Documents for the Record

Subcommittee on Health Hearing
Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape
March 18, 2026

Majority:

1. March 18, 2026, statement by the American Physical Therapy Association.
2. March 18, 2026, statement by Blood Cancer United.
3. March 18, 2026, statement by the American Academy of Dermatology Association.
4. March 18, 2026, statement by the American College of Cardiology.
5. March 18, 2026, statement by the ERISA Industry Committee.
6. March 18, 2026, statement by the American Benefits Council.
7. March 18, 2026, statement by the American Dental Association.
8. March 18, 2026, statement by the Consumers for Fair Hospital Pricing.
9. March 18, 2026, statement by the American Association of Orthopaedic Surgeons.
10. March 18, 2026, statement by the American Nurses Association.
11. March 18, 2026, statement by the Society of Hospital Medicine.
12. March 18, 2026, statement by the American Pharmacists Association.
13. March 18, 2026, statement by the Society of General Internal Medicine.
14. March 18, 2026, statement by the American College of Physicians.
15. March 18, 2026, statement by the Alliance to Fight for Health Care.
16. March 18, 2026, statement by AHIP.
17. March 18, 2026, statement by the American Association of Nurse Anesthesiology.

Minority:

1. March 16, 2026, letter to Majority Leader Thune, Minority Leader Schumer, Speaker Johnson, and Minority Leader Jeffries from the Disability and Aging Collaborative and the Consortium for Constituents with Disabilities submitted by Rep. Pallone.
2. March 18, 2026, statement by Teresa Miller, JD, National Director of Health Initiatives submitted by Rep. Pallone.
3. March 17, 2026, statement by AARP submitted by Rep. Pallone.
4. March 18, 2026, statement by Families USA submitted by Rep. Pallone.
5. March 16, 2026, statement by the American Association of People with Disabilities submitted by Rep. Pallone.
6. March 18, 2026, statement by the Partnership to End the HIV, STI, and Hepatitis Epidemics submitted by Rep. Pallone.
7. April 16, 2025, Health Affairs article entitled “History Repeats? Faced with Medicaid Cuts, States Reduced Support for Older Adults and Disabled People” submitted by Rep. DeGette.
8. March 18, 2026, statement by the Federation of American Hospitals.
9. March 18, 2026, statement by the American College of Physicians.

10. March 18, 2026, statement by the Alliance for Fair Health Pricing.
11. March 18, 2026, statement by Blood Cancer United.
12. 2025, report from Blood Cancer United entitled “High prices, higher stakes: Policy solutions to tackle rising healthcare costs.”
13. March 18, 2026, statement by Consumers for Fair Hospital Pricing.
14. March 16, 2026, article from KFF entitled “CMS’ New Approach to Federal Medicaid Spending in Cases of Potential Fraud.”
15. March 18, 2026, statement by American Academy of Physician Associates.
16. March 18, 2026. statement by AHIP.
17. March 18, 2026, statement by the Children’s Hospital Association.
18. March 18, 2026, statement by American Dental Association.
19. March 4, 2026, article from Caring Across Generations entitled, “Federal Cuts, State Choices, and the Future of Aging and Disability Care.”
20. Report from the National Consumers League entitled, “Aggressive Debt Collection Practices in 340B Hospitals Despite Higher Cancer Burdens.”
21. March 11, 2026, article from the National Health Law Program entitled “Explainer: CMS's Deferral, Disallowance, and Withholding Actions in Minnesota.”
22. March 17, 2026, statement of Leading Mental Health and Substance Use Disorder Organizations on Medicaid.
23. March 17, 2026, article from First Focus on Children entitled, “The Real Scandal is Failing to Protect and Support the Nation's Children.”
24. March 16, 2026, article from Health Affairs entitled, “Unfounded Fraud Allegations Threaten Vital Medicaid Home And Community-Based Services.”
25. March 11, 2026, New York Times article entitled “In Talking to parents About Vaccines, Pediatricians Navigate a Sea of Misinformation” submitted by Rep. Carter (LA).
26. February 25, 2026, CNN article entitled “Hospitals fighting measles confront a challenge: Few doctors have seen it before” submitted by Rep. Carter (LA).
27. March 16, 2026, Washinton Post article entitled “Judge halts RFK Jr.’s vaccine overhaul, citing flawed process” submitted by Rep. Carter (LA).

U.S. House Energy and Commerce Health Subcommittee

Hearing: “Lowering Health Care Costs for all Americans: An Examination of the U.S. Provider Landscape”

March 18, 2026

Statement for the Record by the American Physical Therapy Association

3030 Potomac Ave., Suite 100 / Alexandria, VA 22305-3085 / 703-684-2782 / apta.org

Chairman Griffith, Ranking Member DeGette, and Members of the U.S. House Energy and Commerce Health Subcommittee:

On behalf of the approximately 100,000 physical therapists, physical therapist assistants, and students of physical therapy who are members of the American Physical Therapy Association, APTA, we submit the following comments in advance of the Subcommittee's hearing, *"Lowering Health Care Costs for All Americans: An examination of the U.S. Provider Landscape."* APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in prevention, wellness, fitness, health promotion, and the management of disease and disability across the lifespan, helping individuals improve overall health and avoid unnecessary health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

We also direct the Subcommittee's attention to two relevant and complementary APTA publications: First, "The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants in multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs. The Subcommittee should consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services in rural and underserved areas, and to support policies that position physical therapists as entry-point providers, ensuring beneficiaries have timely access to proven, cost-effective care, as outlined in our recommendations below.

APTA applauds the Subcommittee for holding this hearing, and we offer the following policy recommendations.

Reforming the Unsustainable Medicare Payment Reform System

The most critical issue facing healthcare providers is the uncertainty and instability of the current structure of the Medicare payment and reimbursement system. With declining or flat payment rates and the rapidly increasing cost of owning and operating a healthcare practice, APTA is deeply concerned that many providers may give up a private practice or possibly exit the profession.

It is imperative that Congress enact meaningful reforms to the Medicare Physician Fee Schedule, or MPFS, to improve payment and provide stability for practices. Congress must take action to reform this unsustainable system to ensure that Medicare payments to providers accurately reflect the cost of practice and ensure timely access to care for Medicare beneficiaries. The following are five policy solutions to reform the fee schedule and help provide stability to therapy providers and the patients they serve.

