ability for patients

from rural areas to travel to nearby hospitals to receive this care is paramount and often life-saving. Community care can mean opening your doors and services to a broader area to ensure the highest-quality care is available.

Hospital Mergers and Acquisitions Are a Tool to Sustain Community Care. In this environment, hospitals are often left with limited options to preserve access and sustain care for their communities. One path that hospitals and communities may pursue when facing sustained financial strain is becoming affiliated with another hospital or health system, whether through clinical partnerships, joint operating arrangements, or, in some cases, mergers or acquisitions.

These arrangements can become a necessary tool for maintaining services, expanding access to specialty expertise (including through telehealth and clinical integration), improving care coordination across settings, and securing the scale and resources required to continue serving patients. Affiliation can help hospitals recruit and retain clinicians, strengthen on-call and coverage models, and support workforce pipelines that are difficult to sustain independently.

This may not be the right path for every hospital community, but it can be especially important in rural areas, where hospitals often operate with thin margins, inconsistent patient volumes, and limited access to capital and workforce. In many cases, affiliation supports rural hospitals by connecting them to clinical networks, specialist coverage and operational support that can be difficult to sustain on a standalone basis.

In a continually changing environment, these partnerships help some hospitals with the support needed to overcome increases in the cost of caring, adjust to changing patient and community demographics, and innovate for the future.

OPPORTUNITIES AND ACTIONS TO IMPROVE HEALTH CARE AFFORDABILITY

Despite these ongoing financial challenges, hospitals are committed to advancing meaningful solutions to make care more affordable, and we call on purchasers, drug and supply manufacturers, insurance providers, policymakers and individuals to collaborate with us on these efforts.

The four primary areas where the U.S. health care system could make demonstrable improvements in value and affordability are:

- Improving the health of individuals and communities.
- Advancing value through care transformation.
- Reducing regulatory and administrative waste.
- Innovating to improve care quality and outcomes.

Each of these areas is described below with specific examples of steps the health care system could take. However, these examples are not exhaustive, and we welcome the

opportunity to work with Congress, the administration, patients and other health care stakeholders to identify additional ways to advance these and other strategies.

Improving the Health of Individuals and Communities. One of the most promising opportunities to reduce health care spending is to mitigate the need for high-cost interventions through illness and injury prevention. The U.S. has some of the highest rates of obesity, diabetes, kidney disease, liver disease, mental health conditions and multimorbidity in the developed world. Chronic disease management requires frequent — and often redundant — testing and imaging, medication titration and episodic, often very costly, acute interventions. In addition, medical and pharmaceutical advances allow many individuals to survive conditions that historically would have been fatal, often resulting in greater care needs over longer periods, including near the very end of life.

While the root causes of illness and injury often are outside the health care system, providers, health plans, drug manufacturers and other stakeholders play important roles in supporting patients and communities in achieving their best health. For example, the challenges patients face navigating the financial aspects of care create barriers to getting the services they need to stay healthy.

As such, Congress has spent considerable time on solutions to provide patients with certainty about their health care costs, and since 2021, hospitals have expended substantial resources to increase the availability of pricing information. Unfortunately, these efforts have not resulted in meaningful patient benefits. Complex and excessive cost-sharing requirements imposed by health insurers have left many patients confused about what they owe and faced with bills they cannot pay. In fact, most bills patients cannot pay are for the co-pays, deductibles and co-insurance their insurer requires patients to contribute toward their care. Too many Americans are disadvantaged by health insurance benefit designs that expose them to high out-of-pocket costs that providers are then expected to try to collect from them.

These are some of the greatest challenges patients face when understanding their costs, and are problems current price transparency policies do not address. Patients deserve certainty about what their medical care will cost them, and we look forward to continuing to work with Congress to identify solutions that ensure patients have accurate, reliable, upfront pricing information, as well as coverage they can afford.

Examples of opportunities to improve overall health and reduce excess utilization include:

- Increase capacity for preventive and other primary care and incentivize patients to use these services to better prevent and manage illness.
- Reduce patients' financial barriers to care by using income-related enrollment in high-deductible health plans to ensure that high co-pays and deductibles do not serve as a deterrent to accessing care.

- Provide additional support for patients navigating the financial aspects of care by improving access to reliable, relevant, upfront pricing information, as well as updating billing and financial assistance practices to be more patient-friendly.

Advancing Value Through Care Transformation. The U.S. health care system can deliver high-quality care more efficiently by helping patients better access preventive services and earlier illness intervention; supporting providers in minimizing low-value care; enacting medical malpractice reforms that reduce pressures on providers to order additional tests or procedures; and reducing excess costs for certain medical supplies and prescription drugs.

Examples of opportunities to improve affordability through value-based care transformation include:

- Deploy intensive care coordination and patient navigation for the highest-need patients who constitute a disproportionate amount of care utilization and spending. According to 2022 data from the Agency for Healthcare Research and Quality, the costliest 5% of the population accounts for about half of all health care spending, and the most expensive 1% of the population is responsible for over 21% of costs.
- Support providers in transitioning to value-based models to provide the resources and regulatory flexibilities needed to promote prevention and wellness.
- Increase access to palliative care services and adopt end-of-life conversations as a routine part of care.
- Reform malpractice laws and implement tort reform, especially to provide protections for providers who adhere to evidence-based medicine.

Reducing Regulatory and Administrative Waste. The modern U.S. health care system operates with extensive compliance, reporting and documentation requirements, many of which have been introduced in the past 20-30 years. While some administrative systems and costs are necessary and recognize the need for accountability through balanced regulation, there is a substantial opportunity to streamline through standardization and targeted elimination of low-value, third-party vendors.

For example, while there is great utility in electronic health records, quality reporting metrics and cybersecurity tools, there also are substantial costs, including due to redundancies that could be eliminated. Also costly are the contracting and revenue cycle infrastructure needed to manage increasingly complex coverage, billing and prior authorization processes, as well as the advanced analytics, reporting and clinical integration across independent providers needed to implement value-based purchasing arrangements. The cost for this administrative staff and technology is now estimated at 25%-35% of all health care spending. Administrative burden is a key contributor to staffing shortages and burnout.

Examples of opportunities to reduce administrative costs include:

- Reduce unnecessary burdens associated with outdated and redundant regulations, such as duplicative surveys and documentation requirements. The AHA has compiled a [comprehensive list](#) of suggestions to help reduce the burden on hospitals and health systems.
- Pursue direct contracting arrangements between providers and purchasers to bypass the costs associated with insurers and other middlemen in contracting and administration.
- Standardize the processes for plans and providers to request and transmit clinical information needed to adjudicate claims, improve prior authorization and complete other revenue cycle processes to eliminate duplication due to insurer variation.
- Pursue AI policies that strike the appropriate balance of being flexible to enable innovation while ensuring patient safety.

Innovating to Improve Care Quality and Outcomes. Every day we further expand our medical knowledge, the factors contributing to health and well-being, and ways to prevent and cure disease. Hospitals and health systems have always been at the forefront of medical science, often leading in the development of new drugs, devices, digital tools and care delivery models that make care safer, more efficient and more effective. For example, Rady Children’s Hospital in San Diego uses Whole Genome Sequencing to quickly identify rare diseases in children to guide immediate, targeted treatments. These innovations reduce spending by preventing illness and injury, shortening hospital stays and enabling more care to be delivered safely in lower-cost settings.

In another example, hospitals have been at the forefront of developing advanced stroke systems of care that include using less-invasive mechanical thrombectomy to remove blood clots, specialized neuro-interventional teams who provide care and treatment for the brain and spine, rapid imaging protocols and regional stroke transfer networks. These interventions have dramatically increased stroke patients’ likelihood of achieving functional independence and reduced rates of severe disability. CAR T-cell therapy — a type of immunotherapy that activates immune cells against sick or damaged cells — is another example of a hospital-led intervention that has been transformational for individuals with certain types of cancer. CAR T-cell therapy has enabled many patients with previously fatal cancers to have a markedly higher rate of remission, as well as avoid years of chemotherapy, repeated hospitalizations and, in some cases, transplants.

Sustained progress, however, requires active partnership with the government and other stakeholders to accelerate medical advancement and the affordability of care.

Examples of opportunities to improve affordability include:

- Accelerate prevention and early intervention through expanded access to predictive analytics, advanced screening technologies and early detection

models — such as AI-assisted imaging or genomic testing — to catch disease before it becomes costly.

- Strengthen the digital and data infrastructure by investing in broadband access, interoperable electronic health records and cybersecurity, as well as safe and transparent AI.
- Redesign regulatory structures to facilitate new care models, such as hospital-at-home, remote patient monitoring and advanced telehealth, ensuring adequate payment for proven digital innovations.

AVOID POLICIES THAT WOULD REDUCE ACCESS TO CARE

While the recommendations above would meaningfully improve affordability and expand access to care, some ongoing discussions around several policies could undermine hospitals' ability to care for patients and communities. These proposals would deepen the financial challenges facing many hospitals and could force them to scale back, limit or even eliminate essential services. To protect patients and preserve the stability of hospitals and health systems, we urge Congress to reject so-called site-neutral payment policies that would impose billions of dollars in Medicare cuts and to safeguard the 340B Drug Pricing Program.

Reject Site-neutral Payment Cuts. Hospital outpatient departments (HOPDs) serve as vital extensions of hospitals, offering patients convenient, accessible and coordinated outpatient care directly within their communities. While these HOPDs may appear similar to independent physician offices, the level and complexity of care they deliver are fundamentally different. Current Medicare reimbursements — which still fall well below the cost of caring for Medicare beneficiaries — appropriately recognize the differences between these sites of care.

A key distinction between HOPDs and other care settings, such as physician offices or ambulatory surgical centers, is the patient population they serve. HOPDs consistently see patients who are sicker and more medically complex than those treated in other settings. These patients are more likely to experience severe chronic illnesses, dual eligibility for Medicare and Medicaid, and recent hospitalizations or emergency department visits, as well as living in lower-income communities.¹² Caring for these individuals requires advanced clinical capabilities, multidisciplinary support and integrated resources uniquely available in hospital-based settings.

The reliance on HOPDs is even more pronounced in rural communities. Medicare beneficiaries living in more rural counties are significantly more likely to receive care in HOPDs, and, in many cases, these facilities serve as the only accessible option for essential outpatient services.¹³

¹²[Comparison of Care in Hospital Outpatient Departments and Independent Physician Offices 2019-2024 | AHA](#)

¹³[analysis-hospitals-health-systems-are-critical-to-preserving-access-to-care-for-rural-communities-report.pdf](#)

Association of American Medical Colleges
Statement for the Record
before the
House Ways and Means Committee
“Hearing with Health System CEOs”
April 28, 2026

The AAMC (Association of American Medical Colleges)¹ appreciates the opportunity to submit this statement for the record regarding the “Hearing with Health System CEOs” on April 28, 2026. The AAMC welcomes the chance to share the perspective of academic medicine and to work with you as you discuss making health care more affordable.

Academic health systems and teaching hospitals, in partnership with medical schools and faculty practices, are pillars of their communities and play an indispensable role in our nation’s health care infrastructure. These systems often operate as hub and spoke models, with a major academic medical center at the core, and multiple, smaller “spokes” in the form of smaller hospitals, clinics, and physician offices. This model benefits patients, as they can often receive coordinated care under one system, and across a range of settings and acuity levels, while ensuring that academic medicine is accessible not just in major metropolitan centers but in communities that might otherwise lack it.

However, it is crucial to remember that urban academic medical centers, which are often at or over capacity, rely on the crucial care that is delivered in smaller facilities. In fact, when smaller hospitals or clinics face financial distress severe enough to threaten closure, it is frequently academic health systems that are called upon by those hospitals themselves, and sometimes by state governments, to step in. These are not opportunistic acquisitions; they are often the last viable path to preserving health care access for communities that have no other options. When an academic health system assumes responsibility for a struggling facility, it brings clinical resources, operational infrastructure, and financial stability that allow those hospitals to remain open and continue serving their patients. The alternative, closure, would leave those communities without access to care entirely.

At the same time, our members are also operating under extraordinary financial pressures. While financing the missions of an academic health system has always been a complex and arduous process, it has never been more difficult to operate an academic health system. The AAMC recognizes that health care costs are rising, and we want to ensure that affordability does not impact patient access to care. In fact, our members are committed to doing their part to contain and even lower the costs of health care.

¹ The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 13 Canadian medical schools accredited by the [Committee on Accreditation of Canadian Medical Schools](#); nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

As the Committee considers policies intended to address health care affordability, it is essential to understand the underlying drivers of cost growth in the health care system and the unique financial pressures that are facing hospitals that anchor the nation's health care infrastructure. Specifically, we ask the Committee to:

- Recognize and invest in the unique and costly missions of academic health systems that can drive higher but justified costs;
- Investigate and address commercial insurer practices that impose enormous administrative and financial burdens on health systems, hospitals, providers, and patients, particularly as it applies to Medicare Advantage;
- Preserve the ability for all hospitals to reclassify to an appropriate designation that suits their patient population and needs;
- Reject so-called "site-neutral" Medicare payment cuts that would disproportionately harm academic health systems and teaching hospitals;
- Reject proposals to eliminate or narrow the tax-exempt status of nonprofit academic health systems and teaching hospitals; and
- Recognize the efforts our members are making to make health care more affordable.

Academic Health Systems and Teaching Hospitals Are Facing Historic Financial Pressures, but Must Still Support Their Missions

AAMC members continue to grapple with a confluence of economic challenges. Historic workforce shortages, unprecedented capacity challenges, inadequate reimbursement from public and private payers, supply chain disruptions, rising expenses such as labor costs, significant cuts to the Medicaid program, and the looming risk of other harmful Medicare payment cuts have placed enormous strain on hospital finances.

Although AAMC-member health systems and teaching hospitals represent only 5% of all inpatient U.S. hospitals, they train 69% of residents nationwide, operate 100% of comprehensive cancer centers, 68% of burn unit beds, 56% of level-one trauma centers, and 65% of pediatric intensive care unit (ICU) beds.² Additionally, our members are fulfilling their research and community collaboration missions: approximately 60% of the extramural research that the National Institute of Health (NIH) funds occurs on our member campuses, and about 32% of hospital charity care nationwide is provided in our member hospitals.

Labor costs alone now account for more than half of total hospital expenses, reflecting the highly skilled workforce required to deliver safe and effective care.³ Hospitals have also raised wages substantially in recent years in order to recruit and retain physicians, nurses, and other clinical staff amid persistent workforce shortages. At the same time, hospitals continue to face higher costs for supplies, equipment, and pharmaceuticals.

Despite these rising expenses, payment updates from public programs have failed to keep pace. According to the Medicare Payment Advisory Commission (MedPAC), hospitals' overall fee-for-service Medicare margins fell to a record low of -11.6% in 2022, and this downward trend is expected to continue.⁴ The recently passed

² AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025

³ The Cost of Caring: Challenges Facing America's Hospitals in 2025, <https://www.aha.org/guides-and-reports/2026-03-09-2025-cost-caring-report>

⁴ Medicare Payment Advisory Commission, *December 2023 Report*, <https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf>.

One Big Beautiful Bill Act (OBBBA, P.L. 119-21) and the failure to extend the Affordable Care Act's Enhanced Premium Tax Credits will also pose new challenges for our members as they contend with significant Medicaid payment losses and a potential surge in newly uninsured patients. AAMC-member health systems and teaching hospitals, despite experiencing Medicare margins that average -18.2%, are continually asked to do more with fewer resources, and many are near their breaking point.⁵ This is directly reflected in recent activities to offset mounting losses caused by reductions in research funding and anticipated Medicaid cuts at AAMC member institutions. Since January 22, 2025, AAMC member institutions have reported layoffs, unit closures, and hospital mergers as they attempt to maintain financial stability while continuing to serve their communities.

Caring for the Most Complex and Vulnerable Patients

In addition to providing critical primary and specialty care services, AAMC member hospitals also serve as quaternary and tertiary referral centers, meaning that they provide care for patients with the most serious, rare, and complex conditions. They care for disproportionate shares of dual-eligible, disabled, and non-white patients, and provide 27% of all Medicaid inpatient days and 32% of total charity care costs nationally, despite representing only 5% of hospitals.⁶ Teaching hospitals treat four of every five Medicare transfer patients, and when a patient has a condition that no one else can treat, they come to, or are transferred to, a teaching hospital.⁷ Because these patients are more complex and acute, they are more expensive to care for. In fact, AAMC data show that our members are disproportionately caring for complex patients, with an average case-mix index of 2.28 – meaning that they are treating patients with increased severity (more comorbidities, higher severity of illness, or requiring more specialized procedures) and for longer lengths of stay.⁸ In fact, AAMC members' case-mix has dramatically risen since 2019, from 2.05 in 2019 to 2.28 in 2024. While costs have certainly gone up, patient complexity has similarly increased. The AAMC urges the committee to reject the disingenuous narrative that would compare costs at teaching hospitals to other care settings without accounting for the profound differences in the patients being served.

Training America's Future Physicians

Graduate medical education (GME) is the supervised, hands-on training required after medical school before a physician can practice independently. AAMC members, though just 5% of hospitals, train approximately 70% of all residents, totaling roughly 77,000 physician trainees annually.⁹ They are the backbone of the nation's physician workforce pipeline, and are doing their part to ameliorate this persistent physician shortage, which is projected to reach up to 86,000 physicians by 2036.¹⁰

The cost of this training is staggering at nearly \$26.5 billion per year, but teaching hospitals received only about 6.26 million from Medicare – roughly 24% of the total cost.¹¹ That leaves nearly \$19 billion in unfunded training costs and requires our member institutions to identify alternative funding sources or

⁵ AAMC analysis of FY2022 Hospital Cost Reporting Information System (HCRIS) released in July 2024. AAMC membership data, September 2024.

⁶ AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025

⁷ Association of American Medical Colleges. (2019). Investment in Teaching Hospitals Benefits all: Transfer Cases (Analysis in Brief, Vol. 19, No. 2).

⁸ AAMC analysis of American Hospital Association Annual Survey Database and of MedPAR Medicare FFS claims data and AAMC membership data.

⁹ Ibid.

¹⁰ The Complexities of Physician Supply and Demand: Projections From 2021 to 2036:
<https://www.aamc.org/media/75236/download?attachment>

¹¹ AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) data, July 2025 release. If FY2023 data is not available, FY2022 data is used.

directly absorb those costs. Notably, 90% of AAMC-member teaching hospitals are training residents above their Medicare GME funding caps, out of sheer commitment to their communities and the future physician workforce. This commitment to training the physician workforce is unmatched anywhere else in the health care system. In fact, AAMC member health systems and teaching hospitals train roughly 80 percent of all residents being trained over the Medicare cap.¹² While private industries rely heavily on the care physicians perform and the research that they do, they fail to explicitly fund physician training.

AAMC members stand ready, however, to take on additional residents. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act (H.R. 4731/S. 2439), which would gradually provide 14,000 new Medicare-supported GME positions over seven years. Slots authorized by this legislation would be prioritized to hospitals in rural areas, hospitals serving patients in Health Professional Shortage Areas (HPSAs), hospitals in states with new medical schools, and hospitals operating over their caps. When fully enacted, this legislation would produce an additional 3,500 new doctors every year.

Advancing Research that Saves Lives

Approximately 60% of the research that NIH funds occurs on AAMC member campuses, and they are responsible for the foundational discoveries behind nearly every diagnostic tool, treatment, and preventive measure in clinical use today.¹³ From cancer immunotherapy to Alzheimer's treatments, the breakthroughs that patients everywhere depend on trace back to research conducted in academic health systems.

This research is not cost-free for hospitals. For every federal dollar received, AAMC members contribute an additional \$0.53 from institutional resources.¹⁴ Recent reductions in federal research funding have already triggered layoffs and program closures at member institutions, jeopardizing both scientific progress and the economic vitality of research-dependent communities.

Commercial Insurer Practices Are a Primary Driver of Health Care Costs

While academic health systems struggle financially and dedicate extraordinary resources to their missions, the nation's largest commercial health insurers continue to post billions of dollars in profits annually.¹⁵ The AAMC was pleased that the Committee previously discussed affordability with insurers in a Jan. 22 hearing, and we urge you to ensure that any action taken directly addresses commercial insurer behavior, which imposes enormous and largely hidden costs on hospitals, physicians, and patients alike.

Prior Authorization: A Costly Barrier to Care

Prior authorization is among the most burdensome and costly practices commercial insurers employ to limit care.¹⁶ In 2023 alone, more than 50 million prior authorization requests were submitted to Medicare Advantage plans. Nearly one in nine prior authorization denials were appealed, and 80.7% of those appeals resulted in a full or partial overturn; a striking rate that suggests the vast majority of original denials were clinically unjustified.¹⁷

¹² AAMC analysis of FY2023 Hospital Cost Reporting Information System (HCRIS) data, July 2025 release.

¹³ AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025

¹⁴ Academic Medicine Investment in Medical Research: Summary and Technical Reports, Association of American Medical Colleges, 2015.

¹⁵ U.S. Health Insurance Industry Analysis Report, National Association of Insurance Commissioners, 2024:

<https://content.naic.org/sites/default/files/2024-annual-health-industry-commentary.pdf>

¹⁶ [Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023](https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-50-million-prior-authorization-determinations-in-2023)

¹⁷ <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/#6e420acb-2fc1-4707-8689-ac19594e493a>

Some MA plans use automated algorithms and artificial intelligence to generate mass denials, only to reverse them on appeal. This process imposes devastating costs: patients face delays that worsen outcomes, and in the most tragic cases, die awaiting approval. Physicians must re-prove the medical necessity of care they have already determined is appropriate. Academic health systems and faculty physician practices employ entire teams dedicated to managing prior authorization and claims disputes, wasting resources that could have been used in the pursuit of patient care or other advancement of their missions.

The AAMC has long supported efforts to reform MA prior authorization practices, including the bipartisan Improving Seniors' Timely Access to Care Act of 2025 (H.R. 3514/S. 1816). We also applaud the Centers for Medicare and Medicaid Services (CMS) for advancing deeply needed regulatory requirements that reflect many bipartisan aspects of that legislation. We urge Congress to support further reforms that limit inappropriate denials, prohibit algorithmic overreach, and center the process around clinical judgment and patient health. These protections will become increasingly important as CMS implements the Wasteful and Inappropriate Service Reduction (WISeR) model, which will implement prior authorization in traditional Medicare in six pilot states.

Delayed and Denied Payments Impose Hidden Costs

AAMC members consistently report delayed payments, retroactive denials, insufficient reimbursement rates, and exclusion from plan networks. An American Hospital Association survey found that 50% of hospitals and health systems had more than \$100 million in unpaid claims more than six months old, amounting to over \$6.4 billion in delayed or denied claims system-wide.¹⁸ While insurers hold premium dollars and collect interest, hospitals provide services and wait, or absorb losses.

Retroactive denials in which an insurer pays for care and then seeks to claw back payment months or years later are particularly destructive to hospital financial planning and patient care continuity. AAMC members must dedicate substantial administrative resources to pursue payment for care that has already been rendered and that was medically necessary. The AAMC supports the Medicare Advantage Prompt Pay Act (H.R. 5454/S. 2879), which would require MA plans to reimburse at least 95% of clean claims within 14 days for in-network services and 30 days for out-of-network care, with enforceable penalties for non-compliance and mandatory public reporting.

Rising Premiums and High-Deductible Plans are Driving Patients Away from Care

Commercial health insurance premiums rose 53% from 2014 to 2024.¹⁹ The expiration of enhanced premium tax credits at the end of 2025 is projected to cause millions of Americans to drop coverage, increasing the uninsured rate and compounding the uncompensated care burden on hospitals. At the same time, the proliferation of high-deductible health plans has made cost-sharing so burdensome that patients frequently delay or forgo necessary care, which is a pattern that drives up long-term costs when patients ultimately seek treatment for worsened conditions.

It is insufficient for insurers to point to hospital prices as the primary driver of health care costs while simultaneously designing plans that extract maximum revenue from enrollees, deny coverage for medically necessary services, and delay payment to providers. The Committee should continue its work from its Jan. 22 hearing and pursue a full examination of insurer practices and their contribution to unaffordability.

¹⁸ <https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf>

¹⁹ <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#b80a5be7-6ddd-4d81-b9af-3126336155ca>

Consolidation Among Insurers Suppresses Competition

The insurance market has grown dramatically more concentrated, giving large plans the market power to impose below-market reimbursement rates on providers and above-market premiums on consumers. A recent study found that 73% of metropolitan statistical area-level insurance markets are considered highly concentrated under federal antitrust guidelines, with 90% of those markets featuring at least one insurer holding 30% or more of commercial market share. The top three large-group insurers hold an average of 82.2% of market share in each state.²⁰

Vertical integration between insurers, pharmacy benefit managers (PBMs), and pharmacies compounds these concerns. Four PBMs, all owned by major insurers, control 70% of the PBM market.²¹ This consolidation enables arrangements that favor higher-cost drugs in exchange for rebates, steer patients to insurer-owned pharmacies, and exclude hospital-operated specialty pharmacies from networks. These practices raise costs for patients and undermine the value of the 340B program for safety-net providers.