- **Provide an Annual Payment Update Based on Inflation**: Step one is for Congress to ensure that Medicare payments to providers in 2025 and beyond are adjusted annually with an inflationary update. The MPFS is the only Medicare payment system lacking an annual inflationary update. Physical therapy practices, many of which are small businesses, face rising costs for office rent, clinical and administrative staff wages, and administrative burden. APTA strongly supports the enactment of an annual payment update under the fee schedule tied to the Medicare Economic Index. This reform would provide an annual payment update, helping to stabilize practices and enable long-term planning, investment in practices, and the delivery of high-quality, patient-centered care.

- **Increase the Budget Neutrality Trigger**: Cuts to the MPFS are triggered by a policy known as budget neutrality, which mandates that any estimated increases of $20 million or more to the Medicare fee schedule —resulting from upward payment adjustments or the addition of new procedures or services — must be automatically offset by cuts elsewhere. This rigid $20 million threshold has not been updated since 1992, despite a growing beneficiary population and the increasing number of medical procedures formerly performed in the inpatient setting that are now performed in the outpatient setting and billed to the fee schedule. Increasing the threshold would reduce the triggering of automatic, across-the-board fee schedule cuts, permitting needed spending flexibility to address beneficiary needs without imposing cuts on all providers.

- **Require Regular Update to Practice Expenses:** Congress should direct the Centers for Medicare & Medicaid Services, or CMS, to update the direct inputs for practice expense relative value units at least every five years. Direct inputs include clinical wages, costs of supplies, and prices of equipment, which increase with inflation. In the past, direct inputs were reviewed by CMS only after many years, resulting in significant redistribution of payments and cuts to some providers.

- **Repeal the Multiple Procedure Payment Reduction Policy:** In 2013, Congress implemented the Multiple Procedure Payment Reduction, or MPPR, for physical, occupational, and speech-language therapy services under Medicare Part B. This

decision was made without solid evidence, primarily to offset costs related to the sustainable growth rate, or SGR, which has since been repealed through the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2). As a result, average therapy claim payments dropped by 8.5% in 2013 compared to 2010, despite the lack of justification for these cuts. MPPR applies excessive and unnecessary payment reductions to specific "always therapy" codes, significantly impacting the financial viability of therapy practices and limiting access to vital therapy services.

- **Reform the Quality Payment Program:** The Quality Payment Program, or QPP, comprises two payment tracks: the Merit-based Incentive Payment System, or MIPS, and Advanced Alternative Payment Models, or APMs. In its current form, the QPP poses significant challenges to non-physician providers, including physical therapists. Therapists have struggled to meaningfully participate in MIPS or engage in APMs. One reason for this difficulty is that CMS has failed to pilot or implement several alternative payment and delivery models applicable to therapy providers. Additionally, the cost of participating in these programs often outweighs any potential payment adjustments, and the interoperability requirements for participation are an insurmountable burden for most providers. Congress must enact meaningful reforms to the QPP that recognize the value of therapy providers and facilitate their meaningful participation.

Bolstering the Healthcare Workforce in Rural and Underserved Areas

APTA strongly endorses *H.R. 5621 - the Physical Therapist Workforce and Patient Access Act*. This bipartisan legislation would improve access to physical therapy in rural and medically underserved communities by adding physical therapists as eligible providers under the National Health Service Corps, or NHSC, Loan Repayment Program. This legislation would also better enable federal community health centers to provide patients with greater access to physical therapy care and rehabilitative services. APTA applauds Subcommittee Chairman Griffith and Ranking Member DeGette for introducing this bipartisan legislation.

Many areas throughout the United States are experiencing a dire shortage of health care providers. Patients in medically underserved areas, designated as Health Professional Shortage Areas, or HPSA, by the Health Resources Services Administration, or HRSA, are faced with little access to critical forms of health care treatment. According to the federal Bureau of Health Workforce, an estimated 75 million people live in a region where there is insufficient availability of basic primary care as well as other services, including physical

therapist services.[1] Research published by APTA in March 2025 predicts a continued shortage of physical therapists through 2037, driven by increasing patient demand. Researchers found that over the next 12 years, there will be 22.9% fewer PTs available to patients. Factors contributing heavily to this shortage are burdensome administrative requirements imposed by insurance companies and public health programs, continuing declines in reimbursement rates, student debt, and other variables.[2]

The Physical Therapist Workforce and Patient Access Act would enact two critical steps to support the physical therapist workforce in rural and underserved areas by doing the following:

First, to support the recruitment of physical therapists to rural and medically underserved areas, the legislation would add physical therapists to the list of eligible providers under the National Health Service Corps Student Loan Repayment program, which is effective at recruiting and retaining certain medical providers to practice in rural and underserved regions. The NHSC, administered by HRSA, is a federal program that provides financial incentives to select health care providers to practice in HPSAs. Under the NHSC program, eligible health care providers who complete at least a two-year service commitment in an HRSA-approved facility located in a HPSA may qualify for limited medical school loan repayment of up to $50,000. The NHSC has proven to be highly successful. Based on data from the Congressional Research Service, HPSAs greatly benefit from the NHSC program, as many NHSC providers remain in their service areas. Approximately 85% continue to practice in the HPSA for a year after their service commitment, and about half remain in the HPSA for 10 years.[3]

The NHSC has approximately 16,000 participating providers that care for an estimated 23 million individuals residing in medically underserved with about 16,000 areas across the nation.[4] Currently, participation in NHSC is limited to physicians, physician assistants, dentists, nurse practitioners, nurse midwives, and behavioral/mental health providers. In our view, this means the program is missing a critical element for promoting health across the continuum of care: the program does **not** include a physical rehabilitation component. As experts in rehabilitation and habilitation, physical therapists help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists play an important role on the health care team for the prevention and management of pain, chronic diseases, and conditions such as diabetes, stroke, and obesity, and their impact on an individual's quality of life and ability to work in their community.