The AAMC urges the Committee to investigate insurer consolidation and its effect on patient access, quality, and costs, including the role of vertical integration in health care market dynamics.

Hospitals Reclassify to Designations that Suit their Patient Population and Needs

For nearly 30 years, Medicare has permitted certain hospitals to reclassify as rural under the Inpatient Prospective Payment System when they demonstrate that they meet specific eligibility criteria. Reclassified hospitals, designated as Rural Referral Centers, access some additional, congressionally designed benefits that they earn by virtue of the patients that they serve, who come from far beyond the borders of the hospitals' immediate communities. Hospitals that apply for this status must be approved by CMS and continue to satisfy requirements to maintain their status.

Reclassification reflects the reality of delivering care today, in that rural patients do not stay within rural ZIP code boundaries when they are seriously ill. In addition to seeking much-needed primary care at AAMC-member health systems and teaching hospitals, rural patients travel to academic health systems and teaching hospitals for advanced trauma care, transplant services, neonatal intensive care, and other high-complexity services unavailable closer to home. AAMC-member health systems represent just 7 percent of IPPS hospitals, yet they treat 40 percent of all IPPS transfer cases nationwide.²² Those patients arrive with an average case mix index of 2.58 compared to 2.01 at non-teaching hospitals, and AAMC hospitals lose \$1,669 more per transfer case than per non-transfer case.²³ Geographical location does not always adequately reflect need, and payment policy should reflect where rural patients are receiving their care.

Critics falsely contend that reclassification, and particularly dual reclassification, which allows a hospital to reclassify as rural for IPPS purposes while using the Medicare Geographic Classification Review Board process to determine its wage index, harms geographically rural hospitals. That claim is not supported by how the policy actually operates. By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify; as MedPAC has confirmed, an urban hospital's reclassification can increase, but cannot

²⁰ Guardado, Jose R. American Medical Association. Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update. <https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf>

²¹ Association of American Medical Colleges Research and Action Institute. Why Market Power Matters for Patients, Insurers, and Hospitals (May 1, 2024). <https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-marketpower-matters>.

²² <https://www.aamc.org/media/10771/download>

²³ Ibid.

decrease, the wage index of hospitals that did not reclassify.²⁴ Dual reclassification is a lawful, court-interpreted policy, and facilities utilizing it are leveraging resources made available by virtue of the patients they treat.

Proposals to restrict reclassification would not redirect resources to rural hospitals; rather, they would destabilize the academic health systems that rural patients rely on when they need care no one closer is willing or able to provide. When a critically ill patient is transferred out of a rural hospital, that transfer depends on a regional referral center with the capacity, expertise, and infrastructure to receive them. Undermining those centers does not strengthen rural health care, but rather leaves rural patients with fewer options at their most vulnerable moments. The AAMC urges the Committee to preserve rural reclassification policies and recognize that rural health care is a continuum that extends well beyond rural ZIP codes.

So-called “Site Neutral” Payment Cuts Harm Academic Health Systems and Teaching Hospitals and Limit Patient Access to Care

The AAMC strongly opposes so-called "site-neutral" Medicare payment cuts to off-campus hospital outpatient departments (HOPDs). Although teaching hospitals represent just 5% of U.S. hospitals, AAMC estimates they would bear nearly half of all payment cuts under site-neutral proposals. These cuts would occur as academic health systems are already absorbing historic Medicaid losses, reduced research funding, and negative Medicare margins.

Proponents of HOPD cuts contend that identical services should be reimbursed identically regardless of where they are delivered, but this premise fails to acknowledge that the patients treated in HOPDs are substantially more clinically and socially complex than those seen in physician offices or ambulatory surgical centers. They frequently present with multiple comorbidities, limited mobility, or conditions that require immediate access to inpatient backup and the full array of hospital resources. A physician's office is simply not equipped to manage that level of acuity, and no payment policy can change that reality.

Hospital outpatient departments also operate under far more stringent licensing, accreditation, and regulatory requirements than physician offices or freestanding ambulatory centers. Meeting those requirements carries real, ongoing costs that are appropriately reflected in Medicare's payment structure. Site-neutral proposals ignore those structural differences entirely. Beyond the regulatory burden, HOPDs provide a range of services that simply are not available elsewhere, including outpatient drug administration for chemotherapy and other complex therapies. For Medicare beneficiaries in rural and medically underserved communities, the hospital outpatient department is often the only accessible site for these services. Cutting HOPD payments does not make those services cheaper; it makes them harder to sustain and, ultimately, harder to access.

It is also important to be clear that these cuts would reduce the resources hospitals have available to sustain essential services, support safety-net care, and fund the broader missions that make academic health systems indispensable to their communities. We urge the Committee to reject site-neutral payment cuts as a mechanism for achieving affordability. The real costs are borne by the patients who would lose access to care.

²⁴ “By statute and regulation, reclassifications must hold harmless hospitals that did not reclassify; therefore, the reclassification of hospitals can increase (but not decrease) the wage index of other hospitals that did not reclassify.” MedPAC (Medicare Payment Advisory Commission). 2023. Reforming Medicare's Wage Index Systems. In June 2023 Report to the Congress: Medicare and the Health Care Delivery System (chapter 9, p.381). Washington, DC: MedPAC. <https://www.medpac.gov/document/chapter-9-reforming-medicare-wage-index-systems-june-2023-report/>

Tax-Exempt Status is Critical to Maintaining Investments in the Missions of Academic Medicine

The AAMC strongly opposes any proposal to eliminate or narrow the long-standing tax-exempt status of nonprofit hospitals. Tax exemption is a recognition of the extraordinary public value that academic health systems and teaching hospitals provide. These institutions use the savings afforded by their tax-exempt status to sustain missions that no other type of institution can replicate: delivering advanced patient care to the most complex patients, training the next generation of physicians, conducting the medical research that drives discovery, and serving as safety nets for underserved communities.

Critics of tax exemption often focus narrowly on charity care as the benchmark for whether a hospital has earned its status. That framing fundamentally, and disingenuously, understates the breadth of community benefit that academic health systems provide. While AAMC members account for 27 percent of Medicaid inpatient days and 32 percent of all charity care costs, with a median of nearly \$20 million in charity care and over \$33 million in uncompensated care per hospital annually, these figures do not capture additional losses from Medicare and Medicaid underpayments, nor the cost of maintaining specialized services that communities depend on.²⁵ Beyond direct patient care, these institutions spend nearly \$26.5 billion annually training resident physicians, with Medicare covering only 24 percent of those costs, and contribute \$0.53 of their own resources for every federal research dollar received.²⁶ The contributions of academic health systems extend well beyond the clinic. AAMC-member institutions collectively contribute more than \$728 billion to the U.S. economy, roughly 3.2 percent of GDP, and support over 7 million jobs nationwide.²⁷ AAMC members are research enterprises, educational institutions, and economic anchors that generate returns for their communities far exceeding the value of any tax obligation foregone.

Any serious evaluation of tax-exempt status must reckon with the financial environment in which these institutions operate. Academic health systems already face negative Medicare margins, historic Medicaid shortfalls, and the compounding pressures of the recently enacted One Big Beautiful Bill Act. The threat to tax-exempt status in this environment would not redirect resources toward patients; it would accelerate the erosion of the very institutions that provide care no one else will. The AAMC urges the Committee to reject proposals that would curtail nonprofit hospital tax exemption, and instead to work with the academic medicine community to pursue targeted, thoughtful revisions to IRS Form 990, Schedule H, that reflect a fuller accounting of the community benefit academic medicine delivers.

Academic Medicine's Commitment to Lowering Costs

While most drivers of health care costs remain outside the control of AAMC-member teaching hospitals, there are efforts academic medicine has undertaken to drive down costs.

Bending the Cost Curve by Delivering More Care in the Home

Academic medicine has been a leader in developing and implementing innovative care delivery models that improve efficiency and help lower the cost of care, including the expansion of Acute Hospital Care at Home (AHCaH) programs. AHCaH programs allow eligible hospitals to safely deliver hospital-level care to certain patients in their homes while still receiving Medicare reimbursement. Academic health systems and teaching hospitals have embraced this model as a way to provide high-quality care in a more efficient setting. By

²⁵ AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025.

²⁶ Academic Medicine Investment in Medical Research: Summary and Technical Reports, Association of American Medical Colleges, 2015.

²⁷ <https://www.aamc.org/data-reports/teaching-hospitals/data/economic-impact-aamc-medical-schools-and-teaching-hospitals>

shifting appropriate patients from high-cost inpatient beds to carefully monitored home environments, AHCaH programs help reduce the fixed costs associated with traditional hospital stays while maintaining the same clinical oversight and safety standards.

Evidence from hospital-at-home programs demonstrates that this model can significantly reduce the overall cost of care while maintaining or improving quality. Studies have found that treating eligible patients at home can lower costs per admission, often by 30 percent or more, by reducing facility overhead, shortening lengths of stay, and preventing complications that frequently occur in inpatient settings.²⁸ Patients receiving care at home also experience fewer hospital-acquired conditions and lower readmission rates, which further contribute to cost savings for the health system. For AAMC members that often operate at or near capacity, these programs also help ensure that inpatient resources are reserved for the most complex and critically ill patients. By improving efficiency and reducing avoidable complications, AHCaH programs represent a promising strategy for delivering high-quality care while helping to bend the long-term health care cost curve.

The AAMC is grateful that Congress extended AHCaH for five years in the consolidated Appropriations Act of 2026 and urges continued investment in the program. The AAMC urges the Committee to take steps to encourage commercial insurers to pay for more home-based hospital care.

Lowering Costs Through Advanced Alternative Payment Models (APMs)

Academic medicine and the broader health care community appreciate Congress's continued leadership in advancing value-based care through the extension of the Advanced Alternative Payment Model (APM) incentive payments included in the Consolidated Appropriations Act of 2026. This extension sends an important signal to physicians, hospitals, and accountable care organizations that Congress remains committed to supporting the transition toward payment models that reward better outcomes and greater efficiency. Advanced APMs are designed to align financial incentives with high-value care by encouraging providers to focus on care coordination, prevention, and proactive management of chronic disease. These approaches improve patient outcomes while helping reduce unnecessary spending across the Medicare program.

Evidence demonstrates that these models can generate meaningful savings while maintaining or improving quality. For example, the Medicare Shared Savings Program, which is the largest APM in Medicare, has produced billions of dollars in savings for the program, including more than \$6 billion in reduced spending in 2024 alone, while consistently achieving strong performance on quality and preventive care measures.²⁹ These models also encourage providers to invest in innovations such as team-based care, data-driven population health management, and earlier intervention for chronic conditions, all of which help lower long-term health care costs. Academic health system participation in APMs has led to investments in telehealth innovations and home-based primary care pilots that have helped to improve outcomes and patients' access to care in the most appropriate setting, reducing unnecessary emergency department visits, inpatient stays, and readmissions.

As the Committee continues its work to examine affordability, we encourage you to build on this progress by advancing thoughtful improvements to the Medicare Access and CHIP Reauthorization Act (MACRA). In particular, we recommend modernizing financial and nonfinancial incentives to sustain participation in Advanced APMs, stabilizing Medicare physician payments with predictable annual updates that account for

²⁸ B. Leff, L. Burton, S. L. Mader et al., "Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-Level Care at Home for Acutely Ill Older Patients," *Annals of Internal Medicine*, Dec. 2005 143(11):798–808.

²⁹ <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>

practice cost inflation, and leveraging the Centers for Medicare & Medicaid Services Innovation Center to develop and scale successful payment models, especially those that support rural providers and improve care for patients with chronic conditions. Together, these steps will help ensure clinicians can continue investing in delivery reforms that improve care for patients while helping lower costs for the Medicare program over time.

Improving Population Health Through Education and Training

Academic medicine is committed to helping address the causes of chronic disease, which is an important step in lowering long-term health care costs. Conditions such as cardiovascular disease, Type 2 diabetes, obesity, and hypertension account for a significant share of health care spending in the United States, and academic medicine is working to ensure physicians are prepared not only to treat illness, but also to prevent it. For example, prevention, health promotion, and nutrition are integrated into the education of future physicians. Today, nearly all U.S. medical schools include required nutrition education beyond the basic sciences, a dramatic increase over the past decade. Rather than treating nutrition as a standalone topic, schools are embedding it throughout the curriculum so that physicians graduate with the competencies needed to counsel patients, work with interdisciplinary care teams, and incorporate evidence-based prevention strategies into routine care.

Academic medicine is also advancing national efforts to strengthen training in this area. The AAMC and partner organizations have convened educators, clinicians, and nutrition experts to develop competency-based frameworks and share evidence-based educational resources that can be adopted across medical schools and residency programs. Through initiatives such as national summits on nutrition education, expanded curricular competencies, and dissemination of peer-reviewed teaching materials, the academic medicine community is equipping physicians to address diet-related chronic disease through team-based, patient-centered care. While no single educational intervention on its own can fully resolve challenges with broader systemic drivers, these efforts reflect a broader commitment by medical schools and academic health systems and teaching hospitals to improve population health, reduce preventable illness, and ultimately help bend the long-term cost curve of the nation's health care system.

Conclusion

Academic health systems and teaching hospitals are under extraordinary financial pressure. They are being asked to do more, such as train more physicians, care for more complex patients, and absorb more uncompensated care, with fewer resources and at a moment when federal funding streams are being reduced. While we support the Committee's efforts to improve health care affordability, we urge you to consider the many drivers of these costs.

The AAMC appreciates the opportunity to offer our perspective, and we look forward to working with the Committee as you work to address health care affordability. For further questions, please contact Len Marquez, AAMC senior director, government relations and legislative advocacy, at lmarquez@aamc.org, or Ally Perleoni, AAMC director, government relations, at aperleoni@aamc.org.

Statement for the Record

Alliance for Fair Health Pricing

**Submitted to the
United States House Committee on Ways and Means**

Full Committee Hearing with Health System CEOs

April 28, 2026

On behalf of the Alliance for Fair Health Pricing (AFFHP)¹, we are pleased to submit this written statement that includes concrete recommendations that will lower costs and make health care more affordable for all Americans. AFFHP is a non-partisan coalition of patients, consumers, and employers committed to bold changes that will lower health care prices, the root cause of high health care costs for the privately insured. We commend the Committee for holding this timely series of hearings to improve health care affordability for all Americans.

The affordability crisis today is real. Americans are sounding the alarm, worried they won't be able to pay for needed care or be forced to skip care because it is too expensive.² While only 31% of small businesses offer employer-sponsored insurance to their employees, many of those businesses citing rising health care premiums as a major financial burden.³ And more than half of large employers say they will be forced to make cost-cutting changes to their plans in 2026.⁴

This is unacceptable. High health care prices are a major threat to the economic security of American families. We need to reverse the trend of health insurance premiums increasing faster than inflation and wages, and to do this, we need to focus on the underlying costs of health care.

A recent report by the Centers for Medicare and Medicaid Services (CMS) finds the costs Americans paid “for hospital care, physician and clinical services, and retail prescription drugs all contributed more to overall growth in 2024 than during the 2014–19 period,” with health care spending nationwide growing by 7.2% in 2024, reaching a record \$5.3 trillion.⁵ In the private market, hospital costs alone account for 40 cents of the health care dollar due to the excessive prices charged by corporate hospitals and health systems.⁶

Substantial evidence shows that high and rising hospital prices are the result of decades of health care consolidation in provider markets that have largely gone unchecked.⁷ In fact, over the last two decades, prices in the hospital sector have grown faster than prices in virtually any other sector of the economy.⁸ The Health Care Cost Institute (HCCI) recently published new findings in its Health Care Cost Landscape that illustrate how highly concentrated hospital markets drive up prices.⁹ HCCI's Cost Burden Index, which shows the relative affordability of health care spending

¹ [Alliance for Fair Health Pricing \(AFFHP\)](#).

² [Taking the Pulse of Healthcare in America](#), West Health-Gallup Center on Healthcare.

³ [Voice of Main Street: Small Businesses Support Healthcare Premium Relief, Immigration Reform](#), Small Business Majority. [Opinion Poll: Small Businesses Struggling with Rising Healthcare Costs, Support Bipartisan Policy Solutions](#), Small Business Majority.

⁴ [Survey on Health & Benefit Strategies for 2026](#), Mercer.

⁵ [National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated](#), Health Affairs.

⁶ [Where Does Your Health Care Dollar Go?](#), AHIP.

⁷ [Is there too Little Antitrust Enforcement in the U.S. Hospital Sector?](#). American Economic Review.

⁸ [Lax Antitrust Enforcement Linked to Rising Hospital Prices](#), Yale News. [Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital-Based Care In 2007–14](#), Health Affairs.

⁹ [Health Care Cost Landscape](#), Health Care Cost Institute.

for consumers, found that in more than half of the metro areas studied with a high health care cost burden, spending takes up more than 7% of personal income for consumers.¹⁰

When hospitals merge, evidence shows that prices increase from 3% to a whopping 65% with no changes in quality or outcomes.¹¹ Furthermore, when large hospital systems buy independent physician practices, prices go up, with patients paying up to 4x more for the exact same care, with the same doctor and in the same location.¹² The only thing that's changed is the logo on the door and the increased profit margins for the health system. Despite pre-merger claims of efficiency, returns to scale, and improvements in care coordination and quality, patients do not enjoy any such benefits from consolidation. Instead, these powerful monopolies have the leverage to charge patients unreasonably high and arbitrary prices, which translate into skyrocketing premiums, higher deductibles, and exorbitant out-of-pocket expenses – all without any meaningful improvement in quality of care.

Today, certain large, wealthy hospitals and health systems are outperforming Fortune 500 companies with double-digit profit margins.¹³ This includes large, consolidated nonprofit hospitals that make up nearly half of all the hospitals in the U.S. and are exempt from all federal, state and local taxes – a benefit that far exceeds what they return in charitable giving.

These lucrative,, consolidated hospital systems are using their profits in ways that are counter to high-quality patient care, all while most Americans struggle to afford housing, groceries and gas, in addition to their health coverage. For example:

- **NYU Langone**, a large nonprofit hospital system, spent \$8 million on a Super Bowl ad last year.¹⁴
- **Northwell Health** built its own Hollywood-style studio to make promotional content.¹⁵
- Nonprofit hospitals received \$28B in tax breaks in 2020, increasing to \$37.4B in 2021. More than half spend less on charity care and community benefit than their tax breaks are worth.¹⁶

The consequences of consolidation are not just financial. Hospital consolidation leads to reduced access to care and fewer choices for patients, especially for those in rural communities or who need less profitable, but essential services like obstetrics, mental health, and primary care which

¹⁰ [Cost Burden Index](#), Health Care Cost Institute.

¹¹ [Environmental Scans on Consolidation Trends and Impacts in Health Care Markets](#), RAND.

¹² [Site-Neutral Payment Reform Medicare Growth Differential Report](#), Arnold Ventures and Actuarial Research Corporation.

¹³ [Hospital Cost Tool](#), National Academy for State Health Policy (NASHP). [March 2026 Report to Congress: Medicare Payment Policy](#), MedPAC.

¹⁴ [Nonprofit Hospital Draws Backlash for Super Bowl Ad](#), Axios. [NYU Langone Hospitals Full Filing](#), ProPublica.

¹⁵ [Northwell Health creates film studio to promote the system's brand](#), Healthcare Brew.

¹⁶ [Key Facts About Hospitals](#), KFF. [Estimation of Tax Benefit of US Nonprofit Hospitals](#), JAMA. [Making Hospital Tax Breaks Work for Communities](#), Lown Institute.

are often cut in favor of higher-revenue specialties like cardiac surgery and intensive care.¹⁷ Opaque prices also limit consumers' ability to shop for care and employers' ability to make informed health care purchasing decisions — and leave patients vulnerable to price gouging. Patients and employers should not struggle to afford care while corporate hospitals and health systems continue to raise prices to boost their profits.

As voters continue to face high and rising costs, they are demanding action from policymakers, with 91% of voters saying it's important that Congress and the President act to lower health care costs.¹⁸ The good news is that there are meaningful actions Congress can take now to lower costs for all Americans by:

- **Strengthening price transparency.** Achieving full transparency of health care prices is a critical step towards increasing competition in the U.S. health care system and ensuring our nation's families receive affordable, high-quality health care. Price transparency is an important tool to show how irrational health care prices have become and it will better equip employers, policymakers, and researchers to take action to rein in pricing abuses. Importantly, it allows patients and purchasers of care to compare prices to make the best choice for their health care needs.
- **Advancing comprehensive site-neutral payment reforms.** Patients should pay the same amount for the same services regardless of where the service is performed. Paying more for the same service when delivered in a hospital outpatient facility rather than a community-based physicians' office — as Medicare and commercial insurers typically do — creates a financial incentive for hospitals to vertically consolidate with physicians and shift services to higher-cost hospital settings.

Eliminating price differences for certain routine services (which can result in patients paying up to four times more) based on where care is delivered will create a fairer and more affordable system for patients and reduce the incentives for large, consolidated health systems to buy up physician practices to charge higher prices. This, in turn, lowers the cost of care for the privately insured.

- **Banning anticompetitive contracting tactics.** Corporate hospitals and health systems use anticompetitive practices (e.g., anti-tiering, anti-steering clauses) in their contract negotiations with health care purchasers to enhance their market power and ultimately raise their prices. These practices limit market competition, increase health care prices and ultimately decrease patient and employer choice. Banning anticompetitive contracting would dampen the effects of consolidation in health care markets and lower health care costs for patients, consumers, employers, and taxpayers.

¹⁷ [Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization](#). Brown University.

¹⁸ [2025 Affordability Polling](#), Families USA.

Congress has an opportunity to address market failures, restore competition, and, importantly, improve affordability by lowering health care costs. We urge you to seize this moment and enact these practical policies, as they directly address the root drivers of high health care costs and would meaningfully make health care more affordable for the privately insured, creating a more affordable and accessible health care system. These policies would also save taxpayers money while giving Congress a clear win on the top economic concern for voters, and a fiscally responsible achievement in a moment when Washington urgently needs one.

Voters are exhausted by rising costs, they're frustrated by inaction,¹⁹ and they're paying attention to what happens next. This is the window, the opportunity, and the moment for real leadership. AFFHP stands ready to support your efforts to make good on your promises to lower the cost of health care for millions of Americans.

Sincerely,



¹⁹ [2025 Affordability Polling](#), Families USA.



May 11, 2026

The Honorable Jason Smith
Chairman, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Smith, Ranking Member Neal, and Distinguished Members of the Committee:

On behalf of the America First Policy Institute (AFPI), thank you for holding the April 28, 2026 hearing examining the unaffordable cost of hospital care and the role large hospital systems play in driving up prices. I write to share our views on the perverse incentives that exist within consolidated health systems and how they drive up healthcare costs for patients, employers, and taxpayers. AFPI is a nonprofit, nonpartisan research institute dedicated to advancing policies that put the American people first.

The Cost Burden of Hospital Consolidation

American families and employers have been facing an unprecedented healthcare cost crisis in recent decades. Between 2001 and 2025, the average annual cost of healthcare for a family with employer-sponsored family coverage increased 317%, from \$8,414 to \$35,119 ([Milliman, 2005](#); [Milliman, 2025](#)). Sixty-two percent of the increase in healthcare spending between 2022 and 2024 was caused by increasing spending on hospital care and physician services, according to an analysis by the Kaiser Family Foundation ([Godwin et al., 2026](#)).

The escalating cost of hospital and physician care has imposed substantial financial burdens on American families and employers alike through higher premiums. Studies



indicate that each 10% rise in premiums corresponds to a 2.3% reduction in average worker wages ([Baicker & Chandra, 2005](#)). This compounding effect drained an estimated \$125,340 from the typical family's earnings between 1988 and 2019 ([Hager, 2024](#)). This affordability crisis has also forced many small businesses to drop coverage, with the share of employers offering employee health insurance declining sharply from 78% to 54% ([KFF, 2025](#)).

Health system consolidation is a significant contributor to rising healthcare costs. As large systems acquire independent hospitals and physician practices, they have shown to weaken competition and gain leverage to demand higher prices. Between 2010 and 2024, the share of urban hospitals that were affiliated with a larger system increased from 66% to 80%. By 2024, nearly half of metro areas were served by just one of two hospital systems for inpatient care ([Godwin et al., 2025](#)).

When a large hospital system acquires an independent hospital, prices at the newly acquired hospital increase by an average of 17% to 18% ([Lewis & Pflum, 2017](#)). In some cases, hospital consolidation creates even more dramatic price increases. After Sutter Health acquired Summit Medical Center in Oakland in 1999, creating a local monopoly, hospital prices grew between 23.2% and 50.4% by 2001, according to a 2008 Federal Trade Commission analysis ([Tenn, 2008](#)).

Medicare Is Subsidizing Hospital Consolidation

Federal payment policy often is to blame for the perverse incentives which leads to consolidation. Medicare pays substantially higher rates for services delivered in hospital outpatient departments (HOPDs) than for identical services in independent physician offices. Medicare payments to HOPDs for many preventive services, drug injections, and imaging services are 43% to 670% higher than Medicare's payments to independent physician practices ([Cooper et al., 2023](#)).

This disparity encourages hospital systems to acquire physician practices to capture higher Medicare revenue. Once acquired, large systems then leverage these practices to refer patients to their hospital campuses, diverting patients and revenue from competing community hospitals ([Baker et al., 2023](#)). The consequences for patients are higher costs for essential care and fewer options for accessing quality, community-based services.

President Trump is taking critical first steps to unwind Medicare's payment disparities that fuel hospital consolidation and drive-up inflation. On November 25, 2025, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that equalizes Medicare's payment for drug administration services between HOPDs and independent physician offices ([Centers for Medicare & Medicaid Services, 2025](#)). This critical reform will save cancer patients up to \$1,055 every year ([Bulat, 2023](#)) in reduced out-of-pocket expenses for chemotherapy



drugs while simultaneously removing a key financial incentive for large hospital systems to acquire community physician practices.

Voters are demanding more solutions from Congress to combat the rising cost of hospital care. According to a 2024 survey by Arnold Ventures, 84% of voters say it is important that Congress take action within the next two years to lower the price of hospital care – a clear mandate for reform ([Arnold Ventures, n.d.](#)).

Options For Reform

It is imperative that Congress consider additional patients-first reforms that expand access to affordable, high-quality care and enhance competition among high-quality providers:

- **Comprehensive Site-Neutral Payment Reform:** Medicare should pay the same rate for the same service regardless of whether it is furnished in an HOPD or an independent office, a policy known as site-neutral payment reform. This policy is among the most powerful levers available to end the perverse incentives and curb consolidation-driven inflation. President Trump called on Congress to enact comprehensive site-neutral pay reform as part of his 2021 Budget Request, which the Congressional Budget Office (CBO) estimated would save taxpayers \$141 billion over 10 years ([U.S. Office of Management and Budget, 2020](#); [Congressional Budget Office, 2020](#)).
- **Site-Neutral Payments for Off-Campus Facilities:** Congress could also consider directing CMS to pay for hospital-owned facilities that are located outside the main hospital campus at the same rate as independent physician practices. The CBO estimated this reform would save \$39.1 billion over ten years ([Congressional Budget Office, 2020](#)).
- **Site-Neutral Payment Reform for Common Procedures:** Congress could consider implementing site-neutral payment policies for select services that are safely and routinely performed in both HOPDs and independent physician offices. A 2023 report by the Medicare Payment Advisory Commission (MedPAC) recommended Congress equalize Medicare’s payments for 66 such services, saving seniors an estimated \$1.2 billion and saving taxpayers an estimated \$4.9 billion annually ([MedPAC, 2023](#)).

Conclusion

Perverse incentives are driving up costs for patients, employers, and taxpayers, and federal payment policy is actively fueling it – like with hospital consolidation. The reforms outlined above offer Congress a clear and direct path to reverse this trend. Site-neutral





payment reform would eliminate a major financial incentive for hospital acquisitions of independent practices, restore competition, and deliver meaningful savings to the patients and families who need them most. Whether Congress acts comprehensively or incrementally, the direction must be toward payment reform, market competition, and patient-centered care.

AFPI stands ready to work with the Committee to advance these critical reforms and to provide any additional analysis or support the Committee may find helpful. We thank the Committee for its attention to this critical issue and welcome the opportunity for continued engagement.

Respectfully,

Charlie Katebi

*Deputy Director of Healthy America,
The America First Policy Institute*

The America First Policy Institute

AFPI is a 501(c)(3) nonprofit, non-partisan research institute. AFPI exists to conduct research and develop policies that put the American people first. Our guiding principles are liberty, free enterprise, national greatness, American military superiority, foreign-policy engagement in the American interest, and the primacy of American workers, families, and communities in all we do.



April 28, 2026

The Honorable Jason Smith
Chairman
U.S. House of Representatives
Ways and Means Committee

The Honorable Richard Neal
Ranking Member
U.S. House of Representatives
Ways and Means Committee

Dear Chairman Smith, Ranking Member Neal, and members of the committee:

The **Alliance to Fight for Health Care** applauds the House Ways and Means Committee for continuing to examine the key drivers of the nation's health care affordability crisis, particularly the role of hospitals and health systems in driving higher health care costs, at its April 28 hearing with health system CEOs.

The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage. We are deeply concerned about the rising cost of health care in the United States and are focused on strengthening and improving the employer-sponsored coverage that more than 181 million Americans rely on today¹ while advancing policies that lower underlying system costs.

Rising Health Care Costs

The cost of providing health care coverage continues to rise at an unsustainable pace – and premium increases largely reflect the underlying cost of health care services across the system. National health spending reached \$5.28 trillion in 2024, growing 7.2% year over year and increasing health spending's share of GDP to 18.0%.² Several structural factors are driving this growth, including hospital prices and facility fees and anti-competitive practices.

Hospital prices and facility fees continue to grow faster than wages and inflation, driven in part by consolidation and acquisition of physician practices, which enables hospital-owned facilities to charge higher rates for the same services. Several reports have found that such mergers can lead to up to 65% in price hikes and despite claims to the contrary, deliver no meaningful improvements in quality, but result in higher costs to patients and employers:

- **2025 HHS Consolidation Report:** Found that hospital-to-hospital mergers in already concentrated markets are associated with hospital price increases ranging from 6% to 65%.³

¹ U.S. Census Bureau, *Health Insurance Coverage in the United States: 2024* (2025, September), <https://www2.census.gov/library/publications/2025/demo/p60-288.pdf>

² Centers for Medicare & Medicaid Services (CMS), *National Health Expenditure Fact Sheet*, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>.

³ U.S. Department of Health and Human Services. (2025, January 15). *Consolidation in health care markets: Request for information response report*. <https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf>

- **2025 GAO Report:** Concluded that hospital acquisition of physician practices typically raises prices, with physician service prices increasing ~14% on average after acquisition.⁴
- **2017 MedPAC Report:** Showed that physician-hospital consolidation increases prices for both commercial and Medicare physician services, with no commensurate quality gains identified.⁵

Anti-competitive practices blunt the ability for employers and other payers to meaningfully steer patients to high-value sites of care and negotiate with providers in good faith to enter into network contracts. For example, the U.S. Department of Justice antitrust lawsuits against OhioHealth and New York-Presbyterian Hospital allege that hospitals used anti-steering, anti-tiering, and “all-or-nothing” contract provisions that prevent insurers and employers from steering patients to lower-cost, higher-value providers and sites of care, restricting the ability of payers to design budget-conscious plans, including narrow networks and tiered benefits, thereby blunting competition and keeping prices high.⁶

A report from the O’Neill Institute for National and Global Health Law found that anti-steering and all-or-nothing hospital contracting raise costs by preventing insurers from directing patients to affordable providers, even when insurers use tiered copays or value-based network designs, by forcing insurers to keep higher-priced systems in preferred tiers, reducing price competition across hospitals and outpatient settings.⁷

Policy Solutions to Lower Costs

Policies that reduce price distortions, improve competition, and curb non-value-added billing practices can generate savings for Medicare and taxpayers while easing pressure on employer and household premiums. We believe Congress can play a critical role in targeting specific practices that increase costs for patients and employers without improving outcomes:

1) Expand Site-Neutral Payment Reform

Patients are frequently charged more simply because care is delivered in a hospital-owned setting rather than a physician office or ambulatory setting, even when the service is clinically identical. Expanding site-neutral payment policies and limiting inappropriate facility fees would reduce incentives for consolidation and lower out-of-pocket costs. Currently, Medicare pays hospital

⁴ U.S. Government Accountability Office. (2025, September 22). *Health care consolidation: Published estimates of the extent and effects of physician consolidation* (GAO-25-107450). https://files.gao.gov/reports/GAO-25-107450/index.html#_Toc208982287

⁵ Medicare Payment Advisory Commission. (2017, June). *Provider consolidation: The role of Medicare policy* (Chapter 10). In *Report to the Congress: Medicare and the health care delivery system*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch10.pdf

⁶ Gonen, D. J., & Martin, L. K. (2026, April 14). *DOJ sends clear signal with latest antitrust challenge to hospital contracting practices*. *National Law Review*. <https://natlawreview.com/article/doj-sends-clear-signal-latest-antitrust-challenge-hospital-contracting-practices>

⁷ Friedman, L. (2025, February 26). *Pushing back on anticompetitive hospital contracting*. O’Neill Institute for National and Global Health Law, Georgetown University. <https://oneill.law.georgetown.edu/pushing-back-on-anticompetitive-hospital-contracting/>

outpatient departments (HOPDs) higher rates for similar services, which encourages acquisition of physician practices and conversion to higher-paid billing status. We support expanding site-neutral payments and urge Congress to codify CMS's recent rule⁸ to apply site-neutral payments to outpatient drug administration services. We also support more expansive proposals such as MedPAC's June 2023 recommendation to expand site-neutral payments to services "when safe and appropriate and when doing so does not pose a risk to access."⁹

To address these issues, we urge Congress to advance policies that:

- **Expand Medicare site-neutral payments** for appropriate outpatient services with appropriate protections for rural hospitals.
- **Increase transparency and limits around so-called "facility fees,"** including clearer billing disclosure of site-of-service and stronger guardrails against add-on "junk fees" like facility fees.

2) Hospital Price and Billing Transparency

We strongly support efforts to advance hospital price and billing transparency, ensuring patients are billed accurately based on where and how they receive care. We applaud the advancement of the [honest billing](#) provision that was recently enacted as part of the Consolidated Appropriations Act, 2026. That provision will require off-campus hospital outpatient departments (HOPDs) of Medicare providers to obtain and use a unique NPI, ensuring that patients and payers have the data necessary to dispute erroneous fees, unfair add-on costs, hospital upcharges and other junk fees.

To build on this achievement and further protect patients from inappropriate billing practices, Congress should:

- **Strengthen and enforce hospital price transparency and billing requirements.**
- **Improve billing clarity by overseeing implementation of "honest billing" provisions in the Consolidated Appropriations Act, 2026 so patients can see the location of care and distinguish professional fees from facility fees.**

3) Anti-Competitive Contracting and Network Design Flexibility

One of the most onerous ways hospitals are preventing employers and payers from delivering real value is by imposing contract terms that constrain network design and block steering. The Justice Department's litigation against New York-Presbyterian highlights these plan restrictions that "preclude insurers and employers from offering...budget-conscious health insurance plans," including restrictions that limit tiering and steering.

⁸ CMS. (2025, November) Hospital Outpatient Prospective Payment Final Rule.

<https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

⁹ MedPAC (2023, June): Report to Congress: Medicare and the Health Care Delivery System:

<https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/>

Policies that prohibit anti-competitive contracting – such as “all-or-nothing,” anti-tiering, and anti-steering clauses – can empower employers to offer high-value networks and steer patients toward higher-quality, lower-cost providers, which retains patient choice while delivering cost savings.

- We urge Congress to **support H.R. 6248, the Healthy Competition for Better Care Act**, which would address these anti-competitive practices. The Congressional Budget Office estimated that a previous version of the bill, H.R. 3120, introduced in the 118th Congress, would reduce deficits by \$4.9 billion over 2025–2034.¹⁰

4) Freestanding Emergency Departments

Hospitals are increasingly purchasing freestanding emergency departments (EDs) where they can bill for ED-level billing for care that may be safely delivered in lower-cost settings (when clinically appropriate). Further, oftentimes these freestanding EDs are marketed to appear as independent urgent care facilities, leaving patients surprised when they receive a high bill.

MedPAC’s work on stand-alone emergency facilities documented rapid growth in Medicare ED spending: outpatient and physician ED spending increased from \$4.4 billion (2008) to \$6.1 billion (2013), reflecting 7% per-capita growth per year on average over that period.¹¹

- We urge the Committee to investigate **freestanding EDs** to stem rising costs and inappropriate advertising practices; and
- Additional exploration into **how Medicare payment policy and transparency/ownership rules can curb excess spending** while protecting emergency access.

We thank you for your leadership and your work to advance policies to lower health care costs for working families. We look forward to working together to advance public policy that makes health care more affordable, supports continued innovation, improves job-based coverage, and advances the health care system for all patients.

Respectfully,

The Alliance to Fight for Health Care

¹⁰ Congressional Budget Office. (2024, November 12). *H.R. 3120, Healthy Competition for Better Care Act* (Cost estimate). <https://www.cbo.gov/publication/60976>

¹¹ Medicare Payment Advisory Commission. (2015, September 11). *Emergency department services provided at stand-alone facilities* [Public meeting presentation]. https://www.medpac.gov/document/microsoft-powerpoint-free_ed_presentation_sept2015b-pptx/



**American Podiatric Medical Association
Written Comment to the
U.S. House Committee on Ways and Means**

Full Committee Hearing with Health System CEOs

April 28, 2026

Chairman Smith, Chairman Buchanan, Ranking Member Neal, Ranking Member Doggett, and members of the Committee, thank you for the opportunity to submit a written comment on the role of health systems within the current state of healthcare affordability. Thank you for holding the hearing

APMA represents the vast majority of the more than 15,000 licensed podiatric physicians and surgeons, also known as doctors of podiatric medicine (DPMs), in the United States. As frontline health professionals, our members deliver treatment essential in preventing complications and improving health outcomes for chronic conditions like diabetes and peripheral artery disease. Podiatrists play an important role within health system multidisciplinary care teams to identify and treat lower extremity complications that other physicians cannot.

Reforming Hospital On-Call Requirements

Evidence demonstrates that care provided by podiatrists improves patient outcomes and reduces costly complications. Studies have shown that when podiatrists are integrated into multidisciplinary teams, rates of amputations decline, healing improves, and hospitals save money through reduced lengths of stay and fewer readmissions.¹ Despite podiatrists' specialized training and physician recognition by the federal government, they are often required to provide on-call services without compensation to obtain or maintain hospital privileges.

In 2025, APMA and Marit Health performed a compensation survey and found that a vast majority of doctors of podiatric medicine (88%) are not paid for taking calls.² Among the minority of podiatrists who receive compensation for call, the weighted median nightly rate is \$350. By comparison, broader physician data indicate that many specialists receive daily call

¹ Carls, Ginger S., et al. "The economic value of specialized lower-extremity medical care by podiatric physicians in the treatment of diabetic foot ulcers." *Journal of the American Podiatric Medical Association*, vol. 101, no. 2, 1 Mar. 2011, pp. 93–115, <https://doi.org/10.7547/1010093>

² American Podiatric Medical Association Marit Health. 2025 Podiatry Compensation Report (pp. 29–31). December 2025.

stipends exceeding this amount, suggesting that paid call in podiatry is both relatively uncommon and generally lower than compensation levels seen in other medical specialties.³

Specifically, APMA is concerned about the on-call policies of HCA Healthcare. APMA has received reports from podiatrists practicing at HCA-affiliated facilities in multiple states, including Virginia, that members are expected to provide on-call foot and ankle coverage without compensation as a condition of obtaining or maintaining hospital privileges, or through informal expectations tied to hospital participation. While APMA recognizes that compensation arrangements may vary by facility and specialty, we are concerned that uncompensated call expectations for podiatrists may undermine access to care, strain an already limited specialty workforce, and create instability in hospital coverage for medically complex foot and ankle conditions.

Requiring podiatrists to absorb the financial and operational burden of emergency and inpatient call coverage without compensation is inconsistent with the essential role they play in patient care. The expectation for doctors of podiatric medicine to take call is inconsistent with how other physician specialties are treated and reinforces inequities in reimbursement. This is especially burdensome because, for many podiatrists, on-call pay represents the only reimbursement they receive when treating uninsured patients.

Podiatrists fulfill an essential role in patient care and hospital performance. Evidence demonstrates that care provided by podiatrists improves patient outcomes and reduces costly complications. When podiatrists are integrated into multidisciplinary teams, rates of amputations decline, healing improves, and hospitals save money through reduced lengths of stay and fewer readmissions. In emergency settings, podiatrists manage complex, high-risk cases where timely intervention can be the difference between limb salvage and amputation. Their on-call services improve patient outcomes and generate revenue for hospitals.

APMA strongly opposes policies that condition hospital privileging on uncompensated on-call services and urges policymakers and hospitals to reject such conditional requirements. On-call pay inequities also persist despite podiatrists providing many of the same surgical procedures as orthopedists, who typically receive compensation for on-call services. Podiatrists should be able to decline call duties when compensation is not provided, particularly given the complexity and acuity of the cases they manage. To ensure a sustainable health care workforce and equitable treatment of all physicians, policymakers and hospitals must reject privileging policies that require uncompensated on-call services.

APMA urges Congress to advance policies that prevent health systems from tying hospital privileges to unpaid on-call services, ensuring podiatrists are fairly compensated. Equitable on-call policies enhance professional incentives for podiatrists, helping to prevent care disruptions that drive up healthcare costs. Fair compensation models will, in turn, support a robust podiatric

³ “Call Pay in Medicine: Who Gets Paid, How Much, and Why It Varies.” *Marit Health*, www.marithealth.com/posts/call-pay-in-medicine-who-gets-paid-how-much-and-why-it-varies?utm.

workforce in the hospital setting, strengthen parity with other physicians, and preserve high-quality access to foot and ankle care.

Conclusion

APMA stands ready to work with Congress to advance legislative solutions that ensure podiatrists are fairly reimbursed for their time.



**American Association of Orthopaedic Surgeons
Statement for the Record
U.S. House Committee on Ways and Means
Hearing with Health System CEOs
April 28, 2026**

On behalf of its 39,000 orthopaedic surgeon members, the American Association of Orthopaedic Surgeons (AAOS) is pleased to submit this statement for the record of the April 28, 2026 hearing, with health system CEOs before the U.S. House Ways and Means Committee. We share the committee's goal of addressing the core drivers working against health care affordability—namely inadequate Medicare reimbursement, onerous government interference, administrative burdens, and lack of competition and patient choices.

As a result of an aging population, musculoskeletal diseases are an emerging cause of health and financial burden in the United States¹, where they affect more than one in three people or approximately 127.4 million individuals.² Musculoskeletal care made up 9.4% of total medical services expenditure in 2021, highlighting the significant proportion of healthcare services dedicated to treating bone and joint diseases in the United States. This translates to an annual spend of \$244 billion.³ Musculoskeletal care has an outsized impact on activities of daily living and productivity. Therefore, the impact of MSK diseases leads to a ripple effect on not just the patient, but the caregivers, family members, and larger community involved in the therapeutic recovery from acute and chronic disease. Reflecting this impact, employers rank musculoskeletal conditions among the top two health conditions driving their costs.⁴ Proactive treatment led by expertly trained orthopaedic surgeons focused on the full continuum of care management is the best way to ensure quality care that treats the patient and by extension the entire community. The doctor-patient relationship must remain at the heart of MSK care, unincumbered by payment or administrative barriers.

Healthcare consolidation trends threaten patient choice and access

The rising costs of running a medical practice disproportionately impact small, independent practices, and rural physicians, increasing the risk of access to care issues for some of our country's most vulnerable patients. As a result, the U.S. healthcare system continues to experience unprecedented consolidation as large hospital systems devour smaller facilities and independent physician practices at record rates, raising concerns about the creation of monopolies that could drive up healthcare costs

¹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/>

² <https://pmc.ncbi.nlm.nih.gov/articles/PMC10788788/>

³ <https://www.kff.org/health-policy-101-health-care-costs-and-affordability/?entry=table-of-contents-what-factors-contribute-to-u-s-health-care-spending>

⁴ <https://www.businessgrouphealth.org/resources/2024-large-employer-health-care-strategy-survey-intro>

and limit patient choice. The stress of running a medical practice, including amplified financial pressures and administrative burdens, is causing one in five physicians to consider leaving private practice within two years.⁵ When private practices close, patients may struggle to find care elsewhere. They also may end up paying higher out-of-pocket costs if they now have no choice but to receive the same care they were before from their local doctor in a more expensive hospital setting.

Rural hospitals provide essential healthcare services to millions of Americans, but they continue to face immense financial pressures and workforce shortages threatening their viability. On average, rural hospitals operate with margins of half that of urban hospitals, and over 130 rural hospitals have closed since 2010. The law limits who can own hospitals, which artificially limits options as to the type of entity that can rescue a hospital on the cusp of closure. Lifting the physician ownership ban would allow physician-led hospitals to provide care in these underserved rural communities.

The Physician Led and Rural Access to Quality Care Act (H.R. 2191) would preserve these critical facilities by allowing physicians to be a part of the ownership model of a rural hospital, provided it is not within the existing mileage requirements of an existing critical access hospital (CAH) (35 miles by primary road or 15 miles by secondary road) in order to ensure no new physician-led hospital interferes with a CAH's mileage-based eligibility. However, it also clarifies that this does not require a new physician-led hospital to be a CAH. This legislation provides a targeted solution to empower physician-led hospitals in underserved rural areas. It would represent an incremental and reasonable step that would expand options for maintaining access to care when a rural community is at risk of losing its hospital. Access to local emergency and inpatient care is crucial for rural communities. Passing H.R. 2191 will help keep rural hospital doors open and preserve health care access for rural Americans.

AAOS also supports the Patient Access to Higher Quality Health Care Act (H.R. 4002) which would repeal section 6001 of the Patient Protection and Affordable Care Act (PPACA) prohibiting the formation and expansion of physician-owned hospitals.

Physician-led hospitals have been shown to provide high-quality care at lower costs compared to other hospitals. Studies have found that they deliver savings to Medicare, feature lower prices for procedures, and operate more efficiently. Consolidation of rural hospitals into larger health systems reduces services and responsiveness to community needs. More competition from physician-led hospitals can provide needed alternatives to consolidation.

Impact of Physician Payment Policies

AAOS is grateful to Congress for enacting a 2.5% increase to physician payments in 2026. To ensure seniors continue to have access to the physicians they trust in their communities, Congress must act now to stabilize payments with long-term solutions. We strongly support policies that give physicians

⁵ [https://www.mcpiqjournal.org/article/S2542-4548\(21\)00126-0/fulltext](https://www.mcpiqjournal.org/article/S2542-4548(21)00126-0/fulltext)

an annual, inflation-based payment update. Unlike hospitals and skilled nursing facilities, physicians receive no automatic inflation-based payment updates. This disparity forces many practices to either close their doors or consolidate with larger healthcare institutions – a trend that ultimately drives up healthcare costs for everyone. Congress should permanently rationalize Medicare physician payments by requiring that the annual conversion factor update include the full amount of yearly inflation as measured by the Medicare Economic Index (MEI).

Physicians are not only struggling to keep up with inflation, but they also face Medicare reimbursement cuts year-after-year due to budget neutrality constraints. The Omnibus Budget Reconciliation Act of 1989 contained a provision which mandated that any upward payment adjustments or the addition of new procedures that will increase spending by \$20 million or more must be offset by cuts elsewhere in the MPFS. As a result, the various medical specialties are pitted against each other in competition over the size of their respective shares of the MPFS budget. It is not uncommon for a physician in one specialty to see their payments reduced because of policy decisions aimed at a completely different specialty that have little to do with their day-to-day practice of medicine. This creates even more uncertainty for physicians and ultimately harms patients.

The AAOS enthusiastically supports the Provider Reimbursement Stability Act of 2026 (H.R. 8163) designed to stabilize Medicare payments for physicians and protect access to care.

This bipartisan legislation that would meaningfully increase physician payments to right size reimbursements after decades of inflation-adjusted cuts and protect Medicare beneficiaries' access to care by providing a crucial two percent payment increase. If enacted, this bill would raise the budget neutrality threshold from \$20 million to \$54.3 million in 2027 — indexed at five-year intervals thereafter — capping the annual budget neutrality adjustment to the conversion factor at 2.5%, establishing a utilization corrections mechanism, and requiring regular updates to practice expense calculations.

In addition to these ongoing challenges, certain issues arise because of CMS policy and have an outsized impact on the state of physician payment. For example, the Centers for Medicare & Medicaid Services (CMS) finalized an “efficiency adjustment” in the CY2026 Medicare Physician Fee Schedule. This policy, which took effect January 1, applies a 2.5% cut to procedural work Relative Value Units (RVUs) for most non-time-based codes — with additional reductions scheduled every three years indefinitely absent congressional action. Because work RVUs underpin surgeon compensation across practice settings, this policy would accelerate the decades-long decline in physician payment and intensify zero-sum pressures in Medicare that can force tradeoffs across specialties and primary care.

Orthopaedic surgeons, other specialists, and primary care clinicians are partners in patient care. **The Efficiency Adjustment Delay Act (H.R. 7520) would provide a prudent pause until 2030 to reassess CMS's assumptions through a study and ensure that preserving access to surgical and specialty care does not come at the expense of patients' access to front-line, preventive care.** We appreciate that H.R. 7520 would require any future adjustment to work RVUs deemed necessary by

this study be calculated without relying on a factor that is used to determine productivity relative to inflation, such as the Medicare Economic Index, unless the yearly update to the nonqualifying APM conversion factor is at least as large as the percentage increase in the Consumer Price Index for the previous year.