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[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-health-workforce-report-2024.pdf
[2] https://www.apta.org/apta-and-you/news-publications/reports/2025/apta-supply-demand-forecast-2022-2037
[3] https://sgp.fas.org/crs/misc/R44970.pdf
[4] https://sgp.fas.org/crs/misc/R44970.pdf

Adding physical therapists to the NHSC Loan Repayment Program would help ensure that patients in rural and medically underserved areas have access to physical therapist services and would assist in growing the health care workforce in these communities.

Second, the legislation would provide more options for CHCs in how they provide physical therapist services. More than half of NHSC participants provide care in federal community health centers.[5] CHCs provide health services to approximately 32.5 million patients.[6] However, CHCs are restricted in how physical therapist services are provided and reimbursed. H.R. 5621 would address this limitation by allowing physical therapists to provide care to patients in CHCs and bill Medicare and Medicaid for the benefits covered by their plans. H.R. 5621 does not mandate that CHCs furnish physical therapy but rather presents CHCs with the necessary flexibility to offer physical therapist services to children and adults who may require such services.

H.R. 5621 would also help our nation's health care system address the opioid crisis. There is a growing realization that, at best, opioid-centric solutions for dealing with pain mask patients' physical problems and delay or impede recovery. At worst, they may prove to be dangerous or even fatal. H.R. 5621 will ensure that patients in rural and underserved areas have increased access to nonpharmacological options for the prevention, treatment, and management of pain, such as physical therapy.

Difficulties recruiting physical therapists to practice in medically underserved areas is compounded by a growing need for their services caused by an aging population. As the older adult segment of our population continues to rapidly grow, it will be paramount that older Americans have access to qualified health care professionals who are able to serve their health care needs, including physical therapists. The prompt and coordinated services provided by health professionals, including physical therapists, can help to avoid hospitalizations, reduce falls, decrease the length of institutional stays, reduce the amount of care required after discharge, prevent complications, and improve the individual's level of function. Incentivizing PTs to work in medically underserved areas is vital to the health of our society. However, providing those incentives is challenging given the issue of student debt burden.

Adding PTs as eligible providers in NHSC and providing CHCs with flexibilities and options for how they provide physical therapy will be critical in addressing health care workforce shortages and improving health outcomes in medically underserved areas.

Expanding Locum Tenens Contracting Under Medicare to Provide Staffing Flexibilities for Outpatient Therapy Clinics

[5] https://www.congress.gov/crs_external_products/R/PDF/R44970/R44970.17.pdf
[6] https://www.nachc.org/wp-content/uploads/2023/08/Americas-Health-Centers-2024_FINAL-2.pdf

APTA is endorsing H.R. 1517/S. 2225 - The Prevent Interruptions in Physical Therapy Act. This bipartisan legislation would allow physical therapists in all geographic regions of the United States to enter into locum tenens arrangements under Medicare.

The ability to bring in a replacement provider during a provider's temporary absences for illness, pregnancy, vacation, or continuing medical education is known as locum tenens. The 21st Century Cures Act of 2016 contained a provision that added PTs to the health care professionals who may use locum tenens under Medicare. This allows a PT to bring in another licensed PT to treat Medicare patients and bill Medicare through the practice provider number during temporary absences. The law, however, applies only to physical therapists in nonmetropolitan statistical areas, medically underserved areas, and HPSAs as defined by the U.S. Department of Health and Human Services. This limitation prohibits many PTs in private practice from taking needed absences without interrupting patient care. Locum tenens arrangements are beneficial to both patients and providers, as care is continued by another licensed, qualified provider during a temporary absence.

By expanding the use of locum tenens by physical therapists nationwide, H.R. 1517/S. 2225 will relieve the workforce burdens on outpatient clinics as well as provide uninterrupted patient care to Medicare beneficiaries. It is important that Medicare recipients are treated consistently and efficiently to prevent regression. Patients who experience regression may potentially need more care, resulting in an increase of expenses and an unnecessary barrier to patient care. This legislation would improve the quality of life of Medicare patients and enable clinics to manage situations when PTs must take time off from work when necessary.

Increasing Medicare Patient Choice of Healthcare Providers

APTA supports H.R. 4204 – the Medicare Patient Choice Act, which would add PTs to the list of healthcare provider groups who may privately contract with Medicare enrollees to ensure such patients have continued access to the provider of their choice.

Currently, PTs, OTs, and SLPs may not opt out of being Medicare-enrolled providers if they provide services to Medicare-eligible beneficiaries. This prevents Medicare beneficiaries from exercising their right to select the health care professional of their choice, including allowing beneficiaries to privately contract with these therapists for their care regardless of whether the therapist has elected to enroll in Medicare. To provide true patient choice and ensure access to the most appropriate care, PTs, OTs, and SLPs must be able to opt out of the established enrollment rules set by the Medicare program and federal law along with physicians, physician assistants, dentists, podiatrists, optometrists, social workers, psychologists, nurse midwives, dietitians, and other eligible providers. Denying a patient access to a therapist with expertise because that provider is not enrolled in Medicare also

negatively impacts patients' clinical outcomes and can lead to increased downstream costs to the system.

It is imperative that Medicare enrollees have the opportunity to choose the most appropriate provider and model of care to meet their needs. Medicare's inflexible policies have stifled implementation of innovative programs that can support the long-term health and wellness of Medicare beneficiaries. Certain evidence-based therapy interventions cannot be reimbursed under current Medicare payment policies. Allowing therapy providers to opt out would give Medicare beneficiaries the opportunity to benefit from these critical interventions to which they are currently denied access.

According to an independent study by Dobson DaVanzo, allowing physical therapists, occupational therapists, and speech-language pathologists the option to opt-out is estimated to save roughly $140 million over ten years.

Conclusion

APTA appreciates the Subcommittee holding this hearing and for the opportunity to provide comments. Should you have any questions, please contact Steve Kline (stevekline@apta.org) with APTA Congressional Affairs. Thank you for your time and consideration.

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March 18, 2026

The Honorable Morgan Griffith
Chair
Energy and Commerce Subcommittee on Health

The Honorable Diana DeGette
Ranking Member
Energy and Commerce Subcommittee on Health

Statement for the record Re: Energy and Commerce Health Subcommittee hearing on "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chair Griffith and Ranking Member DeGette -

On behalf of the more than 1.5 million Americans living with a blood cancer diagnosis, Blood Cancer United (previously The Leukemia & Lymphoma Society) appreciates the opportunity to provide this statement for the record regarding addressing the nation's rising healthcare costs and the impact these costs have on patients and their families.

As the largest nonprofit organization dedicated to blood cancer patients and their families, we advocate for policies that ensure access to affordable, comprehensive, and high-quality healthcare without compromising patient outcomes. Patients living with blood cancers face not only the physical burden of disease but also financial toxicity – the cumulative cost burden of treatment, care, and survivorship that can threaten patients' ability to continue therapy or maintain financial stability. Blood Cancer United launched our Cost of Cancer Care initiative in 2017 to address this growing issue, and we continue to advocate for aggressive but feasible cost-cutting policy solutions that would not sacrifice quality of care.[i] We offer the following policy recommendations for the Committee to consider to help lower healthcare costs, incentivize high-quality care, and ensure patients can access the care they need when they need it.

Addressing market consolidation

Today, a handful of large health systems increasingly dominate several U.S. markets. This allows those systems, hospitals, and providers to demand higher reimbursement from commercial payers through concentrated market power. Market consolidation directly impacts patients' ability to afford care and services.[ii] When markets are highly concentrated, insurers and employers have reduced leverage to negotiate with providers to keep prices down and ensure that care is affordable for their members. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums, out-of-pocket costs, and reduced wages.

Despite the promises of efficiency gains by healthcare systems,[iii] mergers and market consolidation come at a cost to patients and consumers—literally. Research on hospital mergers uniformly finds that mergers raise hospital prices for both for-profit and non-profit hospitals.[iv] Post-merger, hospital prices have been estimated to increase by as much as 54 percent.[v] This finding also holds true for physician practices, with practices charging higher prices after merging with other practices, as well as practices in more concentrated markets charging higher prices than those in less concentrated markets.[vi,vii]

Blood Cancer United urges Congress and states to lower the statutory acquisition threshold for healthcare mergers and acquisitions and to mandate more reporting. This would allow the Federal Trade Commission (FTC), Department of Justice (DOJ), and state enforcement agencies the opportunity to review a larger number of mergers and acquisitions in healthcare.[viii] Congress should also evaluate policies that would expand and enhance existing premerger notifications and reviews,

and increase funding for enforcement activities to expand regulatory agencies' capacities to investigate a wider range of anti-competitive consolidation and enhance market surveillance.

Additionally, Congress, the Administration, and states should direct regulatory and oversight agencies to develop and use a robust patient-, consumer-, and equity-focused framework to guide merger and anti-competitive practice evaluations. Unlike many other sectors of our economy, healthcare is a resource that all people will use at some point in their lives; yet it suffers from a chronic lack of transparency and accountability to the patients and consumers who use it. To ensure that patients, including those in medically underserved communities, are not harmed by mergers or market consolidation, we urge policymakers to include patient health and outcomes as key components of healthcare merger review policy, reflecting empirical research that shows reduced competition results in worse outcomes for patients and consumers.[ix]

Prohibiting anti-competitive contracting

Blood Cancer United supports banning 'gag clauses' that prohibit plans from sharing information about provider costs and quality. This information is incredibly valuable to consumers as they consider their treatment options. Yet, particularly in areas where provider consolidation increases the leverage of a hospital or specialty group practice, a clear prohibition on this type of contract clause is the only way to ensure consumer access to this type of information. While the Consolidated Appropriations Act of 2021 formally banned this practice, enforcement of these provisions should be a priority.

Similarly, anti-competitive contracting terms such as non-compete clauses and all-or-nothing clauses drive up healthcare costs for consumers. We urge policymakers to respond to provider consolidation trends by banning or significantly restricting the use of anti-competitive contracting terms that harm patients and consumers, and to focus hospitals and clinicians on providing quality care rather than protecting or increasing revenue through vertical consolidation. Given the monopolistic nature of large hospitals and specialty group practices in certain regions, plans have little leverage to dispute the inclusion of anti-competitive contract clauses that protect the financial interests of providers without incentivizing quality care. We are confident that such efforts will save money for taxpayers and plan participants.

Expanding site-neutral payments

Pricing dynamics can incentivize anticompetitive consolidation and exacerbate the price increases associated with already consolidated markets. The incentive for provider consolidation is largely driven by unchecked pricing practices, allowing providers and hospitals to amass outsized market power and effectively set their own prices with employers and issuers that are divorced from value. For instance, under current law, providers are allowed to charge higher Medicare rates for many services provided by off-campus hospital outpatient departments than for services in the same type of outpatient setting not affiliated with a hospital. This incentivizes hospital acquisition of provider groups and can significantly drive-up prices and consumer costs post-consolidation.

Blood Cancer United strongly supports legislation that would advance recommendations from MedPAC and other experts to implement site-neutral reforms. Such reforms would lower out-of-pocket costs for patients by implementing site-neutral reforms for comparable services in targeted settings and promote transparency in facility billing to understand where a service has been provided. In a study commissioned by Blood Cancer United, patients with chronic and life-threatening conditions – including blood cancer, breast cancer, Crohn's disease, rheumatoid arthritis, and more – could save thousands per year under these reforms.[x] For example, a patient with multiple myeloma, a type of

blood cancer, would save more than $1,100 in out-of-pocket costs annually if site-neutral payments were implemented across the variety of services included in a typical treatment regimen.

Congress must get the details right and limit site-neutral methodology to payments for services that can be safely and effectively provided in any setting. Evidence suggests that some hospitals providing specialty cancer care, specifically NCI-Designated Comprehensive Cancer Centers, routinely deliver higher-quality cancer care that leads to better outcomes than similar care provided in community settings.[xi] As such, we recommend that Congress exempt payments for care provided at these facilities from site-neutral reforms.

Reining in facility fees

In the commercial market, higher patient and consumer costs manifest as facility fees. Facility fees are charges assessed by a healthcare facility in addition to professional service charges. While facility fees were historically used by hospitals to recoup additional overhead costs associated with complex round-the-clock operations, they are increasingly assessed at off-campus sites such as primary care offices, local clinics, and even, in some cases, for telehealth visits. These fees are often not covered by insurance and, as a result, are typically directly billed to patients.