The premise underlying the efficiency adjustment is not supported by the evidence. A peer-reviewed study in the *Journal of the American College of Surgeons* found that 90% of procedures took the same or longer to perform in 2023 than in 2019 as patients grew more complex — contradicting the assumption that services will become more efficient indefinitely, or at the same rate across clinicians and settings. Specifically, within the realm of orthopaedics, our surgeon members have been at the forefront of patient optimization initiatives that have succeeded in improving care to make surgery as successful as possible. Even so, the data reflects the fact that the best patient outcomes are not simply equated with the fastest operative times. Physician work valuation reflects time, complexity, and intensity, not speed alone. An across-the-board reduction untethered from empirical data fails to account for high-risk cases; surgeons newer to a procedure, and teaching environments where additional time is appropriate and necessary.

The impact also extends beyond Medicare. Many employment contracts are tied to work RVUs or total RVUs, meaning cuts can reduce compensation even when the work performed does not change. A recurring reduction every three years adds uncertainty that undermines sustainable practice and employment arrangements.

In addition, CMS finalized a 50% reduction to the indirect Practice Expense RVU for facility-based services. Rising costs and constant policy churn are making the MPFS increasingly unstable for physicians caring for seniors. Until both the “efficiency adjustment” cut is delayed and Congress develops a remedy for this severe cut to indirect Practice Expense RVUs, physicians will continue to struggle with tremendous uncertainty, harming the health of our nation. Small, independent and rural practices will struggle most to absorb these cuts, potentially forcing them to consolidate into large systems; an outcome AAOS, Congress and CMS all want to prevent.

The cost of providing medical services to our seniors continues to grow exponentially, yet physicians’ Medicare reimbursement has decreased by 33 percent since 2001 when adjusted for inflation in practice costs. The Medicare Physician Fee Schedule is the only Medicare payment system that is not tied to inflation, a reality that is not sustainable as the Medicare population grows faster than ever in this time of continued economic uncertainty.

Expecting physicians to provide the same level of care to America’s seniors despite being underpaid by over 30 percent is simply untenable, especially for independent practices struggling to remain in business. These financial pressures are contributing to physician burnout and forcing more independent practices and physician offices to be acquired by larger hospitals and healthcare systems. This accelerating consolidation reduces competition and threatens patients’ access to high-quality care, particularly in rural areas and low-income and historically marginalized communities.

Administrative burdens implemented by payers hinder physicians' ability to provide patient care

Prior Authorization (PA) requirements are put in place by Medicare Advantage (MA) plans to help ensure high-quality, cost-effective care while preventing unnecessary utilization. The current prior authorization system, however, imposes excessive administrative burdens on medical practices through complex requirements and electronic health record maintenance, reducing physicians' time with patients and increasing operational costs. It also regularly delays or completely prevents patients from receiving necessary care and negatively interferes with the all-important doctor-patient relationship.

The Improving Seniors' Timely Access to Care Act (H.R. 3514) would prioritize patient care over paperwork by modernizing and streamlining the prior authorization process in Medicare Advantage.

This legislation would mandate electronic prior authorization for MA plans, standardize transactions and clinical documentation requirements, and increase transparency around MA prior authorization practices. Additionally, it would empower CMS to establish clear timeframes for prior authorization decisions and require regular congressional reporting on program integrity efforts from HHS and other agencies.

The Improving Seniors' Timely Access to Care Act codifies several key provisions of CMS's January 2024 final Interoperability and Prior Authorization rule (CMS-0057-F). Accordingly, the Congressional Budget Office gave the legislation a score of zero dollars. While this regulatory action represents progress, congressional action is still needed.

Questionable hospital billing practices harm independent practices and their patients

As orthopaedic surgeons, we witness firsthand how the lack of transparency in hospital billing practices impacts healthcare costs. Under the current system, it is often unclear to patients, insurers, and even clinicians whether care is being delivered in a hospital or non-hospital setting. This opacity incentivizes large health systems to acquire independent physician practices, only to then bill routine office procedures at higher hospital-based reimbursement rates – despite no change in the location of service or actual care delivered. These acquisitions and subsequent billing practices increase costs across the board, with patients and payers bearing the burden of these inflated charges. The current payment system has contributed to rapid consolidation across the U.S. healthcare landscape. Today, nearly 80 percent of physicians are employed by hospitals or other corporate entities.⁶ This trend has not resulted in improvements in the quality-of-care patients receive but rather has led to higher costs for both patients and the healthcare system. In fact, a 2022 report from the Medicare Payment Advisory Commission (MEDPAC) found that Medicare spent \$1.4 billion more than necessary due to site-of-service payment differentials, which underscores the need for reform.⁷

⁶ <https://www.fiercehealthcare.com/providers/more-and-more-physicians-are-working-under-hospitals-corporate-entities-report-finds>

⁷ https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

AAOS endorsed the FAIR Act in the 118th Congress and was pleased to see certain provisions of this bill included in the government funding package that was signed into law in early February 2026. The FAIR Act's requirement for separate National Provider Identifier (NPI) numbers for off-campus hospital outpatient departments will create much-needed transparency in our healthcare system. Requiring unique identifiers, will clarify when services are being provided in a hospital versus non-hospital setting, allowing for appropriate reimbursement rates based on the site of care and helping to identify cost disparities between hospital-owned and independent physician practices. AAOS strongly supports efforts to bring greater transparency and fairness to medical billing practices.

Payers should not penalize a patient's choice of physician

AAOS is deeply concerned about emerging trends of penalizing hospitals when out-of-network physicians are used in the provision of the care. For instance, Anthem recently announced the Facility Administrative Policy: Use of Nonparticipating Care Provider⁸ in 11 states starting January 1, 2026. It is our understanding that Anthem Blue Cross and Blue Shield plans will begin penalizing hospitals with a 10 percent reimbursement cut for services provided by out-of-network physicians and will consider terminating hospitals from Anthem networks for continued use of nonparticipating physicians. Anthem is attempting to bypass the negotiated bipartisan policy under the No Surprises Act (NSA) that protects patients from surprise medical bills when out-of-network care is provided at an in-network hospital. On average, a physician practice has 20.2 health plan contracts, and even small practices with under five physicians average 13.5 health plan contracts.⁹ The NSA established a system by which patients do not pay more than in-network rates for out-of-network care at participating hospitals, and health plans and physicians engage in negotiations and potentially an independent dispute resolution process to determine a fair payment amount. We find it genuinely concerning that rather than working through the NSA, Anthem is choosing to implement a policy that circumvents the statute.

Patients should not be punished for choosing where they receive treatment

Currently, Medicare beneficiaries who receive treatment in either an ambulatory surgery center (ASC) or hospital outpatient department (HOPD) are typically responsible for 20 percent of their cost of care. In HOPDs, this 20 percent coinsurance is capped at the hospital inpatient deductible amount, which is \$1,736 for 2026.¹⁰ In ASCs, however, there is no coinsurance cap. As a result, Medicare patients treated in an ASC face higher coinsurance payments for approximately 183 procedures, many of which are higher complexity or device intensive procedures that would generate significant savings for the Medicare program if performed at an ASC.

Additionally, when this cap is applied in an HOPD, the hospital is made whole, meaning that Medicare pays the hospital for the difference between what 20 percent of the procedure would have yielded and the capped amount of \$1,736. Since Medicare reimburses HOPDs significantly more than ASCs for

⁸ https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy_FINAL.pdf

⁹ <https://www.caqh.org/hubfs/43908627/drupal/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf>

¹⁰ <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>

virtually every procedure, current policy also incentivizes beneficiaries to choose the higher-cost site of care, adding unnecessary costs to the Medicare program.

The Medicare Beneficiary Co-Pay Fairness Act (H.R. 3006) addresses this issue not by taking anything away from the HOPD setting, but rather by extending the benefits of the coinsurance cap to Medicare beneficiaries seeking care in an ASC. Under H.R. 3006, Medicare beneficiaries would see their out-of-pocket costs decrease when seeking care at an ASC for any of the approximately 183 affected procedures, helping to drive more of these procedures to the lower-cost, high quality ASC setting. This bill complements CMS' policy in the CY2026 Medicare Outpatient Prospective Payment Rule that moved over 250 MSK procedures onto the ASC Covered Procedures List.

More than 6,300 Medicare-certified ASCs currently operate in the US, performing a wide variety of outpatient procedures. Surgery centers represent a significant source of savings potential for the Medicare program, and Medicare beneficiaries because they can perform procedures with greater efficiency and at a lower cost than hospitals. Correcting the imbalance created by the uneven application of the coinsurance cap could help generate even greater savings for the Medicare program.

Conclusion

The American Association of Orthopaedic Surgeons urges Congress to take immediate action to address the growing challenges facing physicians and their patients in the U.S. healthcare system. By removing administrative burdens, accelerating competition, and putting patient access as top priority, Congress can help to reverse the trend of consolidation, preserve patient access to care, and promote the transition to value-based care. We stand ready to work with the Subcommittee and other stakeholders to advance these critical priorities and ensure that our nation's healthcare system remains robust, innovative, and patient-centered for years to come. Thank you for the opportunity to submit this statement for the record, and we look forward to continuing to engage with the Subcommittee on these critical issues.



*We Will Empower Bold Change to Elevate
Human Flourishing.SM*

Statement for the Record

Submitted by the Catholic Health Association of the United States (CHA)

U.S. House of Representatives
Committee on Ways and Means

Hearing: “Health System CEOs”

April 28, 2026

Chairman Smith, Vice Chair Buchanan, Ranking Member Neal, and Members of the Committee:

On behalf of the Catholic Health Association of the United States (CHA), thank you for the opportunity to submit this statement for the record. CHA represents the Catholic health ministry, a nationwide network comprised of more than 650 hospitals and 1,600 long-term care and other health facilities in all 50 states and the largest group of nonprofit health care providers in the nation. Every day, more than one in seven patients in the United States is cared for in a Catholic hospital.

Rooted in Catholic social teaching, our ministry has long supported accessible, affordable health care as a basic human right, while working to improve the health of the communities we serve. Catholic hospitals and health systems often serve as essential community anchors—delivering 24/7 emergency and trauma care, sustaining critical services (including maternity care, behavioral health, and specialized pediatric and neonatal care), and providing more than \$14 billion a year in community benefit programs tailored to local needs.

CHA shares the Committee’s commitment to lowering costs for patients and families. But policies to improve affordability must be grounded in an accurate understanding of what is increasing costs and what patients experience. Hospitals and health systems are not the only factors shaping what families pay. Affordability is influenced by patient acuity and utilization, workforce shortages and labor costs, the prices of drugs and medical supplies, coverage instability that drives uncompensated care, regulatory burdens, and administrative waste driven by insurer practices such as delays, denials, and prior authorization.

The Value of Not-for-Profit Catholic Health Care

Mission-based care and community benefit

Catholic health care is rooted in our mission to bring a healing presence to those most in need in our communities. In collaboration with member hospitals and health systems, CHA developed the first uniform standards for community benefit reporting by non-profit groups and worked closely with congressional leaders and the Internal Revenue Service to develop the guidelines that all tax-exempt hospitals have widely adopted. CHA also worked closely with the IRS to develop its Form 990 Schedule H for not-for-profit hospitals. Beyond their primary charitable purpose and community benefit activities, nonprofit tax-exempt hospitals continue to be critical anchor institutions in their communities. They invest in their local communities, employ millions of people, and create and support non-profit organizations and health innovations that go well above and beyond the requirements of the community benefit standard.

In a time of increasing pressures in the health care sector, safeguarding the unique not-for-profit status of Catholic and other nonprofit health care is critical to ensuring continued access to mission-based, community-focused care.

Putting community first amid financial pressures

Nonprofit hospitals are facing mounting financial pressure as reimbursement lags behind rising costs, and cost-containment strategies shift more of the health system's affordability burden onto providers. Despite these challenges, Catholic and other nonprofit hospitals continue to stand firmly with their communities—offering generous financial assistance, sustaining critical services, and investing in community benefit programs that would otherwise disappear. According to the most recently available IRS Schedule H 990 data, on average, CHA members' financial assistance policies provide free care up to 231% of the federal poverty guidelines (FPG) and discounted care for people up to 381% of FPG. That means a family of four making around \$130,000 per year may still be eligible for discounted care. However, the increasing use of health plans with high-deductible plans and the projected increase in the number of uninsured people means tax-exempt hospitals' financial assistance policies will face increasing challenges to meet the needs of the uninsured and those with inadequate insurance products.

Over the past five years, Catholic and other nonprofit hospitals and health systems have more frequently operated at a financial deficit compared with other hospital types, reflecting a commitment to maintaining access to essential services regardless of profitability¹.

The community return on tax exemption is substantial

Nonprofit tax-exempt hospitals provide far more in measurable community benefit than the value of federal revenue forgone from their nonprofit tax exemption status. National analyses show

¹ See Kaufman Hall, National Hospital Flash Report (monthly), which analyzes operating margins across U.S. hospitals using real-time financial data, and Kaiser Family Foundation (KFF), Hospital Margins Rebounded in 2023, But Rural Hospitals and Those With High Medicaid Shares Were Struggling More Than Others (Dec. 18, 2024), based on Medicare cost report data showing persistent margin disparities between nonprofit and for-profit hospitals.

that tax-exempt hospitals provide more than 11 times greater in community benefit than the value of forgone federal revenue. In 2022 alone, tax-exempt hospitals provided more than \$149 billion in total benefits to communities, including \$65.1 billion in financial assistance (also known as “charity care”) delivered through financial assistance policies and the absorption of underpayments from means-tested programs².

Catholic Health Association members contributed more than \$14.6 billion in community benefits in 2022. This included more than \$2.7 billion in financial assistance at cost, also known as “charity care,” and more than \$7.9 billion to cover the cost of unreimbursed Medicaid and other means-tested programs. Through this work, Catholic health providers invested in a wide variety of community health programs, including healthy housing, community partnerships, community grants, and other social, educational, and health interventions, as documented in their community health implementation plans and community benefit reports. These health promotion programs keep communities healthy. For individuals, this means not having to experience the trauma and personal costs of illness and not missing work or school. For the broader health system, this means reduced burdens and costs. Catholic health providers have done this despite facing ongoing financial struggles to meet the growing needs of the patients and communities that they serve³.

Providing Critical Health Services

One of the distinguishing features of nonprofit hospitals is that they are more likely than for-profit, taxable hospitals to provide needed health care services that are not profitable⁴. In many places, often rural or low-income communities, maintaining health care services needed in the community and/or keeping a hospital open is one of the largest benefits that a hospital can provide.

This commitment to maintaining essential services and access to care is critical to the work of the Catholic health ministry. According to a recently released study, Catholic hospitals “were more likely to preserve or expand access to mission-oriented services—such as chaplaincy and charity care—and were less likely than their non-Catholic counterparts to eliminate obstetrics care, even as many rural hospitals across the country are shuttering these units⁵. This study builds upon previous research that found that Catholic hospitals, compared to other hospitals, were more likely to provide charity care and community benefit services, more likely to provide HIV/AIDS and psychiatric care services, and more likely to operate obstetric care and neonatal intensive care units⁶. These are the services most often needed in communities, and as part of their charitable not-for-profit mission, Catholic hospitals continue to do their best to maintain

² See American Hospital Association (AHA), Tax-Exempt Hospitals Provided \$149 Billion in Total Benefits to Their Communities (Sept. 10, 2025), available at: <https://www.aha.org/guidesreports/2025-09-10-tax-exempt-hospitals-provided-149-billion-total-benefits-their-communities>

³ Susanna Vogel, “Nonprofit providers’ operating margins fall as more challenges loom,” Healthcare Dive, May 22, 2025. Available at: <https://www.healthcaredive.com/news/nonprofit-providers-operating-margins-fall-marketvolatility-washington-policy/748786/>

⁴ Jill R. Horwitz and Austin Nichols, “Hospital Service Offerings Still Differ Substantially by Ownership Type,” Health Affairs 41, no. 3 (2022): <https://doi.org/10.1377/hlthaff.2021.01115>.

⁵ Schulte A, Staiger B, Rodriguez HP, Brewster AL. Mission vs. Margin: The Effects of Catholic Health System Ownership on Hospital Operations. Medical Care Research and Review. 2025;0(0). doi:10.1177/10775587251355541

⁶ Id. Citing, Ferdinand et al. 2024; Zare & Gabow, 2023, White Et al., 2006, Garrido et al., 2012, Weisman et al 1999

and expand this care. The chart in Figure 1 illustrates how Catholic health care provides many of these “unprofitable” services at a greater rate than state/local government or investor-owned facilities. Ultimately, Catholic hospitals’ willingness to sustain these services strengthens affordability by keeping care local, preventing cost escalation, and protecting patients from the financial consequences of lost access.

PERCENT OF U.S. HOSPITALS OFFERING SELECTED PUBLIC HEALTH AND SPECIALTY SERVICES

Catholic hospitals often provide a higher percentage of public health and specialty services than other health care providers. These organizations’ dedication to the common good often leads them to offer these traditionally “unprofitable” services.

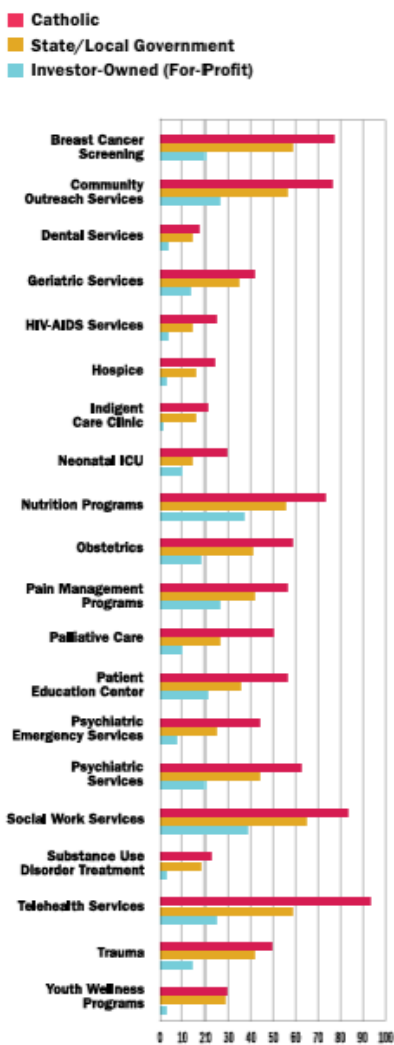


Figure 1

Current Challenges Across Providers

Patients are older, sicker, and more clinically complex

Hospitals care for an increasingly complex patient population, including patients with multiple chronic conditions and higher acuity needs. This reality affects staffing requirements, length of stay, and the intensity of services delivered. Recent national spending trends show that increased utilization and the intensity of services—more patients receiving more complex care—are central contributors to spending growth⁷.

Labor, supplies, and drugs are core pressures—especially for mission-driven providers

Catholic hospitals and health care systems face a “perfect storm of financial pressures” driven by rising costs, rising need, inadequate reimbursement, and policy choices that shift risk onto providers. Labor is the single largest hospital expense—approximately 60 percent of total hospital costs—and ongoing workforce shortages have forced hospitals to raise wages and rely on contract staffing⁸. Hospitals also face elevated costs for drugs, medical supplies, and equipment, including high-cost therapies and the continued effects of supply chain disruptions.

Coverage instability and underpayment are compounding cost pressures across the health system

The expiration of the Affordable Care Act’s enhanced premium tax credits has begun to significantly reduce coverage, with estimates projecting \$32.1 billion in lost provider revenue in 2026 alone, including \$14.2 billion less spent on hospital services, driving higher uncompensated care and threatening access, particularly in rural and underserved

⁷ Hartman M, Martin AB, Lassman D, Catlin A. *National Health Care Spending Increased 7.2 Percent in 2024 as Utilization Remained Elevated*. Health Affairs. Jan 14, 2026.

⁸ American Hospital Association, *The Cost of Caring*, <https://www.aha.org/costsofcaring>

communities⁹. At the same time, historic reductions to Medicaid under H.R. 1 are projected to increase hospital costs by \$443 billion over ten years due to deeper Medicaid shortfalls and coverage disruptions tied to new work and community engagement requirements, which are likely to lead to avoidable emergency department use and higher systemwide costs; based on CHA's internal analysis, Catholic health care alone is projected to lose nearly \$4 billion in a single year from reduced Medicaid reimbursement as a result of the law.¹⁰ Despite these growing demands, Medicare and Medicaid continue to underpay hospitals, reimbursing just 83 cents for every dollar of care provided in 2023, resulting in more than \$100 billion in annual underpayments and widening the gap between the cost of caring for patients and public program payments¹¹.

Administrative burdens and insurer payment practices are a major affordability problem

Patients experience the affordability crisis not only as high bills, but also as delayed care caused by prior authorization and inappropriate denials, including in Medicare Advantage and private insurance. Hospitals must devote substantial staff time and resources to secure payment for medically necessary care already delivered. These delays and denials of care by insurance providers resulted in almost \$18 billion spent on overturning denied claims and \$43 billion spent on efforts to collect payments from insurers.¹² These administrative burdens divert clinicians from patient care, contribute to burnout, and add costs without improving outcomes. Compounding these challenges, hospitals are also subject to increasingly complex and resource-intensive regulatory requirements—such as overlapping federal and state price transparency mandates—that require significant compliance investments but often fail to deliver usable or meaningful information for patients. Taken together, the cost of administrative staff, compliance infrastructure, and supporting technology is now estimated to account for roughly 25–35 percent of all health care spending, diverting limited resources away from direct patient care and access-preserving services.

What Catholic Health Care Is Doing Now to Advance Affordability

Catholic health care is already advancing affordability through prevention, innovation, and stewardship. Our members are working to address the root causes of costly hospital care, such as food and housing insecurity, expanding telehealth, shifting appropriate care to outpatient settings, and investing in the health workforce, including needed nursing programs. Catholic hospitals also maintain significantly lower operating costs than other nonprofit hospitals, demonstrating strong stewardship and efficiency¹³. Collectively, these strategies demonstrate that Catholic health care is advancing affordability by lowering unnecessary utilization while delivering high-value care rooted in stewardship.

⁹ Urban Institute, *Changes in Health Care Spending and Uncompensated Care under Enhanced Tax Credit Expiration for Marketplace Coverage* (Sept. 25, 2025)

¹⁰ Dobson & DaVanzo, *Trends in Margins, Costs and Revenues for Catholic Hospitals Compared to Other Hospitals by Ownership for FY 2019 – FY 2024* (January 13, 2026)

¹¹ American Hospital Association, *The Cost of Caring*, <https://www.aha.org/costsofcaring>

¹² Muoio, D. (2026, March 11). *AHA: Hospitals' total expenses rose by 7.5% in 2025*. Fierce Healthcare. <https://www.fiercehealthcare.com/providers/aha-hospitals-total-expenses-rose-75-2025>

¹³ Dobson & DaVanzo, *Trends in Margins, Costs and Revenues for Catholic Hospitals Compared to Other Hospitals by Ownership for FY 2019 – FY 2024* (January 13, 2026)

Addressing Root Causes to Prevent Costly Hospital Care

Catholic and other nonprofit hospitals and health systems care for the whole person—body, mind, and spirit—by addressing the social and economic barriers that often drive poor health and high-cost hospital utilization. National analyses show most (69.3%) of nonprofit hospitals identified social determinants of health as a significant health need in their community. They responded with initiatives focused on issues such as housing stability, nutrition, and other upstream factors¹⁴.

Nonprofit hospitals lead this work by screening patients for food insecurity, housing instability, and transportation barriers; embedding social care referrals into clinical workflows; and partnering with trusted community organizations to prevent crises before they require emergency care. For example, several of our members partner with Catholic Charities and other faith-based and secular non-profits to provide food assistance, transportation, and real-time connections to community resources; another member has implemented a *Food Is Medicine* program across its 25-state footprint; and one of our members launched a holistic program to address opioid use disorder among pregnant women. These mission-driven approaches reduce preventable emergency department visits and hospital admissions—improving outcomes, lowering costs, and strengthening the well-being of the communities Catholic and other nonprofit hospitals serve.

Expanding Telehealth and Virtual Care to Improve Access and Lower Costs

Telehealth is a cornerstone of Catholic health care’s affordability strategy, particularly for rural, remote, and underserved communities where access to clinicians and specialty services is limited. Catholic systems have pioneered fully virtual care models that provide continuous remote monitoring, improve chronic disease management, and reduce unnecessary in-person visits—contributing to significant reductions in emergency department utilization. In rural areas, Catholic providers are using telehealth to bring specialty services directly to patients, including telestroke, teleoncology, telecrisis, and telehospitalist support, while avoiding costly patient transfers and travel burdens. Remote monitoring programs also allow clinicians to identify early signs of deterioration and intervene before hospitalization is required. These efforts expand access, reduce out-of-pocket costs for patients, and keep care close to home, while ensuring that emergency departments remain available for those who truly need them.