Blood Cancer United supports state and federal legislation that would address financial harm to patients from facility fees. States such as Colorado, Connecticut, Indiana, and Maine have recently taken strong steps toward regulating and curtailing these fees. These measures include prohibiting fees for:

- Routine services, such as "evaluation and management" or E&M codes, regardless of their site of service,
- Care delivered at a facility located separate from a main hospital campus, or
- Fees sent directly to a patient, without being based on the patient's insurance's contracted rates and subject to plan cost-sharing.

Blood Cancer United supports efforts that benefit consumers by limiting or eliminating the direct financial harm from these fees and promoting proper patient financial protections.

Aligning provider payment incentives to rein in prescription drug costs

Over the past several decades, the U.S. healthcare system has developed perverse incentives that reward healthcare providers for prescribing higher-cost drugs when lower-cost alternatives are available and clinically appropriate. Although we have seen some progress in value-based initiatives that better align incentives, too often patients with costly conditions treated in whole or in part by prescription drugs are being prescribed the higher-cost option. These incentives increase patient out-of-pocket costs while simultaneously raising healthcare costs for consumers, employers, and taxpayers.

Although biosimilars have been available as lower-cost, clinically appropriate alternatives to some costly drugs since 2015, provider adoption has been slowed by the fact that reimbursement methodologies typically penalize providers with lower payments when they prescribe lower-cost biosimilar drugs. As one expert recently put it, "This fundamental misalignment between what is best for the provider's bottom line and what is best for the payer's budget is the single greatest barrier to biosimilar adoption for drugs covered under the medical benefit."[xii] To address this perverse incentive in Medicare, in 2022, Congress established a new payment methodology that currently provides a small payment *bonus* (2 percent of the reference product's average sales price) when the provider delivers a biosimilar versus a reference biologic. This bonus payment is intended to apply for the first

five years after biosimilar entry, in order to promote more widespread adoption among prescribers. Policies like this one – aimed directly at removing perverse incentives – are critical to addressing high drug costs. In fact, a recent study found that those Medicare patients who pay coinsurance for their biologic medication saw a significant reduction in their individual out-of-pocket costs after biosimilar competition.[xiii] Congress should consider mechanisms to build on this policy to further adjust provider payment in ways that lower drug costs for patients and taxpayers while promoting access to appropriate care.

Critically, direct reimbursement is not a providers' sole incentive to prescribe higher-priced drugs. The 340B program provides a financial opportunity for participating hospitals that can maximize 340B-related rebate revenue by prescribing higher-priced drugs over lower-priced drugs.[xiv] These incentives have been shown to increase drug spending at 340B-participating hospitals and throttle 340B-participating hospitals' adoption of lower-cost biosimilar drugs.[xv,xvi] Congress needs to thoughtfully address such perverse incentives.

Enforcing and expanding cost transparency

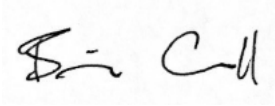
Transparency is essential for accountability and informed policymaking. While federal rules require hospitals to disclose pricing information, compliance with these requirements remains uneven and incomplete, limiting the ability of patients, researchers, and policymakers to understand true costs. Enhancing enforcement and oversight, in addition to expanding data reporting requirements, will make price data more accurate and usable.

In addition to price transparency, policymakers should take steps to improve ownership transparency of health care facilities, particularly as private equity (PE) continues to play an ever-larger role in our health care system. Greater transparency regarding ownership and provider performance information has the dual benefit of allowing regulators – and, to a lesser extent, consumers – to track patient access and outcomes as well as costs stemming from market forces such as consolidation and PE investment.

Blood Cancer United stands ready to work with you and your colleagues in Congress to advance the solutions we have outlined above and other proposals that would achieve savings without sacrificing patient access to appropriate cancer care. We share your belief that we are at a crucial juncture in our healthcare system, and we urge you and your colleagues to capitalize on this real opportunity to make the reforms necessary to promote patient access to appropriate care while eliminating incentives that drive unnecessary spending. We are grateful for your leadership.

If you have any questions or would like to discuss our comments further, please contact us at brian.connell@bloodcancerunited.org.

Sincerely,



Brian Connell
Executive Director of Federal Affairs

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U.S. House
Committee on Energy and Commerce
Health Subcommittee

Hearing:
Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

March 18, 2026

Statement for the Record
American Academy of Dermatology Association

Chairman Griffith and Ranking Member DeGette, on behalf of the more than 18,000 U.S. members of the American Academy of Dermatology Association (AADA), we thank you for the opportunity to submit a statement for the record regarding your hearing, *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape*.

A board-certified dermatologist has extensive training, which allows them to accurately diagnose and properly treat more than 3,000 diseases of the skin, hair, and nails. Administrative burdens and declining Medicare physician payment amplify physician burnout and threaten patient access to care. Every closed practice, every second of delayed care, every unfilled job in a practice, all hampers coordination and threatens the viability of Medicare. Unfortunately, after more than twenty years of cuts to Medicare physician payment, these delays, closures, and unfilled roles are far too common.

Stabilizing Medicare Physician Payment to Ensure Patient Access to Affordable Care

Stable and predictable Medicare reimbursement will help lead to greater access for patients and increase the bandwidth of health professionals to coordinate care. Medicare physician payment cuts threaten patient access as physician offices close or become consolidated within larger health systems with narrow networks to specialists and subspecialists. This results in reduced accessibility to affordable, high-quality dermatologic care, fewer options for patients to choose their own physician and health insurance that best meets their needs and increased national healthcare expenditures.

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Since 2001, the cost of operating a medical practice has increased 59%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. Adjusted for inflation in practice costs, Medicare physician reimbursement declined 33% from 2001 to 2025. This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. Dermatologists are seeing the real effect of cuts. In the past 8 years, private insurance patients for dermatologists have increased by 21% while Medicare patients are down 27%.

The current Medicare physician payment system has led to increased consolidation and hospital ownership of physician practices resulting in higher national health care expenditures and reduced competition to the health care system, which poses significant access and affordability challenges for patients. In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization.