Strengthening Outpatient, Ambulatory, and Home-Based Care to Improve Affordability

Catholic health systems are transforming how care is delivered by moving appropriate services beyond hospital walls and into outpatient, ambulatory, and home-based settings—advancing our commitment to human dignity, stewardship, and affordable access to care. Across the ministry, systems are expanding outpatient capacity, integrating digital navigation tools, and scaling telemedicine to create more seamless, patient-centered experiences.

¹⁴ Franz B, Burns A, Kueffner K, et al. *A National Overview of Nonprofit Hospital Community Benefit Programs to Address the Social Determinants of Health*. Health Affairs Scholar. Published December 6, 2023. <https://doi.org/10.1093/haschl/qxad078>

For example, one of our member systems has significantly expanded outpatient surgery, allowing more patients to return home the same day while preserving safety and quality, and another member has shifted appropriate care to ambulatory surgery centers and community-based settings to reduce reliance on high-cost inpatient care. Home health, transitional care, chronic disease management, and hospital-at-home models further help patients recover safely at home, prevent complications, and reduce avoidable hospitalizations and emergency visits—while supporting older adults, medically complex patients, and working families by keeping care close to home. Providing care in the most appropriate setting improves affordability, enhances patient satisfaction, and decreases unnecessary inpatient utilization while maintaining access to high-quality care.

Investing in the Workforce to Sustain Affordable Care

Health care affordability depends on a stable, well-supported workforce, particularly in communities facing chronic clinician shortages. Catholic health systems are investing in long-term workforce solutions by partnering with high schools, community colleges, and universities to build local nursing and clinical career pipelines; expanding externships, apprenticeships, and tuition support programs; and reducing reliance on costly agency staffing. Many Catholic providers are also strengthening team-based care by integrating community health workers and care coordinators, which has been shown to reduce readmissions, emergency department use, and avoidable hospitalizations while improving continuity and preventive care. Our members have raised that without sustained investment in the workforce, staffing instability and burnout will continue to drive higher costs, reduce access, and threaten hospitals' ability to meet community health needs. By stabilizing the workforce and supporting caregivers at every level, Catholic health systems help lower total costs, improve patient outcomes, and ensure sustainable access to care for the communities they serve.

Recommendations for Congress

CHA urges Congress to pursue a balanced, evidence-based affordability agenda that reduces waste, strengthens coverage, invests in the workforce, and preserves access, especially for rural and underserved communities.

- Strengthen and stabilize coverage in the ACA Marketplace, Medicaid, and Medicare to reduce uncompensated care and prevent avoidable utilization.
- Reduce administrative waste by reforming prior authorization and insurer payment practices, including inappropriate denials and delays.
- Invest in the health care workforce through education and training, and targeted strategies to address shortage areas, including in immigration policy.
- Lower prescription drug costs and address supply cost pressures that affect both hospitals and patients.

- Reject broad site-neutral payment reforms that fail to account for patient complexity and hospital standby costs, and that risk forcing service reductions or closures in hospital outpatient departments relied upon by rural and underserved communities.
- Reduce regulatory burden by ensuring price transparency policies are workable and aligned across agencies, enabling hospitals to provide clear, patient-friendly information without imposing costly, duplicative compliance demands that do not improve affordability or access.
- Preserve and strengthen the not-for-profit model and community benefit framework that sustains access and community health investments.

Conclusion

CHA shares the Committee's commitment to lowering health care costs for all Americans. Achieving lasting affordability requires policies that address the true drivers of cost growth: workforce shortages and labor costs, high-cost drugs and supplies, coverage instability, and administrative waste, while protecting the mission-based nonprofit infrastructure that sustains access in communities nationwide.

Through robust community benefit investments, Catholic health care helps advance affordability by investing in prevention, addressing social needs, increasing access to care and improving community health. These investments are reducing illness and complications of chronic disease, preventing avoidable utilization, and reducing the total cost of health care in our nation. CHA stands ready to partner with Congress on sustainable solutions that promote value, quality, and affordability while ensuring that patients, especially those who are poor, vulnerable, and medically underserved, can obtain timely care.



April 28, 2026

Ways and Means Committee
1139 Longworth HOB
Washington D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

The Chronic Care Policy Alliance (CCPA) appreciates the opportunity to provide input as the Ways and Means Committee holds hearings aimed at identifying improvements that can be made to the U.S. health system. We urge the committee to ensure that the 340B Drug Pricing Program works effectively and lowers costs for patients.

The 340B program plays an important role in supporting safety-net providers and improving access to care for low-income and underserved patients. However, as the program has evolved, ongoing questions about transparency, accountability, and oversight have raised concerns about whether its current structure consistently ensures that savings are reaching patients.

The rapid growth of contract pharmacies and increasing vertical integration among program participants has added further complexity and underscores the need for clearer guardrails and greater visibility into how program funds are generated and used. At the same time, there is growing, bipartisan recognition that reforms are needed to strengthen the program and ensure it more effectively supports patients and the providers who serve them.

CCPA supports efforts by Congress to explore reforms to the program to improve the program's transparency and accountability. Reforms should focus on requiring greater visibility into program use and allow for clearer tracking of how 340B savings are generated and ultimately used.

Importantly, efforts to reform the 340B program should be viewed as an effort to strengthen, not weaken, the program. Calling for greater transparency and clearer expectations is not a call to dismantle 340B, but rather to ensure it functions in a way that more directly benefits the patients it is intended to serve. Strengthening oversight and transparency will be essential to ensuring the program delivers for patients in a more consistent and measurable way.

Thank you for your consideration and your continued commitment to patients.

Sincerely,

A handwritten signature in blue ink that reads "Elizabeth Helms". The signature is fluid and cursive, with the first name being more prominent.

Elizabeth Helms
CEO
Chronic Care Policy Alliance (CCPA)
lizh@chroniccarealliance.org



Statement for the Record

House Ways and Means Committee
Full Committee Hearing with Health System CEOs

Prepared by:
Consumers for Fair Hospital Pricing

April 28, 2026

Chair Smith and Ranking Member Neal:

On behalf of the *Consumers for Fair Hospital Pricing* coalition and allied organizations representing families, health care consumers, employers, and workers across the United States, we want to thank you for holding this important and timely hearing on the role of large hospital corporations in driving unaffordable health care. We sincerely appreciate all of the Members and witnesses who are lifting up the impact that skyrocketing health care costs have on people all across this country.

Across the country, America's families are sounding the alarm: the cost of health care is too high, the system too complex, and relief is desperately needed. An estimated 72.2 million—or nearly one in three¹—American adults did not seek needed care in the past three months due to cost.² When people in the U.S. do seek care, they are burdened with unmanageable costs and often forced to choose between basic necessities, such as housing and food, and paying their health care bills. Now, over 40% of U.S. adults — an estimated 100 million people—face medical debt they may never be able to pay off.³

Our health care affordability crisis is largely driven by unchecked health care industry consolidation — **particularly among hospitals** — that has eliminated healthy competition and led to irrational and inflated health care prices that have little to do with the actual cost or quality of the care they offer.⁴ As a result, between 1990 and 2024, health care prices, and hospital prices in particular, have increased by more than 500%. Hospital expenditures now account for nearly one-third of U.S. health care spending and grow more than four times faster than workers' paychecks.⁵

Policymakers have taken steps in recent years to begin to tackle this problem, including the recent passage of billing transparency reforms that will help ensure large hospital systems do not overcharge for the care they deliver in outpatient settings. Yet much more is needed to meaningfully address the root causes driving unaffordable American health care. **Congress must waste no more time in taking on the health care industry's anticompetitive behaviors and the misaligned incentives that are driving up costs for families in order to provide real relief to the American people.**

To that end, we urge the House Ways and Means Committee to advance an agenda that prioritizes health care affordability for American families and holds corporate health systems accountable for charging excessive prices. The list below of pro-consumer reforms to the health care system are proven solutions that would put money back in people's pockets, are overwhelmingly popular with voters across the political spectrum,⁶ and have strong bipartisan and bicameral support in Congress:

- Prohibit health systems from charging Medicare more for the same procedure if performed at a hospital facility instead of a doctor's office, saving an estimated \$157 billion over 10 years.⁷ (84% of voters support)
- Strengthen hospital and health plan price transparency by requiring all hospitals and health plans to disclose their negotiated rates in dollars and cents with no exception. (91% of voters support)
- Prohibit anticompetitive contracting terms including between providers and insurers such as "all-or-nothing," "antisteering," and "antitiering" clauses in provider and insurer contracts and noncompete clauses in employee contracts that limit patient access to alternative sources of higher-quality, lower-cost care, saving \$3.2 billion to \$194 Billion over 10 years.⁸ (78% of voters support)

Consumers for Fair Hospital Pricing and the undersigned allied organizations look forward to the discussion today and to working with you to enact bipartisan and commonsense improvements to our nation's health care payment and delivery system. We stand ready to support you in this essential and urgently needed work. Please contact Jane Sheehan, Deputy Senior Director of Government Relations at Families USA, JSheehan@familiesusa.org, for further information and to let us know how we can best be of service to you.

Sincerely,

Consumers for Fair Hospital Pricing

Colorado Consumers Health Initiative
Consumers for Affordable Healthcare, Maine
Consumers for Quality Care
Families USA
Health Access California
Iowa Citizen Action
Pennsylvania Health Access Network
U.S. PIRG
Utah Health Policy Project

Allied Organizations

ACA Consumer Advocacy
AFSCME
Access Care Anywhere, Oregon
Autistic Women & Nonbinary Network
BLKHLTH
California LGBTQ Health and Human Services Network
Children's Advocacy Alliance, Nevada
Citizen Action Wisconsin
Coalition of Texans with Disabilities
Colorado Latino Leadership, Advocacy & Research Organization (CCLARO)
Connecticut Health Policy Project
Consumer Action
Disciples Center for Public Witness (Disciples of Christ)
Doctors for America
El Centro, Inc.
Georgia Watch
Health Care for America Now (HCAN)
Iowa Citizen Action
Kintegra Family Medicine
Long Term Community Care Coalition, New York
Lupus and Allied Disease Association, Inc.
Main Street Alliance

Maine People’s Alliance
Metro NY Healthcare for All
MoveOn.org
National Alliance of Healthcare Purchaser Coalitions
National Consumers League
Network Lobby for Catholic Social Justice
New Jersey Citizen Action
North Carolina Justice Center
Northwest Health Law Advocates
Organization for Latino Health Advocacy
Pearl Suite, California
Serving At-Risk Families Everywhere (SAFE)
Small Business Majority
South Carolina Appleseed Legal Justice Center
Vermont NEA
Virginia Organizing
Tennessee Justice Center
West Virginians for Affordable Healthcare
West Virginia Center for Budget and Policy
Young Invincibles

¹ West Health-Gallup, “West Health-Gallup Health Care Affordability and Value Indexes 2021-2024”, July 2024, [https://westhealth.org/news/new-study-reveals-more-struggling-to-affordhealthcare/#:~:text=Forty%2Dfive%20percent%20of%20American,3%25\).](https://westhealth.org/news/new-study-reveals-more-struggling-to-affordhealthcare/#:~:text=Forty%2Dfive%20percent%20of%20American,3%25).)

² Emma Wager, Jared Ortaliza, and Cynthia Cox, How Does Health Spending in the U.S. Compare to Other Countries?, PetersonKFF Health System Tracker, January 21, 2022, <https://www.healthsystemtracker.org/>. See also, Nisha Kurani, Emma Wager, How does the quality of the U.S. health system compare to other countries?, PetersonKFF Health System Tracker, September 30, 2021. <https://www.healthsystemtracker.org/>.

³ Noam N. Levey, “100 Million People in America Are Saddled With Health Care Debt,” KFF Health News, June 16, 2022, <https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medicaldebt/>.

⁴ Robert A. Berenson, Jaime S. King, and Katherine L. Gudiksen, “Addressing Health Care Market Consolidation and High Prices,” The Urban Institute, January 2020, <https://www.urban.org/research/publication/addressing-healthcare-market-consolidation-and-high-prices>. See also, “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services,” Congressional Budget Office, September 2022, <https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf>.

⁵ U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Hospital and Related Services in U.S. City Average [CUUR0000SEMD], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/CUUR0000SEMD>, January 8, 2025. See also, Drew DeSilver, “For Most U.S. Workers, Real Wages Have Barely Budged in Decades,” Pew Research Center, August 7, 2018, <https://www.pewresearch.org/short-reads/2018/08/07/for-most-us-workers-real-wages-have-barely-budged-for-decades/>; Matthew McGough, et al., “How has U.S. spending on healthcare changed over time?” Peterson-KFF Health System Tracker, December 20, 2024, <https://www.healthsystemtracker.org/chart-collection/u-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20%20per%20capita,%201970-2023>

⁶ https://familiesusa.org/wp-content/uploads/2025/10/102125_Families-USA-Online-Survey_Affordability_Final.pdf

⁷ Options for Reducing the Deficit: 2025 to 2034 (Congressional Budget Office, December 2024), <https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf>.

⁸ “S. 2840, Bipartisan Primary Care and Health Workforce Act: As reported by the Senate Committee on Health, Education, Labor, and Pensions on November 8, 2024,” Congressional Budget Office, November 8, 2024, <https://www.cbo.gov/system/files/2024-02/s2840.pdf>; “Noncompetes: What You Should Know”, Federal Trade Commission, 2023, <https://www.ftc.gov/news-events/features/noncompetes>.



May 5, 2026

Children's Hospital Association Statement for the Record U.S. House Ways and Means Committee: Hearing with Health System CEOs

The Children's Hospital Association (CHA) is the nation's leading advocate for children's health, uniting children's hospitals to improve care and amplify impact. On behalf of the more than 200 children's hospitals and the millions of children and families we serve, we appreciate the Committee's attention to strengthening the health care system for patients in communities across the country. Ensuring that children can access timely, specialized care requires a continued federal commitment to a strong and sustainable pediatric health care system. As the Committee examines policy solutions to address affordability, we strongly recommend a specific focus on the unique needs of children. We stand ready to work with you on policies that strengthen children's access to needed health care.

When it comes to health care, children are not little adults. The same is true of the providers and hospitals that take care of them, which have very different needs than adult hospitals. As you explore affordability and broader policies to improve the health care system for patients, we ask you to consider these priorities:

- **Protect and strengthen Medicaid for children.** Medicaid covers nearly half of all children in our country and provides coverage for more than half the children cared for in children's hospitals. Because of this, Medicaid is the backbone of the pediatric health care system. Last year, significant changes were made to Medicaid that will roll out over the next several years and threaten access to care at children's hospitals. We would like to work with the committee to ensure implementation of these changes protect children and do not exacerbate current access to care problems for children enrolled in Medicaid. Thank you for passing the Accelerating Kids' Access to Care Act and eliminating scheduled Disproportionate Share Hospital (DSH) payment cuts through FY 2027. Accelerating Kids' Access to Care will reduce red tape for families and streamline Medicaid provided out-of-state care for children and continued DSH funding directly supports children's hospitals and the critical care provided to children.
- **Boost the Pediatric Workforce.** Access to care and the future of children's health is directly tied to the strength of the pediatric workforce. Like adult providers, children's hospitals face serious difficulties recruiting and retaining physicians and non-physician clinicians. However, pediatric clinicians need additional specialized training which leads to more education debt and often have lower reimbursement rates than their adult counterparts. We ask you to prioritize ways to bolster this workforce and reduce administrative burdens. Specifically, we ask for strong support for the Children's Hospitals Graduate Medical Education (CHGME) program to ensure pediatric training at children's hospitals is sustainable. CHGME training is a main pipeline for the pediatricians and pediatric specialists who care for our nation's children. CHGME hospitals train more than 90% of certain pediatric subspecialists, serve 99.6% of all counties in the U.S., and are responsible for 80% of the increase in the number of new pediatric subspecialists since the program's inception in 1999. Learn more about our proposals to boost the pediatric workforce in our newly released **blueprint**.
- **Address the Youth Mental Health Crisis.** Far too many children and adolescents face challenges accessing needed mental health services. Finding mental health providers and being able to afford care when it is found is a real issue for families. Ensuring the Medicaid program is fulfilling its commitment to providing needed care and examining ways to support patients and families with private coverage are key to making progress for children with



behavioral health needs and their families. We also encourage the committee to pass Reps. Pfluger, Castor, Joyce, and Schrier's EARLY Minds Act (H.R. 1735) to expand access to mental health care for children and adolescents at the earliest signs of need.

- **Elevate Healthy Kids.** We ask you to explore policies that bolster care for children, including protecting the reach of children's hospitals to provide care closer to children's homes and communities; protect the 340B program, which supports care for children, invest in pediatric medical research, and prioritize policies that improve children's health and reduce chronic illness.

Adopting policies in these areas will improve care for children and their families and increase their satisfaction with the health care system while providing lifelong benefits and cost-effective outcomes for them and our country.

Impact of Proposed "Site Neutral" Policies on Access to Care for Children

Children's hospitals care for children with the most complex and challenging conditions in pediatrics. As regional care providers, hospital-based clinics extend critical care, urgent care, emergency services, and specialized services found at a hospital to a location closer to home for patients.

CHA opposes site neutral policies, including eliminating "facility fees" or other policies, that decrease support for pediatric outpatient care, directly reducing children's ability to access needed specialized care. Congress has considered various proposals to establish site neutral and other payment policies that would reduce support for hospitals. Including children in these policies under Medicare or private insurance will significantly reduce support for clinics and outpatient departments located closer to where children live. The result will be disruptions in access to specialized, team-based care for children with medical complexity that is generally not offered by physician offices.

- **Under site neutral policies, there will be less support for children's hospitals to sustain, expand, and open outpatient facilities farther from the hospital, which would discourage the promotion of community-based care.** Children should not be forced to travel long distances away from home, family members, school and their community solely to hospital campuses for their appointments.
- **Patient access to timely care could be restricted, especially for children with medically complex conditions who are sicker and are cared for more frequently in ambulatory, outpatient settings.**
- **Rural communities may lose access to outpatient facilities that the hospital can no longer afford to keep open with negative implications for children with medical complexity who need coordinated care that continues outside the hospital setting.** Often, families do not have direct access to specialized pediatric services in their immediate community and must travel long distances to receive care, a situation exacerbated by national shortages of pediatricians and pediatric specialists. To improve access, in many cases, children's hospitals provide off-campus specialty services in different areas of their own states or other states.
- **Site neutral policies directly impact children's hospitals' ability to pay the salaries of staff, maintain needed equipment and technology, and keep the outpatient departments running.** Children's hospitals use site neutral fees to pay staff, including nurses, nursing assistants, behavioral health therapists, social workers, and child life specialists to support an integrated team-based approach to care for children. The fees also support security guards,



maintenance of buildings, expansions to provide access to meet growing needs, and integrated electronic medical records.

- **Specialized outpatient clinics provide critical triage support during public health and other emergencies by supporting children who can be cared for effectively in an outpatient department rather than taking scarce inpatient beds.** We saw this occur during the RSV crisis a few years ago.

Transparency for Patients

We support providing patients and their families information on health care costs and currently comply with the growing number of federal and state requirements. In addition, children's hospitals have developed and use their own consumer-friendly tools to provide price information to families. Children's hospitals want to ensure that any new requirements align with already existing state and federal policies, provide meaningful information for patients and families, and do not result in administrative burdens that require significant staff time and resources without providing actionable benefits to the children and families.

Medicare and Pediatrics

Medicare covers only a very small number of children but is often the driver of policies on affordability and transparency that can affect their care. However, these new systems and requirements do not make sense for very low Medicare providers, such as children's hospitals. Therefore, Medicare policies, including Medicare site neutral policies and Medicare driven price transparency requirements, should not be applied to children and children's hospitals.

Innovating Care for Children

Each day children's hospitals are advancing care for children and implementing ways to provide more effective and efficient care to their patients. They are providing more real-time information to patients on care and costs, adopting new care delivery and payment models that support the highest quality of care, expanding access to community-based care, addressing behavioral health challenges, investing in the pediatric workforce, and embracing new technologies, like AI, in ways that improve care for children. Children's hospitals are pillars in their communities, prioritizing services and supports inside and far outside of their facilities. There is much promise in these practices and at CHA we work to spread those practices throughout the children's health and children's hospital communities. Developing policies to support and sustain these efforts through Medicaid and other payors will directly impact patient experience and better manage costs in the system.

Children's hospitals are facing significant headwinds with Medicaid cuts looming, a growing list of policy and regulatory requirements, downward pressure on pediatric research funding, delays and reductions in grant support for community-based initiatives, and threats to policies like the 340B program that demonstrate real patient value. We ask for thoughtful consideration of these pressures and impact before levying additional reductions and requirements. We support your goal of better supporting children and families and want to work with you on ways of proceeding that don't threaten the foundation of children's health care and the providers and hospitals that care for them.

Thank you for the opportunity to submit a statement for the record. We look forward to continuing to collaborate with the Committee in its goal to better support children and families.

Statement for Hearing with Health System CEOs

House Committee on Ways and Means

April 28, 2026

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

AHIP is committed to working with the Committee to address the core drivers of health care affordability throughout the entire health care system. Patient costs, in the form of insurance premiums, ultimately reflect the underlying costs of care – hospital services, prescription drugs, physician visits, diagnostics, and more. Health plans play an essential role in helping to bring down these costs by negotiating more competitive hospital rates and directing patients towards high-value care. Plans use data-driven tools to support value-based care models, identify cost variations, and promote more efficient care delivery. These core functions help reduce rising medical costs, reduce waste, and ensure high quality care.

AHIP's statement for the record focuses on the role health plans play in protecting consumers from the full impact of rising health care costs as well as practical policy steps Congress can take to improve affordability of hospital costs and modernize practices while aligning incentives across the system and meeting the needs of consumers. We support efforts in Congress to advance common-sense policies that tackle soaring hospital costs, ensure honest billing, and promote competition to make health care more affordable.

Rising Hospital Costs Keep Pushing Consumers' Premiums Higher

Health care affordability remains out of reach when hospital systems continue to raise their prices at rates that outpace inflation, accompanied by opaque fees that drive up costs for every American. AHIP's most recent analysis shows that 40.7 cents of every commercial market premium dollar Americans pay now goes to hospital costs, more than any other category.¹

¹ <https://www.ahip.org/resources/where-does-your-health-care-dollar-go>

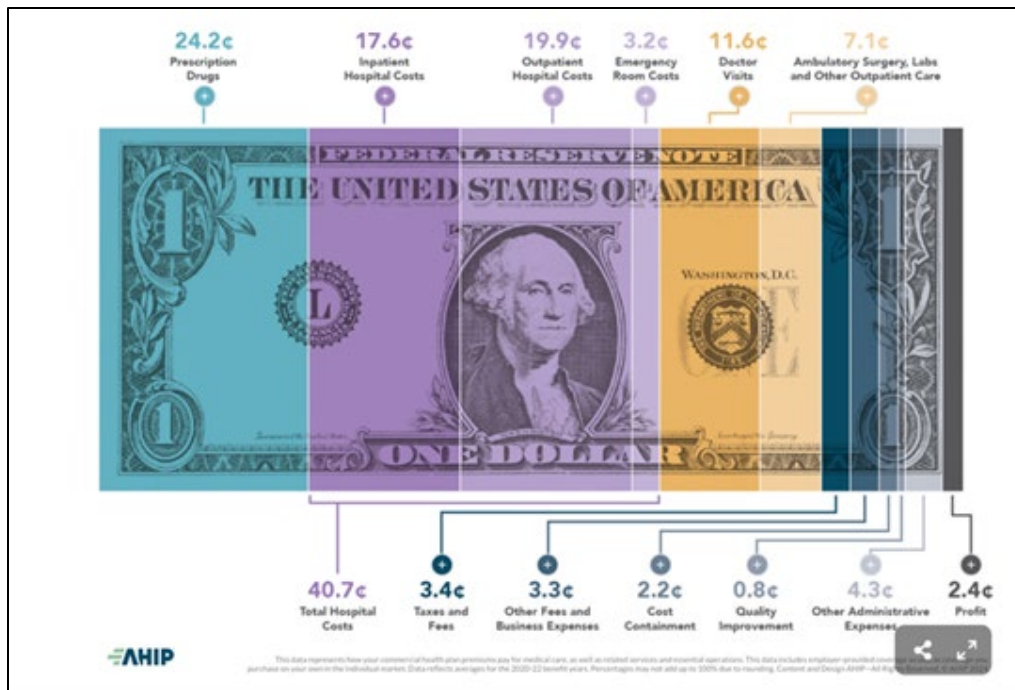


Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf.

Hospital systems play a central role in rising health care costs and are one of the most significant cost pressures facing consumers and employers today. Hospitals alone accounted for 40 percent of national health spending growth from 2022-2024, far outpacing all other care categories.² Furthermore, in 2024 alone, spending on hospital services reached a staggering \$1.6 trillion.³ Ever-higher hospital spending places significant and growing pressure on the broader health care system. Since health insurance premiums directly reflect the cost of medical care, rising hospital costs flow directly through to the monthly premiums families and employers pay each month.

Hospital systems – especially large, consolidated hospital systems – are at the center of unsustainably rising costs. As they relentlessly acquire independent physician practices, consolidated systems increasingly bill routine services performed in doctors’ offices as hospital-based care. Meaningfully addressing certain hospital business practices is one of the most important steps toward bringing costs down.

Anticompetitive Hospital Consolidation

A major reason hospital costs continue to rise is the growing concentration of market power within the hospital sector through consolidation, private equity ownership, and billing practices

² <https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/>

³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.01683>

that push routine care into higher-cost settings. Taken together, this creates an environment where patients and employers face escalating costs year after year without corresponding improvements in value.

The evidence is unequivocal: when health care providers consolidate and create a monopoly, prices go up. In a systematic review of 16 studies of horizontal hospital consolidation, researchers found price increases in every single study.⁴ Recent studies estimate price increases of 4-6 percent from hospital consolidation, though increases were as high as 65 percent.⁵

Decades of consolidation among hospitals have shifted the negotiating power in many local markets – and higher prices have followed. Larger hospital systems use their market leverage to demand higher prices and reimbursement from health plans, employers and consumers. Over time, those higher prices become the new threshold for negotiations, leaving families and employers paying more, often without any improvement in access or the quality of care provided.

- **Recommendation:** AHIP urges policymakers to promote greater competition among hospitals by blocking anticompetitive hospital mergers. While federal authorities have successfully challenged provider mergers in the past, many are uncontested due to a lack of resources or because the size of the merger does not trigger federal oversight.⁶ AHIP urges policymakers to scrutinize provider mergers for anticompetitive impacts, combat anticompetitive hospital contract terms, and support health plan-provider integration that improves care efficiency and lowers costs.⁷

Anticompetitive Contracting Terms Raise Costs

Health plans create networks to provide access to high-quality, affordable care for enrollees. Many plans experience significant difficulties in contracting due to anticompetitive provider practices like “all-or-nothing” contracting and anti-tiering clauses. “All-or-nothing” contracting requires health plans to include an entire health system in a network, even when only a small number of providers are necessary to meet network adequacy standards. Additionally, anti-tiering clauses prevent plans from placing providers on particular network tiers as part of their contract agreement.

These practices, when combined with network adequacy requirements, inappropriately increase provider leverage in negotiations and drive up health care costs for consumers. Certain providers or facilities can use network adequacy rules to demand increased rates, additional network

⁴ <https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/environmental-scan-consolidation-hcm.pdf>

⁵ Ibid

⁶ <https://www.kff.org/health-costs/issue-brief/understanding-the-role-of-the-ftc-doj-and-states-in-challenging-anticompetitive-practices-of-hospitals-and-other-health-care-providers/>

⁷ <https://www.ahip.org/resources/make-provider-markets-more-competitive>

contracts for other member or system facilities, or inappropriate placement in a particular network tier. Provider consolidation amplifies these challenges, making negotiations extremely challenging despite good faith contracting efforts by plans.

- **Recommendation:** AHIP urges Congress to explore legislative options to combat anticompetitive hospital contract terms. Targeted reforms to address “all-or-nothing” contracting and anti-tiering clauses would help restore balance to negotiations, reduce certain providers’ ability to leverage network adequacy rules to demand higher rates, and give health plans greater flexibility to build affordable, high-value networks for consumers.

Program Integrity: Ensuring Fair and Appropriate Hospital Billing

Health plans are advocates of program integrity across the commercial market and public programs and have long supported strong program integrity measures to protect taxpayers and consumers. Efforts to reduce health care costs must include a serious focus on eliminating fraud, waste, and abuse in hospital spending.

Certain hospital practices – such as overbilling, opaque pricing, and charging hospital-level prices for routine care – add billions of dollars in avoidable costs to the system each year and directly increase Americans’ premiums and out-of-pocket expenses. Greater transparency and accountability are essential to ensuring hospitals are paid fairly for care, not rewarded for wasteful spending.

For example, hospitals are increasingly billing health plans for more complex care than what was actually delivered, ballooning health care spending.⁸ Significant price variation among common hospital-administered drugs also exists; for many, pricing remains “opaque,” with hospitals often listing multiple prices for the same drug on the same day, despite federal transparency rules.⁹ Hospitals substantially mark up drug costs for commercial health plans, charging 50 percent to 103 percent more than specialty pharmacies for the same drug.¹⁰ These markups increased commercial insurance premiums by \$13.1 billion in 2024 alone, forcing patients to pay even higher costs for already expensive prescription drugs.

These trends make it clear that stronger program integrity safeguards are needed to address wasteful spending and opaque billing by hospital systems in order to lower costs for patients, employers, and taxpayers.

⁸ <https://www.bcbs.com/news-and-insights/report/ai-boosting-hospital-billing>

⁹ <https://www.axios.com/2026/03/05/disparities-hospital-drug-prices>

¹⁰ <https://www.ahip.org/news/press-releases/new-research-highlights-premium-impact-of-provider-markups-on-specialty-drugs>

Excessive Site-of-Care Price Variation

Hospital consolidation does not just raise prices for Americans; it impacts where care is delivered and how care is billed. Routine services increasingly billed in hospital outpatient departments – instead of physician offices or ambulatory surgical centers – come with significantly higher prices. A recent analysis found that for services commonly provided in both settings, prices in hospital outpatient departments were consistently higher than in physician offices, with prices ranging up to 13 times higher for the exact same services.¹¹ For patients, it is often "the same visit, higher bill." These increased fees and other opaque hospital billing practices mean higher premium costs year after year.

We thank Congress for requiring off-campus hospital outpatient departments to obtain unique National Provider Identifiers (NPIs) and submit provider-based attestations to receive Medicare payment in the recent CAA of 2026, but more must be done.¹²

- **Recommendation:** Protecting Medicare beneficiaries with site-neutral payment reforms will help level the playing field on prices, reduce patient cost-sharing, and lower premiums – saving more than \$170 billion over 10 years.¹³ Additional studies show that adoption of these reforms can lead to \$898 billion in savings and a 5% premium reduction in the commercial market.¹⁴ Congress should pursue policies that equalize payments for provider-based, off-campus outpatient clinics for low-acuity services with that of physician offices, and require upfront patient disclosure notices when physician offices convert to provider-based, off-campus clinics so patients are aware of higher out-of-pocket costs.

The Growing Role of Private Equity in Hospital Care

As of February 2025, 488 U.S. hospitals were owned by private equity firms, and at least 27 percent of private equity-owned hospitals are in rural communities.¹⁵ This ownership trend regularly translates into access and affordability challenges, including higher prices, for patients.

Research shows that private equity ownership results in inflated sticker prices for care and higher negotiated prices between hospitals and commercial health plans. One study found that after private equity takeover of a physician practice, the average bill submitted to a health plan rose by 20 percent, and the average payments health plans made rose by 11 percent – despite the fact that patients were no sicker than those treated by comparable practices across that same time

¹¹ <https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings/>

¹² The Consolidated Appropriations Act, 2026, Section 6255

¹³ <https://www.cbo.gov/budget-options/60908>

¹⁴ [Impact of Site-Neutral Payments for Commercial and Employer-Sponsored Plans - PMC](#)

¹⁵ <https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/>

period.¹⁶ In addition to appropriately raising prices, private equity's focus on short-term profits often leads to reduced health care staffing, stretching workers further and putting patients at risk.¹⁷ These studies demonstrate that when outside investment groups who are focused on profit, not patient care, acquire local providers, costs increase and quality suffers.

- **Recommendation:** AHIP urges policymakers to enforce and publicly disclose existing hospital cost reporting requirements on private equity investment and real estate holding companies. Hospitals should also be required to disclose staffing arrangements with private equity-backed provider groups, including the compensation structure and any incentives.

Health Plans are Working to Make Health Care Coverage as Affordable as Possible

Simplifying Prior Authorization

Health plans are the only part of the system that does not benefit from higher utilization or higher prices. Health plans are incentivized to help ensure patients receive the right care at the right time. Because unnecessary costs and excessive reimbursements lead directly to higher premiums, health plans – which compete for members in robust markets – are structurally motivated to reduce low-value care, reinforce clinical best practices, and drive better outcomes.

As part of this role, prior authorization is an important, value-based tool used to ensure care is safe, evidence-based, and as affordable as possible. Health plans have invested heavily in developing and improving electronic prior authorization options, which reduce administrative burden for providers, accelerate patient access to necessary treatments, and minimize delays in care. However, nearly half of prior authorization requests (45 percent for medical services and 47 percent for prescription drugs) are manually submitted by providers using phone, fax or traditional mail – creating inefficiencies and friction for patients. As plans adopt electronic prior authorization (ePA) that integrates into electronic health records by January 1, 2027, a coordinated effort from both plans and providers will be essential to fully streamline the prior authorization process to the benefit of patients and eliminate manual processes.

Last June, health plans announced a series of commitments to streamline, simplify and reduce prior authorization. These new actions will connect patients more quickly to the care they need while minimizing administrative burdens on providers. These commitments are being implemented across insurance markets, including for those with MA, Commercial coverage, and Medicaid managed care consistent with state and federal regulations, and will benefit nearly 270 million Americans.¹⁸

¹⁶ [Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization | Health Policy | JAMA Health Forum | JAMA Network](#)

¹⁷ <https://www2.nber.org/digest/202104/how-patients-fare-when-private-equity-funds-acquire-nursing-homes>

¹⁸ <https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization>

During our first update on progress, we announced leading health plans eliminated 11 percent of prior authorizations across a range of medical services. This reduction is helping to ease administrative burdens and speed access to evidence-based care ahead of ePA adoption in 2027. Health plans also affirmed improvements that make it easier for members who switch insurance to maintain their prior authorization approvals, known as continuity of care, and enhanced communications on prior authorization determinations.

Moving towards 2027 when commitments related to achieving real time responses as part of a faster, more standardized and simplified experience, take effect, health plans recently announced the adoption of a standardized approach for providers submitting electronic prior authorization requests for the majority of medical services. The standardized approach will be used for medical services that are commonly subject to prior authorization, such as orthopedic surgeries and imaging services, including CT scans and MRIs. These services span commercial coverage, Medicare Advantage and Medicaid managed care. Additional services will be added over time with the goal of supporting the widest possible adoption by 2027.¹⁹

Driving Solutions to Reduce Chronic Disease

Meaningfully addressing the drivers of preventable chronic disease requires tailored support and strong collaboration across the health care system. Health plans are uniquely positioned to drive effective prevention efforts through their close engagement with patients, providers, employers, community-based organizations, and policymakers. Together, they can lead efforts that improve health outcomes and reduce avoidable costs, supporting greater affordability across the system.

To help confront the chronic disease epidemic, AHIP convened a Task Force of Chief Medical Officers and public policy leaders from more than 30 health plans – representing about 200 million covered Americans – to identify evidence-based strategies to reduce chronic disease prevalence by at least 10 percent by 2035. The resulting roadmap emphasizes stronger prevention, earlier intervention, and more effective care management, supported by policy changes that facilitate progress.

AHIP encourages policymakers to modernize policies that promote healthy behaviors, strengthen value-based care models focused on chronic disease prevention, support technology and data interoperability to better enable coordinated patient care, and provide greater flexibility for benefit designs that help people prevent and manage chronic conditions.

Conclusion

AHIP thanks the Committee for its attention to the growing impact of hospital pricing on rising health care costs. As Congress considers these challenges, AHIP appreciates the opportunity to comment on ways to improve affordability in hospital and provider markets while preserving

¹⁹ <https://www.ahip.org/news/articles/health-plans-take-next-step-to-streamline-and-simplify-prior-authorization-for-patients-and-providers>

access to high-quality care. AHIP looks forward to continuing to work collaboratively with the Committee to identify and implement common-sense, market-based policy solutions that make the health care system more affordable for patients and families and more sustainable for the country over the long-term.



AMERICAN BENEFITS --- COUNCIL

Statement for the Record

U.S. House of Representatives
Committee on Ways & Means

Hearing with

Health System CEOs

Submitted by the American Benefits Council

April 28, 2026

Dear Chair Smith and Ranking Member Neal:

On behalf of the American Benefits Council (“the Council”), I want to thank you for holding this hearing examining the role of health systems within the current state of health care affordability. This committee has taken significant steps over the last several years to advance bipartisan policies that target the root causes of rising health care costs – namely a lack of transparency and competition and misaligned incentives that drive higher-cost care. **We urge Congress to advance important policies that target these root causes of rising health care costs to make health care more affordable for employers and working families.**

The Council is a national non-profit organization dedicated to protecting employer sponsored benefit plans. The Council represents more major employers – over 220 of the world’s largest corporations – than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or support health and retirement plans covering virtually all Americans participating in employer-sponsored programs.

Providing health coverage to more than 181 million Americans,¹ employers play a critical role in the health care system and drive innovations from which the entire health system benefits. With a vested interest in securing the health and well-being of their employees, employers deliver high-value, innovative health coverage to workers and their families. However, employers are deeply concerned about rising costs and other impediments to value and innovation.

Rising health care prices are placing an increasingly large burden on American employers and workers. According to a survey by the Kaiser Family Foundation, annual premiums for employer-sponsored health coverage reached \$26,993 in 2025, an increase of 6% from the prior year, with workers, on average, paying \$6,805 toward that cost.² Employers are bracing for even higher costs this year.³ This trajectory is unsustainable for employers, employees and their families.

The only way to truly make health care more affordable for employers and working families is to understand and address the root causes of rising spending: (1) misaligned incentives that promote hospital and provider consolidation and higher-cost care and (2) a lack of transparency. Hospital spending is the largest health spending category in the United States, and hospital prices are a primary driver of rising health care costs for

¹ [U.S. Census Bureau, *Health Insurance Coverage in the United States: 2024* \(September 2025\)](#)

² [Kaiser Family Foundation, *2025 Employer Health Benefits Survey* \(October 22, 2025\)](#)

³ [Mercer, “Employers prepare for the highest health benefit cost increase in 15 years” \(September 3, 2025\)](#)

employers and workers.⁴ Therefore, examining and addressing the factors fueling higher hospital costs is essential to lowering health care costs for all Americans.

While employers continue their efforts to lower health care costs, federal legislative solutions are needed to create a more competitive, transparent health care marketplace and to remove payment distortions that drive higher cost care. We applaud Congress for including in the Consolidated Appropriations Act, 2026 important policies to ensure fair and transparent hospital billing practices and to provide greater transparency and accountability for pharmacy benefit managers. We urge Congress to build on these efforts and take additional action to lower health care costs. Specifically, **the Council strongly supports legislation to:**

- **Expand site-neutral payment reforms**
- **Modernize the 340B drug pricing program**
- **Ensure greater transparency in the health care system**
- **Restrict anti-competitive contracting provisions**

EXPAND SITE-NEUTRAL PAYMENT REFORMS

As noted above, hospital spending is the largest health spending category in the United States. Hospital costs account for 44% of total personal health care spending for the privately insured and hospital price increases are key drivers of recent growth in per capita spending among these individuals.⁵ Rising prices for hospital services have contributed to a nearly 50% increase in private health plan spending from 2012 through 2022.⁶ This spending is being fueled by hospital consolidation and vertical integration with physician practices. In concentrated markets, prices do not flow from competitive market negotiations, but from the outsized leverage that market concentration affords. Consolidation corrodes the competitive market forces needed to align health care costs with value, resulting in higher costs for plans and patients alike⁷ without higher quality or access.⁸ At the same time, many private hospital systems are becoming vertically

⁴ [U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy* \(October 2, 2024\)](#)

⁵ [Rand Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* \(2020\)](#)

⁶ [U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy* \(October 2, 2024\)](#)

⁷ [Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physician practices on prices and spending," *Journal of Health Economics* \(May 2018\)](#)

⁸ [The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care*](#)

integrated with physician organizations.

Rising hospital costs are being fueled by hospital and provider consolidation that leads to higher health care costs *without* an increase in quality.⁹ After hospitals purchase physician practices, they are able to rename the practices as “hospital facilities” and thereby bill at higher hospital rates (that now include a “facility” fee) for the exact same service. This payment distortion incentivizes provider consolidation, in turn, fueling higher costs.

An important way for Congress to reduce incentives that are leading to increased hospital/provider consolidation — and higher hospital cost care — is to expand site-neutral payment reform. Site-neutral payment reform aligns payment rates for certain services that can be safely delivered regardless of where care is received across the three main sites where patients receive outpatient care: hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. According to polling by the Winston Group,¹⁰ voters favor adopting site-neutral payment policies by a two-to-one margin.

The Council urges Congress to expand site-neutral policies for additional services and facilities and to implement site-neutral policies as soon as possible. Ending Medicare payment policies that provide incentives for consolidation is a key action Congress can take to increase competition and thereby lower health care costs.

MODERNIZE THE 340B PROGRAM

Employers are deeply concerned about the significant cost that explosive growth of the 340B program has imposed on employer-sponsored health plans. Last year, the Council issued a paper¹¹ explaining how employers, working families and taxpayers are shouldering a significant cost of the 340B drug pricing program’s expansion, while the program is failing to sufficiently benefit the vulnerable patients it was intended to serve. Employers seek to ensure that the 340B program indeed serves vulnerable patients yet does not raise costs for employer-sponsored health plans. The Council calls upon Congress to carefully consider the impact of the program on employers and working families.

[Market, pp. 7 \(March 2020\)](#)

⁹ [Cory Capps, David Dranove and Christopher Ody, “The effect of hospital acquisitions of physician practices on prices and spending,” *Journal of Health Economics* \(May 2018\); The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market*, pp. 7 \(March 2020\)](#)

¹⁰ [The Winston Group, *Alliance to Fight for Health Care National Survey* \(September 11, 2024\)](#)

¹¹ [American Benefits Council, *GROWTH UNCHECKED: A Call to Action for Policymakers to Reform 340B, to Stop It from Driving Up Health Care Costs for Employers, Working Families and Taxpayers* \(February 2025\)](#)

As explained in the Council’s report, the 340B program is an important factor driving higher hospital prices and, in turn, higher prices for employer-sponsored health coverage. The 340B program should not be seen as unrelated to employer-sponsored health coverage. The program does not operate in isolation, but instead impacts payers across the health care system including the commercial, Medicare, and Medicaid markets. Proponents of 340B claim it has no federal cost because it relies on discounts provided by one private entity (a prescription drug manufacturer) to another (a covered entity).¹² This claim that the 340B program has no cost beyond the discounts provided by manufacturers fails to consider the program’s impact on employer-sponsored health plans, through which the majority of Americans receive their health coverage.

Offering health coverage to more than 180 million Americans, employers are a key stakeholder in legislative efforts to amend the 340B program. The Council has strong concerns that the growth of the 340B program is raising costs for employers and working families by fueling hospital-physician consolidation, affecting discounts in the commercial market and promoting increased use of higher-cost therapies. The Council urges Congress to work with us on much-needed changes that modernize the 340B program and help make health care more affordable for employers and their employees and families nationwide while ensuring that the 340B program actually benefits vulnerable, low-income patients.

ENSURE GREATER TRANSPARENCY IN THE HEALTH CARE SYSTEM

The Council wishes to express its support for, and emphasize the vital importance of, health care price transparency across the industry. The Council has long been a leader in supporting meaningful, increased health care price and quality transparency and access to data for employer plan sponsors to improve health care value. Transparency is not an end in and of itself. It is, however, a means to fuel competition, track when and where health care prices are relatively higher or increasing and use that information to encourage health care that is more value-driven. An essential element of making health care more affordable for employers and working families is to help them more fully understand what is driving the increase in health care spending so employers can deliver affordable, high-value health care benefits.

Notably, of those employers that have had success in decreasing the rate of health care spending, many have done so by analyzing their own health care data to better understand what health care services are being utilized and how much is being spent on specific health care services, and in turn, using that information to promote higher-value, relatively lower-cost providers. Employers not only need access to their data in a

¹² The American Hospital Association has asserted, “340B doesn’t cost the government one penny.” See [340B Hospital Community Benefit Analysis \(2023\)](#)

useful manner, but also the freedom to take action.

Despite important legislative and regulatory action to advance health care transparency, impediments remain to meaningful access and utilization of health pricing data. Removing barriers to accessing and using price and quality information is foundational to unleashing the power of transparency to help employers drive lower cost and provide higher value health care. According to the Winston Group poll,¹³ more than 80% of voters with employer-sponsored health insurance cited transparency of how much services cost as either the top priority or one of the high priority health care issues Congress should address.

The hospital price transparency (HPT) final rule issued by the U.S. Department of Health and Human Services establishes requirements for hospitals operating in the U.S. to establish, update, and make public a list of their standard charges for the items and services that they provide. The fact remains that far too many hospitals across the country remain out of compliance – or *meaningful* compliance – with the hospital price transparency rule.¹⁴ Improving HPT compliance and enforcement is critical to these efforts, including by codifying and strengthening price transparency for hospitals.

Our plan sponsor members are doing their part to support increased transparency. They recognize that access to pricing data is critical to unleashing the power of employers to drive lower cost and higher value health care, and employers have made great efforts to comply with the full range of requirements of the “transparency in coverage” rule. We want to ensure the optimal utility of these requirements to support those employer efforts as rulemaking and legislative efforts to improve price transparency are ongoing.

We also stress the importance of minimizing burdens on employers and their service provider partners that add cost and complexity but not value or useful information to achieve these goals. Employers want to be able to use health care pricing information as a tool to make more value-driven decisions that bring down the overall cost and improve the quality of healthcare for employees and their families. The Council recognizes that price is just one piece of the puzzle and, in terms of value, the price of the health care service does not always correlate with the quality of care and, thus, equate to better value. We note, however, that while increased price transparency will be most effective when coupled with quality information, price transparency efforts should proceed apace even if quality transparency will take additional time to realize.

¹³ Id.

¹⁴ [Families USA, *The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs* \(April 19, 2023\)](#)

ELIMINATE ANTI-COMPETITIVE CONTRACTING TERMS

Legislation such as the bipartisan Healthy Competition for Better Care Act (H.R. 6248) restricts anti-competitive contracting provisions that limit employers' efforts to promote high value care. The most important driver of higher prices for hospital care is the rise of regional hospital monopolies.¹⁵ Large hospital systems attempt to leverage their significant market share in forcing plans and issuers to contract with all affiliated facilities and prevent steering patients towards lower-cost, higher quality care. These anti-competitive contract terms in the form of “all-or nothing,” “anti-steering,” “anti-tiering” and “most-favored-nation” contract provisions foster highly inflated costs and limit a plan sponsor’s flexibility in plan design to promote access to high-value care. The Healthy Competition for Better Care Act would increase competition and promote lower costs by restricting such contract terms. We urge Congress to pass such legislation.

CONCERNS WITH IMPLEMENTATION OF THE NO SURPRISES ACT IDR PROCESS

As you examine the root causes of rising health care costs, we also bring your attention to implementation of the Independent Dispute Resolution (IDR) process under the No Surprises Act. Employers are deeply concerned that implementation of the IDR process is undermining the law’s intent to both protect patients from surprise billing and lower health care costs. Instead, the IDR process has generated at least \$5 billion in total costs through the end of 2024.¹⁶ This higher spending will likely be reflected in higher overall health costs and consumer premiums in the future. Moreover, it is being driven by a select group of providers who are capitalizing on the process, which has seen far more IDR disputes than anticipated and overwhelmingly results in providers prevailing with median payment determinations over four times the in-network amount. We urge the agencies to take immediate action to strengthen enforcement to ensure only eligible claims are submitted to IDR, increase transparency in arbitration decisions and penalize abuse of the process.

* * * * *

¹⁵ [The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* \(January 31, 2020\)](#)

¹⁶ [Jack Hoadley and Kennah Watts, *Health Affairs Forefront*, “The Substantial Costs Of The No Surprises Act Arbitration Process” \(August 25, 2025\)](#)

This committee has undertaken substantial bipartisan steps over the past several years to advance important policies to make health care more affordable for employers and working families. We ask the committee to continue to build on those efforts and urge Congress to take prompt and decisive action to enact the policies outlined above. The Council stands ready to assist you in any way possible. Please do not hesitate to reach out with any questions.

Sincerely,

A handwritten signature in black ink that reads "Ilyse Schuman". The signature is written in a cursive, flowing style.

Ilyse Schuman
Senior Vice President, Health and Paid Leave Policy

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE
NATIONAL FEDERATION OF INDEPENDENT BUSINESS



Statement for the Record of Tyler Dever
Principal, Federal Government Relations

United States House of Representatives
Committee on Ways and Means

Full Committee Hearing with Health System CEOs

April 28, 2026

National Federation of Independent Business
555 12th Street NW, Suite 1001
Washington, DC 20004

Chairman Smith, Ranking Member Neal, and distinguished Members of the Committee:

On behalf of NFIB, the nation's leading small business advocacy organization, thank you for the opportunity to submit this statement for the record on the growing impact that hospital system consolidation is having on health care affordability.

Small businesses employ nearly half of the private-sector workforce and generate 44% of U.S. economic activity, yet they face some of the greatest challenges in providing health benefits.¹ For more than 40 years, small business owners have consistently identified rising health care costs as their top concern.² Today, only 32.2% of small employers are able to offer coverage, largely due to unsustainable premium increases.³

These unsustainable cost increases leave small businesses in a bind. The ability of small businesses to offer health insurance has declined since the passage of the Affordable Care Act (ACA), while 96% of their larger competitors are able to offer the benefit.⁴ This leaves small businesses at a competitive disadvantage in attracting and retaining employees, and their ability to grow.