The impact of these burdens is unsustainable. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The inability to provide inflationary pay raises to practice employees is contributing to the current health care workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries.

Fewer physicians in our communities means longer waiting times for patients to receive care. According to the Health Resources and Services Administration, currently, dermatology is only able to meet approximately 37.1% of patient demand in non-metro areas. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in suboptimal settings including emergency departments and hospital-based practices. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost. Declining reimbursement and increasing administrative burdens will exacerbate this shortage of physicians when offices close their doors.

Recently, the Medicare Payment Advisory Commission (MedPAC) shared its concerns about whether beneficiaries will continue to have adequate access to care in the coming years as growth in physician practice operating costs is expected to exceed growth in Medicare payment rates by a greater amount than it did in the prior two decades. This larger gap could create incentives for physicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals, which could increase spending for beneficiaries and the Medicare program.

To protect access and ensure affordability for patients while protecting physician practices from further consolidation, Congress must take action to advance Medicare physician payment reform by:

- Establishing a positive annual inflation adjustment; and
- Increasing the budget neutrality threshold.

We urge Congress to pass H.R. 6160, the Strengthening Medicare for Patients and Providers Act, which would provide for an inflationary update under the Medicare physician fee schedule tied to the Medicare Economic Index (MEI) beginning in 2026. This legislation is a critical step toward ensuring financial stability in the Medicare physician payment system so that patients have continued access to high-quality care. The AADA also urges Congress to pass legislation like H.R.6371 – 118th Congress, Provider Reimbursement Stability Act of 2023, which would raise the outdated budget neutrality threshold in the Medicare Physician Fee Schedule (MPFS).

The failure of the MPFS to keep up with inflation is the greatest threat to access to care in physician offices. Stabilizing the MPFS is critical to fortify independent medical practice, combat consolidation and maintain access for patients. On January 16, 2025, the MedPAC voted to recommend tying Medicare physician payment for CY 2026 to MEI minus 1 percentage point. The MEI, which measures practice cost inflation, is projected to increase by 2.3% in 2026.

The AADA is appreciative of the 2.5% plus-up to Medicare physician payment that Congress provided for calendar year 2026. Additionally, the AADA was supportive of the policy included in the original House-passed version of H.R. 1 that would have tied the MPFS to inflation by establishing a permanent, annual update based on a portion of MEI. This could have been a building block towards long-term, sustainable reform of predictable annual inflationary adjustments, but unfortunately this policy was not finalized, meaning permanent reform based on even a portion of MEI is desperately needed to protect patient access to affordable, convenient care.

Concerns In the CY 2026 MPFS

In the CY 2026 MPFS, CMS finalized a proposal to apply a 2.5 percent “efficiency adjustment” policy. The AADA is strongly opposed to this policy as it is not supported by valid data, is inconsistent with the Medicare statute, undermines the relativity of resource-based relative value scale (RBRVS), and most importantly, risks harming patient care.

CMS has not explained the rationale for selecting 2.5 percent for the efficiency adjustment beyond citing productivity adjustments in the MEI, which has no meaningful relationship to physician work. Applying an economy-wide productivity factor to physician services is arbitrary and ignores the realities of clinical care. Further, reliance on the MEI is particularly misplaced in this policy because, unlike hospitals and other Medicare payment systems that receive routine inflationary updates, physician services do not benefit from an automatic adjustment for rising costs.

There is no evidence that dermatologists, or physicians in general, are performing procedures more efficiently today than in the past. The time it takes for local anesthesia to become effective or for a patient to stop bleeding has not changed and cannot be made more efficient simply through repetition. In fact, many modern tools require additional physician time, including the use of artificial intelligence. Advanced imaging systems and artificial intelligence tools produce far more data that must be carefully reviewed, interpreted, and documented. A recent national study of 1.7 million surgical procedures found that operative times have increased over the past five years, while patient complexity has also grown. The authors concluded that there is no evidence to support CMS's assumption that physicians are performing procedures more efficiently today.

Unsupported and meritless policies such as the "efficiency adjustment" destabilize the healthcare system by encouraging consolidation and further exacerbate the failures within Medicare, which reinforces the need for long-term sustainable reform. To address this flawed policy, Congress should enact recently introduced legislation, H.R.7520, the Efficiency Adjustment Delay Act, which is critical in ensuring patient access to medical care by delaying the flawed "efficiency adjustment" finalized in the Calendar Year 2026 Medicare Physician Fee Schedule until 2030. The AADA stands ready to work with CMS and Congress on an alternative path forward such as linking Medicare physician payment to a positive inflationary adjustment and reforming budget neutrality.

On behalf of the AADA, thank you for your leadership and help ensuring that Medicare meets the needs of Americans. The AADA is committed to excellence in the medical and surgical treatment of skin diseases; advocating for high standards of clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease. The AADA welcomes the opportunity to continue working with Congress to identify opportunities to maintain patient access to affordable care and improve outcomes. Together, we can make a positive difference for patients across the nation.

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Statement for the Record

House Energy & Commerce Subcommittee on Health
Lowering Health Care Costs for All Americans:
An Examination of the U.S. Provider Landscape

March 18, 2026

Submitted by the American College of Cardiology

The American College of Cardiology (ACC) appreciates the opportunity to submit this statement for the record for today's third hearing in the committee's health care affordability series that will examine the role that providers play in shaping the cost of care for Americans nationwide. The ACC represents more than 60,000 cardiovascular professionals dedicated to improving heart health and ensuring patients receive timely, evidence-based cardiovascular care.

As Congress examines drivers of health care costs and access challenges, it is critical to focus on two key factors: structural shortcomings in the Medicare payment system and administrative burdens that impede timely access to care.

One of the most significant issues is the ongoing stability and inadequacy of physician reimbursement under Medicare. For physicians caring for Medicare beneficiaries – particularly those managing complex and chronic cardiovascular conditions – the current payment system is increasingly unsustainable and threatens long-term patient access to care. At the same time, prior authorization, while intended as a cost-management tool, has been widely shown to delay medically necessary care and contribute to administrative burden, with physicians reporting that these delays can lead to adverse patient outcomes and potentially greater downstream utilization.