Congress must address the rapid cost increases in health care. It must eliminate laws and mandates that drive up the cost of care, fuel industry consolidation and reduce competition. Congress should begin by closely examining the role of industry consolidation, particularly among hospital systems. Hospital prices have increased at rates that far exceed both inflation and wage growth.⁵ Americans now spend approximately \$1.6 trillion annually on hospital care, which is approximately a third of all health care spending.⁶

As a first step, Congress must eliminate ACA mandates that limit flexibility in the small group market, which could allow for more tailored and lower-cost coverage options. Additionally, Congress must remove restrictions on physician-owned hospitals to encourage new market entrants, increase competition, and generate innovation in the health industry. Congress should also pursue site-neutral payment reforms to eliminate reimbursement disparities across care settings, a step that would reduce incentives for consolidation and align payments more closely with the value of services provided.

The ACA has fueled the rapid cost increases and industry consolidation observed over the last two decades. The ACA imposed many new mandates that increased costs, reduced flexibility and limited lower-cost coverage options for small businesses. The law has also constrained insurers'

¹ Small Business Administration, Office of Advocacy, Frequently Asked Questions About Small Business, 2024. <https://advocacy.sba.gov/2024/07/23/frequently-asked-questions-about-small-business-2024/>.

² Holly Wade & Madeleine Oldstone, Small Business Problems and Priorities, 2024 NFIB Research Center, 2024 <https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf>.

³ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 2024.

⁴ *Id.*

⁵ John R. Graham, The Hospital Cost Crisis: How Government Policies Drive Consolidation, Undermine Competition, and Fuel Soaring Prices, April 2026, <https://paragoninstitute.org/private-health/the-hospital-cost-crisis-how-government-policies-drive-consolidation-undermine-competition-and-fuel-soaring-prices/?nab=0>.

⁶ *Id.*

ability to price plans based on risk, which was historically used as an important tool for small employers to manage costs. While large corporations have the scale to adapt, small businesses have been left navigating a more rigid, complex, and expensive marketplace.

A great example of how the ACA's burdensome mandates are harmful to small businesses is the Medical Loss Ratio (MLR) requirements. By capping the percentage of premium revenue insurers can retain for administrative costs and profit, MLR rules encourage enormous health system footprints and reduce incentives for any industry insiders to push back on rising costs. As hospital systems grow larger and command higher reimbursement rates, those costs are passed through into premiums, increasing the burden on small employers.

As the Wall Street Journal Editorial Board argued in 2023, "It's a familiar story: Big government intervention creates incentives and raises costs that help big business, and then politicians demand more government intervention to fix the distortions they caused."⁷ Small businesses know that until Congress addresses the root causes of exploding health costs, any "reform" efforts amount to simply rearranging deck chairs on the Titanic."

In addition, the ACA curtailed the growth of physician-owned hospitals, which previously served as an important source of competition. By restricting new physician-owned facilities from fully participating in Medicare, the law reduced market entry, limited innovation, and weakened a key competitive check on hospital pricing.

The absence of site-neutral payment policies creates another hurdle to health care affordability. Current reimbursement structures often allow hospitals to charge significantly more for the same service when it is delivered in a hospital-owned setting rather than a private physician's office. This disparity creates strong incentives for hospitals to acquire independent practices and reclassify sites of care to receive higher payments, which ends up adding more fuel to the fire of industry consolidation.

For small business owners, the consequences are severe. As independent practices disappear, lower-cost care settings are replaced by higher-priced hospital-owned facilities. Unlike large corporations, small businesses lack the power to negotiate favorable rates, making them especially vulnerable to the pricing power of consolidated systems. When combined, all these factors reinforce one another. Acquisitions expand access to higher reimbursements, regulatory mandates limit competition, and care shifts toward higher-cost settings without corresponding improvements in quality. The result is a continuous cycle of rising prices, declining competition, and reduced affordability.

Small businesses are the backbone of the American economy, but they cannot continue to absorb escalating health care costs driven by policies that limit competition and benefit larger businesses. Restoring a more competitive health care marketplace is critical to improving affordability and ensuring that small business owners can continue to provide health coverage for their employees.

⁷ Editorial Board, *Wall Street Journal*. Nov. 23, 2023. "Elizabeth Warren Has an ObamaCare Epiphany." <https://www.wsj.com/opinion/obamacare-medical-loss-ratio-elizabeth-warren-mike-braun-letter-healthcare-pbm-af77e284?msocid=3efaf226485565230208e7e7493964c4>.

Sincerely,

A handwritten signature in black ink that reads "Tyler Dever". The signature is written in a cursive style with a large, prominent "D" at the end.

Tyler Dever
Principal, Federal Government Relations
NFIB

May 12, 2026

U.S. House of Representatives
Committee on Ways and Means
Re: Full Committee Hearing with Health System CEOs

On behalf of the 1.8 million members of the AFT, including 250,000 healthcare professionals working in an array of clinical settings, I write to offer our comments on the April 28 hearing on healthcare affordability, and respectfully request that my letter be made part of the written record.

I commend the Committee on Ways and Means for focusing on the impacts of rising healthcare costs on patients and families by examining the role of health systems within the current state of healthcare affordability. Specifically, I want to address two key issues raised during last month's hearing.

First, labor costs were mentioned multiple times during witness testimony, and I want to make clear that healthcare professionals are not living a lush life. The reality is that decisions by healthcare CEOs to prioritize profits are putting patients in danger. Their refusal to implement safe staffing levels is putting lives at risk and driving people out of nursing and health professions.

A [recent study](#) noted that "each percent change in [registered nurse] turnover stands to cost or save the average hospital \$295,000 per year. ... Over the past five years, RNs in telemetry, step down and emergency services were most mobile with cumulative turnover rates of 117.8 percent, 115.4 percent and 113.6 percent, respectively. ... Essentially, these departments will turn over their entire RN staff in less than four and a half years."

If healthcare CEOs were truly concerned about reducing costs and improving quality, they would address safe staffing levels and workplace violence to make hospitals places that can retain healthcare professionals, but this is not about high-quality care; it is about protecting power and profits. As Chairman Smith [noted](#), "hospitals with more than 100 beds have a higher profit margin than Delta Air Lines, Target, or Disney."

Second, I must reject the notion, put forward by some during the hearing, that highlighting the impact of H.R. 1, the One Big Beautiful Bill Act, becoming law on access to healthcare, or the consequences of refusing to extend the Affordable Care Act's enhanced tax credits on affordability, are somehow partisan or distractions from moving forward on addressing affordability. I represent higher education members who utilize the ACA marketplace as well as retirees on Medicare, and we serve many students and patients who receive support through Medicaid. These policy changes approved by Congress and the White

The AFT is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

AFT, AFL-CIO

AFT Teachers
AFT PSRP
AFT Higher Education
AFT Public Employees
AFT Nurses and Health
Professionals
AFT Retirees

555 New Jersey Ave. N.W.
Washington, DC 20001
202-879-4400
www.aft.org

Randi Weingarten
PRESIDENT

Fedrick C. Ingram
SECRETARY-TREASURER

Evelyn DeJesus
EXECUTIVE VICE PRESIDENT

VICE PRESIDENTS

J. Philippe Abraham
Frederick R. Albert
Jackie Anderson
LeRoy Barr
Victor M. Bonilla Sánchez
Vicky Rae Byrd
Monica Byron
Zeph Capo
Larry J. Carter, Jr.
Kathy A. Chavez
Jaime Ciffone
Melissa Cropper
Amanda Curtis
James C. Davis
Stacy Davis Gates
GlenEva Dunham
Christian L. Fern
Francis J. Flynn
Jeffery M. Freitas
Ron Gross
Anthony M. Harmon
Karla Hernández-Mats
Jan Hochadel
David Keepnews, RN
Frederick E. Kowal
Terrence Martin, Sr.
Kara McCormick-Lyons
Daniel J. Montgomery
Michael Mulgrew
Cecily A. Myart-Cruz
Shari Obrenski
Melinda Person
Juan Ramirez
Andrew Spar
Denise Specht
Wayne Spence
Arthur G. Steinberg
Jessica J. Tang
Adam Urbanski
Debbie White, RN
Carl Williams
Lakia Wilson-Lumpkins
Sarah Wofford
Todd Wolfson

House are not abstract, and they need to be central to any conversation about affordability.

As the [*Wall Street Journal*](#) notes “around 14 percent of enrollees in ACA plans failed to make payments, data shows. ... [The] decline in January payments is driven by loss of federal Affordable Care Act subsidies.” This reality cannot simply be ignored or dismissed.

It is not just our members receiving healthcare through the ACA or Medicare who are facing affordability challenges. I represent hundreds of thousands of people concerned about healthcare costs. To put it bluntly, “our broken healthcare system is driving families deep into debt and despair. [More than 8 in 10 AFT](#) members describe healthcare costs as a driver of financial distress, with more than 1 in 5 describing the cost of healthcare as ‘a major challenge.’” Describing how they use credit card debt to stay afloat, half ... reported paying for medical or dental care with a credit card over the past 12 months. One AFT member said, “[w]hen our adopted child was young, he needed a lot of medical care, and twice we had to refuse care we could not afford—some of the worst moments of my life.” CRS has estimated that millions will lose access to healthcare because of H.R. 1 and be forced to face similar choices as the AFT member just quoted.

Congress must take action to address healthcare access and affordability. While there is debate on how best to address these issues, we must first agree to a shared understanding of the actual impacts that H.R. 1 will have on our healthcare system. At a minimum, I hope that Congress can unite in addressing the needs of those who provide care to patients, particularly through addressing the safe staffing and workplace violence crises. As noted above, ignoring the needs of these professionals makes addressing affordability and access even more challenging. We can and must do better.

Thank you for considering the views of the AFT on this crucial topic.

Sincerely,

Randi Weingarten
President, AFT

RW : emc opeiu #2 afl-cio

April 28, 2026

**United States House of Representatives
Committee on Ways and Means
Full Committee Hearing with Health System CEOs**

Testimony of Natalie Davis, United States of Care

Chairman Smith, Ranking Member Neal, Members of the Committee, thank you for the opportunity to submit testimony for the record.

United States of Care (USofCare) is a nonpartisan, nonprofit organization working to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. Importantly, we are committed to improving the health of everyday people and are eager to engage in solutions that do just that. We advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our [work in states](#) and [listening to people's experiences](#) with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the [federal level](#).

The concept of “affordability” may have [recently entered](#) the political consciousness in a more prominent way, but for a long time, **cost has been the driving concern** people across demographic, geographic, and ideological spectrums have about health care – and that’s irrespective of their coverage type or status.

Through USofCare’s extensive work since we launched the organization in 2018 to listen to people about the health care system and their experiences with it, [cost is consistently the first – and most prominent – issue people raise](#). It is not solely about their inability to pay, but also the anxiety and the worry they won’t be able to afford the care they or a family member need in the future. For people, affordability impacts every facet of their experience – it’s the through-line of every single entry point into the health care system and impacts every decision they make. Cost also [impacts people’s decisions not to seek care](#).

As Congress and this Committee put health care affordability into sharper focus, one resounding truth is clear: people are struggling to pay for the care they need.

Year after year, people are straining to access care as costs and prices continue to skyrocket. Hospital spending continues to make up the [largest share](#) of total health care expenditures – outpacing spending on retail prescription drugs and physician services combined.

Since [2000](#), more than 1,300 mergers have occurred among roughly 5,000 hospitals nationwide – and market consolidation is one of the primary drivers of hospital price increases. This [decades-long hospital consolidation has resulted in](#) large hospital systems amassing substantial market power, crowding out competition, and hiking prices and fees for patients who are

ultimately left making an impossible decision to assume financial hardship to afford care, or forego care altogether.

If Congress is going to meaningfully address the affordability challenges that people are facing, it must prioritize excessive hospital prices. USofCare offers the following solutions to tackle this affordability crisis, which have broad, bipartisan public support, as demonstrated by [recent polling](#) we conducted.

Solutions are available to Congress that address health care costs for people without impacting hospital solvency. USofCare partnered with the Brown University Center for Advancing Health Policy through Research (CAHPR) to [evaluate](#) the impact of three different policies – facility fee limitations, site neutral payments, and commercial payment caps – on consumer premiums and out-of-pocket costs in three states (Indiana, Massachusetts, and North Carolina), as well as on hospital operating margins. **This analysis demonstrated savings for consumers while also having virtually no impact on hospital operating margins.**

Facility Fee Limitations

A growing body of research shows that provider consolidation is **raising out of pocket health care costs for consumers**. As more sites of care fall under hospital ownership, consumers have more exposure to facility fees for even routine services. In some cases, patients are being charged facility fees for telehealth visits with their doctors, without ever stepping foot in a facility. In one instance, a [Colorado family](#) was billed for an \$847.35 facility fee for one speech therapy session that was conducted via telehealth.

In addition, as hospital prices rise, consumers face increased out-of-pocket costs through deductibles and coinsurance, which are tied to the underlying cost of the service. One [study](#) found that between 2011 and 2017, outpatient surgeries saw a 53% increase in facility fee charges and consumer out-of-pocket expenses grew by 50 percent. These additional charges and higher prices are expected to only [increase](#) as provider consolidation intensifies. And finally, as overall hospital prices go up, commercial payers are [more likely](#) to pass those costs onto consumers in the form of higher premiums.

Hospitals have argued they need to charge facility fees to account for key features that are unique to hospital care like 24/7 hour operations and staffing for high-acuity services like emergency and trauma care. But physician offices owned by hospitals that have none of these key features are charging facility fees – something that these very same offices didn't do before they were bought by the hospital. Policies that put reasonable limits on facility fees for services like routine doctors' office visits and telehealth appointments have been successfully implemented in [states](#) such as Indiana, Connecticut, and Colorado. Despite hospital arguments that these policies will devastate hospitals financially, a [recent study](#) found that Connecticut's 2017 facility fee law had no overall impact on hospital profits in the state, while it also protected consumers from facing additional exorbitant fees.

We strongly urge Congress to take steps to prohibit facility fees for routine, preventive, and telehealth services.

Improved Price Transparency

Despite good-faith reform efforts, the health care system **remains complex and difficult to understand for patients**. Federal efforts to promote hospital price transparency have represented an important step forward, but patients remain as baffled as ever by a health care system that is designed to confuse. More than five years after federal rules from CMS [first required](#) hospitals to post the prices of hundreds of everyday services on their websites, [compliance](#) with the rules is still a problem, leaving patients in the dark about the true cost of hospital care.

As health care costs continue to rise and exacerbate the health care affordability crisis people are facing, medical debt is a growing financial burden that many people face when they need care. A recent [poll](#) from USofCare found that 49% reported experiencing at least one financial pressure related to a medical bill (i.e. put a medical bill on a credit card, contacted by a credit agency, took out a loan, etc.) in the past two years. 21% of people reported that they've carried medical debt in the last two years. Nearly [30%](#) of adults who owe medical debt owe it entirely for hospital bills.

Many [states](#) have taken action to promote price transparency to provide patients with the information needed to make educated health care decisions for themselves and their families. By making this information available and transparent, **policymakers are also able to use this data to pursue additional cost-savings solutions that can ultimately lower the underlying cost** of care and deliver savings for people, employers, and state budgets.

Congress should build on CMS's efforts to improve hospital price transparency by codifying these requirements and enhancing civil monetary penalties for hospitals that fail to follow these requirements. Additionally, Congress should follow the lead of states – like [Colorado](#) – that have prohibited hospitals not in compliance with hospital price transparency rules from taking extraordinary collection actions on medical debt from patients. **This comes down to basic fairness – if a patient can't find out the cost of the care they need, they shouldn't face financial ruin through [lawsuits](#), [wage garnishments](#), [liens on their homes](#), and lower credit scores.**

Site Neutral Payments

A **major driver of high costs** in hospital care – and the health system as a whole – stems from **payment differentials between care settings**. Under their respective payment systems, Medicare pays outpatient health facilities, including hospital outpatient departments (HOPDs) higher rates than physician offices for delivery of the same service. This discrepancy incentivizes hospitals to move patients into higher-cost settings in order to receive a higher payment rate. The payment rate under the OPDS is often [200-300%](#) of the rate paid for the same services in physician offices – shifting additional costs onto beneficiaries and the Medicare program as a whole.

Hospital and health system acquisition of physician offices and outpatient facilities has highlighted the need to implement site neutral payments in [Medicare](#) and also in the [commercial market](#). In too many instances consumers are charged more for a service on the sole basis of where it's performed, **increasing costs to them personally as well as to the system overall**. What's more, there's **no improvement in the quality** of that service.

The Centers for Medicare & Medicaid Services (CMS) took action in the Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment [final rule](#) to establish a site-neutral payment rate for drug administration services. This change alone is estimated to save Medicare beneficiaries \$70 million in reduced coinsurance costs and the Medicare program \$210 million for CY 2026 alone.

There is evidence indicating that billing for a number of different services has shifted from the PFS to the OPDS, resulting in increases in utilization of higher-cost settings. Similarly, the Medicare Payment Advisory Committee (MedPAC) has also signaled the misalignment in payment rates when it comes to charges for care across dozens of services delivered at off-site locations. **We strongly urge Congress to build on regulatory efforts from CMS and apply site neutral payment rates to additional services that can be safely performed in outpatient settings with a particular consideration of the [66 services](#) identified by MedPAC.**

Ensuring Reasonable Prices in Anticompetitive Markets

Rising health care costs **limit people's health care choices and put a strain on family and government budgets**. [A main driver](#) of those rising costs are the [prices charged by hospitals](#), which only continue to increase as a consequence of [consolidation](#). In some states, hospitals charge commercial carriers an average of [three times what they charge Medicare](#). These [higher prices](#) paid by health insurers result in health plans increasing premiums and out-of-pocket costs as they attempt to recoup revenue. This impacts patients, employers, and state and federal governments in significant ways – [costs](#) go up, health care [value](#) stagnates, and [quality](#) does not improve.

Recognizing the [impact](#) of these trends on state budgets and people alike, state policymakers are increasingly pursuing [solutions](#) to lower hospital prices. One emerging solution USofCare has advocated for in states is to directly limit the prices hospitals charge by implementing [reference-based pricing](#) within programs or markets states run or regulate, such as the commercial market or within state employee health plans (SEHPs). This policy directly targets what hospitals can charge by benchmarking prices to a "[reference price](#)" – most often a percent of Medicare reimbursement rates. This would bring the prices charged for hospital services more in line with the [actual cost](#) to provide services, rather than relying on negotiated rates set by hospitals as Medicare rates are [regularly](#) reviewed and updated to reflect local market conditions. Reference-based pricing programs can also be designed to improve access to [high-value care](#) by creating payment floors for specific services or types of providers, such as behavioral health services or for primary care providers.

A recent [report](#) found that capping hospital payments at 200% of Medicare rates would have saved SEHPs an average of \$150.2 million per state in 2022, totalling \$7.1 billion nationwide, all while minimally impacting hospital operating margin. When used in the commercial market, reference-based pricing benefits other purchasers by helping to [lower](#) premiums and out-of-pocket costs. For example, a recent USofCare [analysis](#) looked at the impact of capping hospital payments in the commercial market and found three states alone could save almost \$26 billion through lower premiums and out-of-pocket costs. This policy can also provide more predictability for people by establishing more uniformity and fairness with prices that don't rely on how well their plan is able to negotiate with an individual hospital or health system.

This policy provides the opportunity to constrain cost growth, lowering costs for the state and other purchasers, such as people and employers. **Congress should follow the lead of red, blue, and purple states that have worked to tackle hospital costs inflated by rampant consolidation and anticompetitive health care markets to place reasonable limits on hospital costs.**

Conclusion

Thank you for your attention to this important issue, and USofCare appreciates the opportunity to submit this testimony for the record. We stand ready to help support any efforts from the Committee to help address hospital and health system consolidation and the high costs that result for consumers.



Testimony submitted to the United States House Committee on Ways and Means

As the president of the United Federation of Teachers (UFT), I would like to thank Chairman Jason Smith, Ranking Member Richard Neal and all the members of the House Committee on Ways and Means for holding a hearing on the impact of rising health care costs on patients and families. The UFT represents 210,000 employees in New York City, including teachers, paraprofessionals, school secretaries, attendance teachers, guidance counselors, psychologists, social workers, adult education teachers, administrative law judges, nurses, speech therapists, laboratory technicians and 70,000 retired members. Preserving access to high-quality, affordable health care for these members and their families is of the utmost importance to our union.

Currently, health care costs are skyrocketing across the United States. We are acutely aware of this in New York City, which is home to some of the best hospitals and medical facilities — but also to some of the highest health care costs — in the country. Large hospital networks are drivers of price increases as they continue to put profits before patients without regard to how their actions hurt working people. NewYork-Presbyterian continues to threaten to throw 40,000 municipal employees, retirees and their families out of network if the city doesn't agree to pay its astronomical prices.

Recently published public pricing data exposed just how much Presbyterian was charging compared to other hospital systems in New York City. On average, the hospital giant has been charging 77 percent more for medical services than other New York City hospital systems, and their rates have been nearly 500% above the approved Medicare rate. Presbyterian has also been charging twice as much for services like C-sections and colonoscopies as other hospitals in NYC and 74% more for asthma and bronchitis treatments.

I wish that I could say Presbyterian were an outlier, but it is not alone in this practice. Countless other hospitals continue to make money on the backs of workers. This is simply unacceptable.

I am grateful to the Justice Department's Antitrust Division and the U.S. Attorney's Office for the Southern District of New York for recently filing a lawsuit against NewYork-Presbyterian, charging the institution with stifling competition to protect its high prices and preventing New Yorkers from being able to select more affordable health care. Holding health systems accountable for their part in the health care affordability crisis is critical in the fight to ensure that health care remains accessible and affordable for everyone.



I thank you again for holding this hearing and for the opportunity to submit testimony.

STATEMENT FOR THE RECORD BY
THE ERISA INDUSTRY COMMITTEE (ERIC)
TO THE U.S. HOUSE OF REPRESENTATIVES
UNITED STATES HOUSE COMMITTEE ON WAYS & MEANS
“FULL COMMITTEE HEARING WITH HEALTH SYSTEM CEOS”

April 28, 2026

Chairman Smith, Ranking Member Neal, and members of the Committee, thank you for the opportunity to submit a statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing with health system CEOs. We appreciate the Committee’s attention to the impacts of rising health care costs on patients and large employers and look forward to working with you to make quality health care more affordable and accessible.

ERIC is a national advocacy organization exclusively representing the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. With member companies that are leaders in every economic sector, ERIC is the voice of large employer plan sponsors on federal, state, and local public policies impacting their ability to sponsor benefit plans. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and congressional district.

ERIC member companies offer comprehensive health coverage for employees, their families, and retirees through self-insured plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). They do so to attract and retain employees, improve health and productivity, and provide peace of mind. Large employers, like ERIC member companies, roll up their sleeves to improve how health care is delivered in communities across the country.

ERIC member companies provide health benefits not only to attract and retain employees, but also to support employee well-being and provide financial security. Across the country, our members invest in their employees and communities by improving access to care and driving innovation in health benefits. These efforts include a broad array of approaches, including expanding the use of digital health tools, establishing onsite clinics, and implementing direct primary care arrangements. Employers also develop value-based and coordinated care programs, offer employee wellness initiatives, and deploy transparency tools and other innovations designed to improve quality and value while helping to mitigate rising health care costs

However, rising health care costs continue to place significant financial strain on both employers and their employees. Large, self-insured employers typically cover roughly 75 to 80 percent of overall expenses. Surveys and industry analyses show that employers are bracing for substantial cost increases this plan year, with projected increases ranging from six to nine percent.¹

¹ [Mercer](#), Employers are bracing for the highest health benefit cost increase in 15 years, a projected 6.5% increase in 2026, September 4, 2025.

At the same time, premiums for family coverage now average approximately \$27,000 per year, reflecting roughly a six percent increase in 2025.² Unless Congress takes affirmative action to address market consolidation and anticompetitive practices within the health care system, employers and working families will continue to face the consequences of these costs.

The cost associated with payments to providers is one of the largest drivers of health spending costs for employers, with prices charged by hospitals to private plans continuing to rise rapidly. Several reputable research findings show that employers and private insurers pay, on average, 224 percent of Medicare rates for hospital services, with some hospitals charging more than 300 percent.³ Additionally, research published in *Health Affairs* consistently shows that price variation—not utilization—is the primary driver of spending growth in the commercial market.⁴

Likewise, ERIC issued a policy brief, *Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices*, which examined the primary drivers of hospital pricing in employer-sponsored insurance markets.⁵ The brief focused on research conducted by Charm Economics as evidence that hospital prices are not primarily driven by cost shifting from underpayments in federal programs. Instead, market dynamics, particularly provider consolidation, employer bargaining power, and regional pricing patterns play a much larger role in determining the rates employers ultimately pay. These findings underscore a central problem: hospital pricing in the commercial market is currently not disciplined by competition or tied to underlying costs.