The ACC urges Congress to advance legislative solutions that address these systemic challenges and help ensure the cost of delivering care becomes more predictable, accessible and affordable for patients and clinicians nationwide.

Threats to Patient Access from Medicare Payment Instability

For more than two decades, the Medicare Physician Fee Schedule (PFS) has failed to provide predictable and adequate payment updates that reflect the rising costs of delivering care. Unlike hospitals, skilled nursing facilities, and other health care providers, physician payments under Medicare do not include a permanent inflationary update for physician services. As a result, when adjusted for inflation, Medicare physician reimbursement has fallen by more than 33 percent since 2001, while practice expenses have risen by more than 60 percent during the same period.[1]

This structural imbalance places financial pressure on practices, particularly smaller and independent practices and those in rural and underserved communities with already limited resources. Rising

[1] https://fixmedicarenow.org/sites/default/files/2026-01/medicare-updates-inflation-2015-2026-chart.pdf

costs for staff, technology, regulatory compliance, and supplies necessary to provide cardiovascular care threaten the ability of cardiovascular clinicians to maintain access to high-quality, patient-centered care for the Medicare beneficiaries in their communities.

A recent analysis published in the *Journal of the American College of Cardiology (JACC)* highlights the severity of today's access challenges: nearly half of U.S. counties do not have a single cardiologist. In rural counties, this gap is even more pronounced – an alarming 86.2 percent lack of access to a cardiologist. Patients residing in these rural counties must travel an average of 87.1 miles roundtrip to reach the nearest cardiologist, while those in urban areas only need to travel 16.3 miles.

When clinicians cannot sustain their practices locally, patients are left with no choice but to travel long distances for care, increasing expenses, delaying treatment, and risking worsening health outcomes, which can lead to higher downstream costs.

Without meaningful reform to stabilize physician payments, instability in the Medicare payment system will continue to accelerate practice consolidation. From 2019-2024, more than 40 percent of rural independent practices closed or were acquired. At the same time, hospitals and health systems expanded their reach, resulting in a 15 percent increase in the number of employed physicians and an 11 percent increase in the number of practices they own.[2] This consolidation limits patient access to specialists and can lead to an average 14 percent price increase for physician services.[3] To avoid these costly increases and ensure the stability of the Medicare program, reform is essential.

As we explore potential solutions, it is crucial to consider how reform initiatives can not only stabilize payments but also enhance the overall accessibility and quality of cardiovascular care for vulnerable populations.

Impact on Cardiovascular Care

Cardiovascular disease remains the leading cause of death in the United States and disproportionately affects older Americans enrolled in Medicare. Cardiologists and cardiovascular teams provide essential services including diagnostic testing, management of chronic conditions such as heart failure and atrial fibrillation, and life-saving procedures that prevent heart attacks, strokes, and sudden cardiac death.

To provide these services, ongoing investment in new technologies, equipment, and clinical staff is essential to deliver comprehensive care to seniors with complex cardiovascular conditions. When Medicare payment fails to keep pace with practice costs, it becomes increasingly difficult for practices to maintain this necessary infrastructure.

A reduction in capabilities can result in longer wait times, delayed diagnoses, and fragmented care. This may ultimately require more intensive interventions, thereby increasing costs for both patients

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[2] https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Report%20on%20Rural%20Physician%20Ownership%20Trends%20-%20final.pdf?ver=A7ouK0EF0N0_zrs1qQraOQ%3d%3d

[3] https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf#:~:text=*%20j%20This%20study%20found%20muted%20wage,Private%20Equity%20(PE)%20and%20other%20private%20investors.

and the broader Medicare program. A nationwide study of Medicare beneficiaries 65 and older with acute cardiovascular conditions found significantly higher 30- and 90-day mortality among patients presenting in rural areas compared with urban areas. Research indicates that limited access to timely care and essential treatments is likely contributing to these disparities.[4] Furthermore, cardiovascular death rates have remained consistently higher in rural areas – reaching up to 1.5 times those in urban or metropolitan areas in recent years.[5]

Therefore, Medicare physician payment reform is not only a physician workforce issue; it is essential for ensuring patient access to timely, affordable, and high-quality cardiovascular care.

Legislative Solution: Establishing Inflationary Updates to Preserve Practice Stability and Patient Access

The ACC strongly supports the ***Strengthening Medicare for Patients and Providers Act*** *(*H.R. 6160), bipartisan legislation that would update the PFS conversion factor and tie future payment updates to the Medicare Economic Index (MEI).

By linking payment updates to the actual cost of delivering care, this legislation would bring much-needed stability and predictability to physician reimbursement. Aligning Medicare payment updates with practice cost inflation would allow physician practices to maintain staff, invest in care delivery infrastructure, and adopt innovative care models that improve outcomes for Medicare beneficiaries with cardiovascular disease.

Stabilizing physician payments through legislation like H.R. 6160 is essential to protecting patient access to cardiovascular care and sustaining the physician workforce that Medicare beneficiaries rely upon.

Legislative Solution: Delaying Harmful Medicare Payment Cuts to Protect the Health Care Workforce

The ACC also supports the ***Efficiency Adjustment Delay Act*** (H.R. 7520), which would delay the implementation of the flawed "efficiency adjustment" included in the 2026 PFS.

This policy imposes an across-the-board 2.5 percent reduction to work relative value units (wRVUs) based on the assumption that physician services become more efficient over time. However, evidence does not support this claim. Efficiency gains are not universal, as complex cases and teaching environments often require more time and are not exempted in the rule. If allowed to remain in place, this recurring reduction would further destabilize physician reimbursement and create additional financial uncertainty for physician practices. Because physician employment contracts and compensation models are often tied to RVU values, these reductions could have widespread impacts beyond Medicare reimbursement itself.

Passing H.R. 7520 and delaying the efficiency adjustment would allow policymakers to evaluate the policy using empirical evidence before imposing across-the-board cuts that may jeopardize patient access to care.