Provider Consolidation and Unfair Pricing Practices

Hospital pricing remains a primary driver of rising health care costs for employers and workers. As large health systems acquire hospitals and physician practices, they eliminate competition and increase the prices charged to patients and purchasers of care.

Over the past several decades, hospital systems have significantly expanded their market power through acquisitions and consolidation. By 2017, approximately 90 percent of health care markets were considered “highly concentrated.”⁶ Studies have repeatedly found that hospital mergers lead to price increases, with no consistent evidence of quality improvement.⁷ Dominant health systems frequently use their market power to block lower-priced competitors and demand higher reimbursement rates from employers and insurers negotiating on their behalf.

Provider consolidation continues to accelerate, including the widespread acquisition of physician practices by hospital systems. This consolidation enables providers to command higher prices and exert increased pressure in contract negotiations.

² [KFF](#), 2025 Employer Health Benefits Survey, October 22, 2025.

³ Whaley, C. M., Briscoe, B., Kerber, R., O'Neill, B., & Kofner, A. (2022). [Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative](#). RAND Corporation.

⁴ ["The Role Of Prices In Excess US Health Spending."](#) *Health Affairs*, 9 June 2022.

⁵ [Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices](#). ERIC, May 2025

⁶ Johnson, Noah, et al. ["Is Hospital Market Concentration Related to Medical Debt?"](#) *Urban Wire*, Urban Institute, 16 Oct. 2024

⁷ Gale AH. [Bigger but not better: hospital mergers increase costs and do not improve quality](#). *Mo Med*. 2015 Jan-Feb;112(1):4-5. PMID: 25812261; PMCID: PMC6170097

ERIC member companies experience these pressures firsthand through wide variations in payment rates for identical services depending solely on the site of care.

Allowing such market failures to persist unchecked threatens the affordability of employer-sponsored coverage. Action is needed to preserve competitive markets in health care and prevent costs from continuing to rise for employers and working families. The committee can take several important steps to discourage consolidation and unfair pricing practices, including expanding site-neutral payment policies, strengthening transparency reforms, and promoting fairness in contracting practices.

Site-Neutral Payments

Provider consolidation has contributed to problematic billing practices. Hospitals increasingly reclassify physician offices they own as hospital facilities to charge higher rates for the same goods and services, and “facility fees” despite services not taking place on an actual hospital campus. Congress took an important, but very narrow, first step towards addressing this issue in *the Consolidated Appropriations Act of 2026* (CAA 26) by requiring the use of a unique National Patient Identifier (NPI) for off-campus hospital outpatient departments when billing Medicare. However, broader site-neutral reforms are needed, and Congress should build upon this momentum to fully address the distortions created by differential payment structures. Site-neutral payment reform will help curb unnecessary spending and restore fairness in health care pricing.

Strong Transparency Reforms

ERIC member companies believe that transparency is essential to reducing health care costs and improving quality of care. Too many hospitals still fail to meaningfully comply with Department of Health and Human Services (HHS) regulations requiring the public disclosure of standard charges, including negotiated rates. ERIC applauds the House’s work last Congress on the *Lower Costs, More Transparency Act* (LCMT, H.R. 5378). The legislation would have codified the requirement that hospitals publicly post negotiated prices for health care items and services in a machine-readable format and would have strengthened compliance and enforcement. Access to timely and accurate information allows employers to design better benefits and manage costs more effectively on behalf of their employees.

ERIC encourages the Committee to build upon the principles of the LCMT and pass the *Patients Deserve Price Tags Act* (H.R. 5582), which provides clear statutory authority requiring hospitals and others to disclose key pricing information. Specifically, hospitals would be required to publish their standard charges, including negotiated rates with insurers, cash-pay discounts, and billing codes, and disclose the costs of services that can be scheduled in advance. The enhanced disclosure requirements under this bill will lead to a better understanding of the costs associated with care for employers and their workers, empowering them to require competitive prices for high-quality care.

Fairness in Contracting

Provider market power is increasingly reflected in unfair contracting practices that raise costs while limiting competition and choice. The Committee should advance the bipartisan *Healthy Competition for Better Care Act* (H.R. 6248), led by Ways and Means Committee member and Budget Committee Chairman Jodey Arrington (R-TX).

This legislation would improve fairness in contracting by allowing employers and insurers to provide incentives for enrollees to choose high-quality, lower-cost providers, and prevent the use of anti-competitive contract requirements imposed by hospitals and health systems on health benefit plans. These reforms would enable health benefit plan sponsors to design provider networks that maximize value for patients and exclude sites of care with inflated prices or poor quality—creating truly value-driven benefits for plan beneficiaries.

The No Surprises Act Independent Dispute Resolution Process is Adding to Costs

The *No Surprises Act* (NSA) was intended to protect patients from surprise medical bills and reduce health care costs by encouraging network agreements between providers and carriers. However, emerging Centers for Medicare and Medicaid Services (CMS) data, academic research, and real-world experience show that the Independent Dispute Resolution (IDR) process, originally designed as a last resort to solve surprise billing disputes, has become a significant driver of medical cost inflation, administrative inefficiency, and payment manipulation. The system is being exploited by provider organizations who have turned the arbitration mechanism into a routine profit-extraction strategy. The result is a system that increases health care costs and undermines our health care system.

Every dollar added through inflated arbitration awards, wasteful administrative fees, or inappropriate claims, ultimately flows back into premiums and out-of-pocket costs. Insurers faced with mounting arbitration losses adjust premiums to maintain solvency. Employers, from small businesses to Fortune 100 companies, face increased financial pressure that limits wage growth and restricts benefit enhancements.

Changes to the IDR process must be made to restore the integrity of the NSA and mitigate the impact of the process' failings on the ever-rising costs of health care. Without changes, the NSA will continue to be undermined by a system that rewards excessive pricing, encourages profiteering, and burdens the very people it was designed to protect. The IDR process must be restored to its original purpose: a fair, limited, and transparent tool.

Conclusion

ERIC remains committed to working with the Committee and Congress to advance policies that improve health care access, affordability, quality, transparency, and patient safety. We believe the policy recommendations outlined above can help address key drivers of rising costs while strengthening the employer-sponsored health system that serves over 160 million American workers and their families. We look forward to continuing to work with the Committee to develop and enact meaningful reforms.



May 12, 2026

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richie Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students across the country, I write to thank the Committee for its continued focus on exploring policies to address health care affordability issues with the recent hearing with health system CEOs.

Hospitals and health systems play an integral role in communities across the country. They bolster local economies, connect patients to necessary and often lifesaving health care services, and employ an increasing number of physicians, including family physicians. More than half of the nation's hospitals are non-profit entities, as is the case for three of the hearing's witnesses, which allows many of their employed family physicians the opportunity to participate in the Public Service Loan Forgiveness program and practice in communities that would otherwise be financially detrimental for them. Further, many hospitals and health systems serve as critical residency training sites for physicians. Protecting the viability and success of these hospitals is of significant interest to family physicians, patients, and entire communities. This is why the AAFP advocates for a policy environment which incentivizes and holds them accountable for meeting their commitment to reinvest revenue back into the community and patient care, not the pockets of shareholders and administrators.

Unfortunately, while high-value, low-cost primary care services are essential to improving patient outcomes and reining in system-wide costs, some hospitals fail to prioritize investments in this line of business. Primary care has regularly been described as a "loss leader," particularly in rural communities, with evidence finding that undervaluation of and inadequate payment for primary care makes it structurally at risk when hospital margins deteriorate. A recent example of this includes the closure of two primary clinics by Fitzgibbon Hospital in Missouri in December 2025 as part of a broader cost-cutting plan.ⁱ This national trend of divestment in primary care by hospitals has meaningful impacts for patients. Lack of access to a usual source of primary care (USC) is becoming more commonplace across the country, with nearly a third of adults reporting they had no USC in 2022.ⁱⁱ According to a December 2025 report from the Health Resources and Services Administration (HRSA), there will be a shortage of 70,610 primary care physicians by 2038, and this will be "particularly acute in nonmetro areas."ⁱⁱⁱ In 2025, 7.3 percent of U.S. counties did not have a primary care physician and by 2036 rural communities will experience a 29% shortage of family physicians and a 39% shortage for all primary care physicians.^{iv}

There are numerous factors, such as lower compensation, administrative burden, and a flawed graduate medical education system, which are contributing factors to a shortage of primary care. This shortage is only further exacerbated by hospital consolidation where large health care systems prioritize profit rather than patient care. The AAFP has long emphasized the importance of embedding primary care clinicians into hospital settings, but this collaboration should not *require* family physicians to become hospital employees. Our policy environment should equally support the ability for family physicians to freely choose to work in the setting that best suits them: whether it be in a hospital or a physician-owned practice.

The AAFP recommends that the Committee consider the following recommendations to address the negative impacts of hospital consolidation and ensure hospitals are investing in patient access to high-quality primary care:

- **Reform misaligned incentives that have led to rampant health care consolidation by hospitals, which has not generated higher quality care or improved patient outcomes;**
- **Ensure that tax-advantaged hospitals adhere to the rules and principles that allow them to benefit from that status;** and
- **Change the distribution of graduate medical education (GME) program slots to focus on primary care training in community-based settings instead of large hospital systems.**

Hospital and Health System Consolidation of Primary Care

The rampant consolidation of the health care system – particularly acquisition of primary care practices by large hospital systems, insurers, and corporate entities – has been a principal concern for the AAFP in recent years. Family physicians are a trusted first contact for health concerns, allowing them to serve as the focal point of care for patients and provide referrals to other health care services and sites when necessary. Their significant influence and trust from patients have made primary care clinicians an appealing acquisition target for hospitals, health systems, and other corporate entities.

More than half of primary care practices are affiliated with a hospital (either by common ownership or joint management) compared to 38 percent in 2016.^v With fewer opportunities to join an independent practice, nearly three-quarters of all primary care physicians are now employed by hospitals or corporations (53 percent by hospitals and 20 percent by corporate entities). Hospitals are often motivated to acquire or control primary care practices to maximize the financial success of their organizations by securing referrals to high-margin services or facilities.

Consolidation is not inherently negative and can drive innovation that expands physicians' capabilities, improves care quality, and enhances practice environments. However, in March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. Anecdotal comments from the survey cited disconnects between the stated mission of non-profit and other larger health systems and decisions to close local services that were less profitable. Survey comments expressed

physician views that centralized decisions from health system leaders prioritized profits over patient care.

The Academy has [previously detailed](#) the primary factors fueling the consolidation of primary care practices with large hospitals and health systems, plans, and other corporate entities, including financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by hospitals and large health systems, and the autonomy and community focus of independent practice. Increasingly, family physicians report that independent practice is simply unsustainable.

There may be circumstances in which market integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown that integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes.**^{vi} One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.^{vii}

Thankfully, this Committee can address one of the key contributors to inflated costs for patients caused by consolidation: addressing site-of-service payment differentials. Currently, hospitals are directly rewarded financially for acquiring physician practices and other lower cost outpatient care settings. Medicare and other payers allow hospitals to charge a facility fee for providing outpatient services that can be safely performed in an ambulatory setting. However, there is little evidence that these additional payments are reinvested in the acquired physician practice, many of which are primary care practices. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance. **Patients should not be subject to higher costs simply because a hospital owns the outpatient office they visited, and physician practices should not be effectively penalized financially for remaining independent.**

The AAFP has long [supported](#) thoughtfully-designed payment policies that would establish payment parity across care settings. For example, we have and continue to call for an expansion of site neutral payment to all on-campus and off-campus hospital-based outpatient departments. Addressing site of service payment differences enables patients to make more informed health care decisions by making costs more transparent while reducing patient cost-sharing.

It should be noted that although the AAFP supports the expansion of site neutral payments we also support limited exceptions to protect access to care in rural and underserved communities. The AAFP recently [supported](#) a proposal from the Centers for Medicare and Medicaid Services (CMS) that would expand site neutral payment policy but exclude sites designated as rural sole community hospitals (SCH). To qualify for the SCH designation, a hospital must be the sole source of care in an isolated community, based on meeting criteria that assess the distance (in miles or travel time) from the SCH to the next closest inpatient hospital.^{viii} Closing an SCH means patients would have to take long trips (generally, more than 35 miles) to receive treatment. Because it is not unusual for certain drugs administered by

infusion or injection to require repeat visits over the course of weeks or months, the closure of an SCH or elimination of drug administration services would create a significant burden on patients. Because low-volume providers in low-competition communities may also be at risk of closure if site neutral payments are expanded, certain exceptions should be allowed. The AAFP [supports](#) delivery system support for physicians serving rural communities to eliminate disparities in access to quality care, and recommends some limited exceptions or exclusions as necessary to safeguard access in communities at risk of closures.

In addition to the Committee's oversight and policy ideas to deter the negative effects of health care consolidation, it is important that work continues to specifically support the independent physician practice model. Independent family physician practices could benefit from tax policy changes, Small Business Administration (SBA) loan reforms, and other financial incentives or benefits to support a practice type that both provides quality health care and embodies the Main Street business model that is essential to our nation's economy. The AAFP has several policy ideas to support independent primary care physician practices, and we welcome the opportunity to work directly with the Committee to advance them.

Oversight of Tax-Advantaged Hospitals

As stated earlier, non-profit, or tax-advantaged, hospitals can play an integral role in the health care needs of communities across the country. It is crucial however, that these entities are closely adhering to the rules through which they achieve that special status. One of the key policy mechanisms available to non-profit hospitals are tax exemptions, including state, federal, and local. We firmly believe that the tax-exempt status of non-profit hospitals that are fulfilling their commitment to advancing the health and well-being of their communities should not be subject to threat if they uplift the patient-physician relationship and offer comprehensive, patient-centered, evidence-based care.

In exchange for tax exemptions, which totaled \$37.4 billion in 2021, non-profit hospitals are required to provide charitable contributions to the community.^{ix} However, we are concerned by growing evidence that non-profit hospitals receiving tax exemptions are not prioritizing this responsibility. One study of tax-advantaged hospitals found that 24 percent received more tax benefits than they spent on community benefits, and 81 percent received more than they spent on charity care.^x

Some research has suggested that non-profit hospitals commit a similar or, in some cases, a smaller share of their operating expenses to charity care and unreimbursed Medicaid costs (one of the most common community benefit activities) when compared to for-profit hospitals.^{xi} Meanwhile, compensation for CEOs of non-profit hospitals and medical systems increased 30 percent between 2012 and 2019.^{xii} In some cases, the highest paid non-profit hospital CEOs made 60 times the hourly pay of general hospital workers.^{xiii} Additional research indicates non-profit hospitals have higher operating margins than for-profit hospitals, and these surpluses are used to increase cash reserve balances, not to provide charity care.^{xiv} The same study found that a one dollar increase in profit was not associated with a statistically significant increase in charity care for non-profit hospitals, while for-profit hospitals had a four-cent increase in charity care for every additional dollar of profit.^{xv}

Hospital financial reserves can help non-profit health systems maintain solvency during downturns or emergencies, such as the COVID-19 public health emergency.^{xvi} However, some large systems direct cash reserves to launch venture capital funds.^{xvii} There is no evidence that gains from these investment funds are used to maintain or expand charity care during economic downturns. For example, one system reporting operating losses in 2023 cited significant gains in an associated investment fund, but funding for charity care was still cut that year.^{xviii}

To be federally-tax exempt, non-profit hospitals must meet the general requirements applied to all 501(c)(3) organizations, as well as two hospital-specific requirements: 1) they must meet the "community benefit standard" evaluated by the Internal Revenue Service (IRS), and 2) they must comply with requirements specified under I.R.C. § 501(r). The community benefit standard is a test the Internal Revenue Service (IRS) uses to determine whether a hospital is organized and operated for the charitable purpose of promoting health.

However, there remains a lack of specificity about what services qualify or how many tax-exempt non-profit hospitals must provide. There is no federal minimum community benefit standard spending threshold or requirement that they must meet to maintain their tax exemptions. Additionally, there is no explicit definition of what a community benefit is. This has led to significant variations across states and areas in how much non-profit hospitals are reinvesting into the community. Some states have implemented requirements for non-profit hospitals to provide a certain minimum level of charity care or community benefits, but no states tie meeting this requirement to maintaining a hospital's tax-exempt status.^{xix}

To ensure that tax-advantaged hospitals are truly meeting their mission, the Academy strongly encourages Congress to pursue the following policy recommendations:

- **Implement greater transparency and accountability through more explicit community benefit standard requirements.** Specifically, Congress should establish a federal minimum benchmark for hospital spending toward community benefit activities. Examples of metrics states have used include "in an amount equivalent to the hospital's property tax liability in the absence of exemption" and "in an amount equivalent to 5 percent of the hospital's operating expenses." Further, there should be a clear definition of what specific activities and services meet the community benefit standard.
- **Prohibit the use of overly restrictive non-compete agreements by non-profit hospitals.** As the landscape of employment for physicians has shifted toward employment, non-compete agreements in health care threaten to disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated health care market. In the absence of prohibiting their usage across all non-profit hospital physician contracts, lawmakers could consider tying a hospital's tax-exempt status to their inclusion of non-profit agreements within physician employment contracts.

- **Ensure that the IRS and oversight agencies, such as the Federal Trade Commission and the Department of Justice, have the appropriate resources to monitor and pursue bad actors as needed.** We have urged the Departments of Justice and Health and Human Services and the Federal Trade Commission to increase monitoring of tax-exempt health systems to ensure profits are used to reinvest in it the organization's stated mission to provide care, not channeled to speculative investments.
- **Require more accurate and updated data reporting by non-profit hospitals.** Specifically, policymakers should require hospitals to disclose their estimated tax benefits so that community benefits and tax exemptions can be compared. We also encourage updates to Schedule H of Form 990 so that community benefits are reported at the individual hospital facility level – as the Government Accountability Office has recommended – rather than across the entire hospital organization.^{xx} This would provide greater transparency as an aggregated total does not capture what benefits are flowing down to each individual community.

Reimagining Graduate Medical Education for Primary Care

We appreciate that this Committee continues to have conversations about the need to reimagine and reform our nation's federally funded GME system, as evidenced by a recent hearing on the topic. The AAFP continues to believe that there are significant opportunities to alter our existing approach to GME in a way that better serves and supports the growth of primary care physician workforce.

To address current and projected physician shortages, many physician groups advocate for a large overall increase in new GME slots. While the AAFP supports an overall increase in slots, we have not identified a specific number of slots needed to address the projected shortage of all physicians. However, AAFP policy is that effective health care systems should have a physician workforce that includes around 50% of physicians focused on primary care. Any legislation that aims to increase GME slots should therefore allocate at least 50% to primary care specialties. Additionally, the AAFP believes that the geographic distribution of slots – specifically for rural and underserved communities – should also be a key component of any GME reforms. Most physicians are trained at large academic medical centers and hospitals in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.^{xxi} **As a result, the current distribution of GME slots has led to physician shortages that are particularly dire in medically underserved and rural areas.**

The AAFP also [supports](#) policy proposals that modify the current definition of "rural hospitals" to better tailor the distribution of GME slots into *truly* rural areas. The AAFP believes that an updated definition of "rural" should align with other CMS-defined criteria (*all people and territory in an area with less than 50,000 people*) and that parameter should be used to allocate at least 10% of slots to rural hospitals, regardless of their Health Professional Shortage Area (HPSA) score. The AAFP appreciates the work that HRSA and other agencies have undertaken in recent years to promote health and health equity in rural and


underserved communities, and we believe this change would better support their goals of delivering better care where patients most need it.

The Committee should also prioritize efforts to require greater transparency and data collection to ensure that GME slots are being allocated appropriately and most effectively for the communities they serve. The AAFP [supports](#) policies that would provide authority to the Secretary of Health and Human Services to utilize existing data and to collect any additional data necessary to enable tracking, research, and analysis on the impact of federal GME funding on the geographic and specialty distribution of the physician workforce, as well as other outcomes of interest to the health of the public. This data should also include analysis of the benefits and potential negative outcomes that may result from rural reclassification.

Further, the AAFP would appreciate the opportunity to collaborate with the Committee and to share the Robert Graham Center's [Graduate Medical Education Impact Quotient \(GME-IQ\)](#) metric and associated data tool to assist with transparency and measuring outcomes regarding the successful recruitment and retention of primary care physicians, especially into rural areas. Using the [GME-IQ](#) data tool, we can track the recruitment of primary care physicians into rural GME programs, but more importantly we can measure whether or not that physician chose to stay in those same areas and provide the continuity of care that is a cornerstone of primary care services.

Thank you for the opportunity to provide this feedback. The AAFP appreciates the Committee's commitment to ensuring that hospitals and health systems are serving the best interests of the physicians who deliver care and the patients who need it. If you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs at mmortimer@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Jen Brill, MD". The signature is written in a cursive, flowing style.

REMOVE ONCE APPROVED

Jen Brill, MD, FAAFP

American Academy of Family Physicians, Board Chair

ⁱ https://www.fitzgibbon.org/news/fitzgibbon-hospital-adjusts-to-economic-headwinds?utm_source=chatgpt.com

ⁱⁱ <https://www.milbank.org/publications/the-health-of-us-primary-care-2025-scorecard-report-the-cost-of-neglect/ii-workforce-access-insufficient-funding-is-diminishing-the-primary-care-workforce-and-access-to-care/>

ⁱⁱⁱ Health Resources and Services Administration. "The Future of the Health Workforce: Primary Care Physician Supply and Demand Projections." December 2025.

^{iv} Starfield B, Shi L, Macinko J. "Contribution of primary care to health systems and health." *Milbank Q.* 2005;83(3):457–502.

-
- [iii] Health Resources and Services Administration. "The Future of the Health Workforce: Primary Care Physician Supply and Demand Projections." December 2025.
- [xiv] U.S. Government Accountability Office. "Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status." GAO-20-679. September 17, 2020.
- [v] [Financial Integration's Impact On Care Delivery And Payment Reforms: A Survey Of Hospitals And Physician Practices - PMC](#)
- [vi] [GAO-25-107450, HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation](#)
- [viii] Schwartz K, Damico A, Neuman T. "What we know about provider consolidation." KFF. September 20, 2022.
- viii Congressional Research Service, "Medicare Payment for Rural or Geographically Isolated Hospitals, 2021". Available: <https://www.congress.gov/crs-product/IG10023>
- [ix] [U.S. Nonprofit Hospitals Received More than \\$37 Billion in Total Tax Benefits in 2021 | Johns Hopkins | Bloomberg School of Public Health](#)
- [x] [Beyond the Bottom Line: Assessing Charity Care, Community Benefits, and Tax Exemptions in Nonprofit Hospitals | HBHI](#)
- [xi] Petterson SM, Liaw WR, Phillips RL Jr, et al. "Projecting US primary care physician workforce needs: 2010–2030." *Ann Fam Med*. 2012;10(6):503–509.
- [xii] Plummer E, Socal MP, Bai G. "Estimation of tax benefit of US non-profit hospitals." *JAMA*. 2024;332(20):1732–1740. doi:10.1001/jama.2024.13413.
- [xiii] Zare H, Anderson GF. "Beyond the bottom line: assessing charity care, community benefits, and tax exemptions in non-profit hospitals." *J Healthc Manag*. 2024;69(6):439–454. doi:10.1097/JHM-D-24-00080.
- [xiv] Bai G, Zare H, Hyman DA. "Evaluation of unreimbursed Medicaid costs among non-profit and for-profit US hospitals." *JAMA Netw Open*. 2022;5(11):e2244260. doi:10.1001/jamanetworkopen.2022.44260.
- [xv] Jenkins D, Short MN, Ho V. "The determinants of non-profit hospital CEO compensation." *PLoS One*. 2024;19(7):e0306571. doi:10.1371/journal.pone.0306571.
- [xvi] Economic Policy Institute. "CEO pay has skyrocketed 1,209% since 1978." October 2, 2024.
- [xvii] Jenkins D, Ho V. "Non-profit hospitals: profits and cash reserves grow, charity care does not." *Health Aff (Millwood)*. 2023;42(6):866–869. doi:10.1377/hlthaff.2022.01542.
- [xviii] Jenkins D, Ho V. "Non-profit hospitals: profits and cash reserves grow, charity care does not." *Health Aff (Millwood)*. 2023;42(6):866–869. doi:10.1377/hlthaff.2022.01542.
- [xix] Jenkins D, Ho V. "Non-profit hospitals: profits and cash reserves grow, charity care does not." *Health Aff (Millwood)*. 2023;42(6):866–869. doi:10.1377/hlthaff.2022.01542.
- [xx] [The Future of Non-profit Hospitals: How New Charity Care Rules Could Shape What's Next](#)
- [xxi] Lown Institute. "Hospitals invest billions in Wall Street while cutting services." 2024.
- [xxii] America's Essential Hospitals. "Hospital Innovation and Venture Funds: Emerging Models for Investing in Health Care Innovation." 2019.
- [xxiii] [The Impact of Graduate Medical Education on Physician Maldistribution](#)