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[4] https://www.jacc.org/doi/10.1016/j.jacc.2021.10.045
[5] https://www.jacc.org/doi/10.1016/j.jacc.2024.09.1215

Legislative Solution: Reforming Budget Neutrality to Mitigate Financial Uncertainty for Clinicians

The ACC believes long term, structural Medicare payment reform is necessary to improve patient access to care and reduce clinician burnout. A critical component of a long-term fix should include addressing budget neutrality. The current $20 million threshold was established in 1992 and has not been updated since. This greatly limits the ability for pricing adjustments for services without triggering across-the-board cuts.

As it stands now, if the Centers for Medicare and Medicaid Services (CMS) projects that net pricing changes for existing services across the Medicare PFS will increase total Medicare spending by more than $20 million, the agency must reduce all Medicare physician services by that excess amount, typically by adjusting the Medicare conversion factor.

The ACC has previously endorsed legislative efforts to increase the budget neutrality threshold from $20 million to $53 million and a built-in, regular increase, such as one equal to the increase in the MEI, to ensure the threshold is in line with real world costs.

Reducing Delays in Care and Costs Through Prior Authorization Reform

Compounding these payment challenges are administrative barriers that further increase costs and delay patient care. Cardiologists consistently report that prior authorization requirements – particularly within Medicare Advantage plans – represent one of the most significant administrative burdens in clinical practice.

Prior authorization delays can be particularly harmful for cardiovascular patients. Conditions such as heart failure, coronary artery disease, and atrial fibrillation are progressive and time sensitive. Delays in diagnostic tests or treatments can lead to emergency department visits, avoidable hospitalizations, and worse clinical outcomes. In fact, 29 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care. Moreover, 88 percent report that prior authorization leads to higher overall utilization.[6]

These delays ultimately increase costs for both patients and the Medicare program by shifting care from timely outpatient management to more expensive emergency or inpatient treatment.

Legislative Solution: Streamlining Prior Authorization Practices to Keep Costs Low and Care Timely

The ACC strongly supports bipartisan legislative solutions that improve the functioning of the Medicare program for both patients and physicians. One such example is the ***Improving Seniors' Timely Access to Care Act*** (H.R. 3514), which would modernize prior authorization processes in Medicare Advantage.

The legislation would codify CMS's 2024 Advancing Interoperability and Improving Prior Authorization Processes Final Rule, establishing electronic prior authorization, standardized clinical attachments, real-time approvals for routinely covered services, and enforceable timelines for both

[6] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

urgent and standard requests. It is estimated that these reforms will reduce administrative burdens on clinicians by 220 million hours over 10 years, leading to cost savings exceeding $16 billion[7] and ensuring seniors receive timely access to medically necessary care.

Conclusion

The urgent challenges posed by the current Medicare payment system threaten patient access to high-quality cardiovascular care for the nearly 70 million Americans enrolled in Medicare. As cardiovascular disease remains a leading cause of death in the United States, we must do everything we can to stabilize physician payments to ensure the ability of our physicians to care for these vulnerable populations.

Medicare has long served as a cornerstone of health security for America's seniors, and thus it is vital that the program remains strong and sustainable. This requires policies that support both patients and the clinicians who care for them. Without meaningful reform, we risk exacerbating disparities in care and contributing to increased costs and adverse health outcomes.

To protect access to care and avoid higher downstream costs for the broader health care system, we urge Congress to pursue reforms that:

- Provide predictable annual payment updates tied to the MEI
- Stabilize physician reimbursement to prevent repeated payment cuts
- Streamline prior authorization practices to ensure timely access to care

Addressing these issues through commonsense legislative solutions will help ensure that Medicare beneficiaries receive the care they deserve while strengthening the long-term sustainability of the program. Through these reforms, we can build a system that prioritizes the health and well-being of our seniors for years to come.

The ACC appreciates the opportunity to provide this statement for the record and looks forward to working with Congress to advance policies that improve cardiovascular care for America's seniors.

[7] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

STATEMENT FOR THE RECORD BY

THE ERISA INDUSTRY COMMITTEE

TO THE U.S. HOUSE OF REPRESENTATIVES
HOUSE COMMITTEE ON ENERGY AND COMMERCE
HEALTH SUBCOMMITTEE

"LOWERING HEATLH CARE COSTS FOR ALL AMERICANS: AN EXAMINATION OF THE U.S. PROVIDER LANDSCAPE"

March 18, 2026

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to submit this statement for the record on behalf of The ERISA Industry Committee (ERIC) for the hearing entitled *"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape,"* the third hearing in the health care affordability series. We appreciate the Committee's attention to the role providers have in driving rising health care costs, particularly for employers and working families. We look forward to supporting your efforts to advance solutions that make high-quality health care more affordable and accessible for all Americans.

ERIC is a national advocacy organization that exclusively represents the largest employers in the United States in their capacity as sponsors of employee benefit plans for their nationwide workforces. Our member companies are leaders across every major sector of the economy, and ERIC serves as the voice of large employer plan sponsors on federal, state, and local public policies that affect their ability to offer and maintain employee benefit plans. ERIC member companies provide benefits to tens of millions of employees and their families in every state, city, and congressional district.

Members of this Committee—and your constituents—interact with ERIC member companies every day. Whether driving a car or filling it with gas, using a cell phone or computer, visiting a bank or hotel, flying on an airplane, watching television, supporting our national defense, shopping, sending or receiving a package, dining at a restaurant, or enjoying a soft drink, Americans regularly engage with companies that are part of ERIC's membership.

Rising health care costs in the United States continue to place significant financial strain on both employers and their employees. 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] At the same time, premiums for family coverage now average approximately $27,000 per year, reflecting roughly a six percent increase in 2025.[2]

[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,
[2] KFF, 2025 Employer Health Benefits Survey, October 22, 2025.

These rising costs are forcing many employers to consider shifting more expenses to employees through higher cost-sharing, deductibles, or premium payroll contributions. Such changes would have profound consequences for the more than 160 million Americans who receive health insurance through their employer.[3]

Large self-insured employers already bear the majority of health care costs for their employees, typically covering roughly 75 to 80 percent of overall expenses. 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 rising prices, including delayed care, worsening chronic conditions, limited provider choice, and costly hospitalizations.

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.

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".[4] 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. ERIC member companies are experiencing these pressures firsthand, including wide variations in payment rates for identical services depending solely on the site of care.

[3] KFF's analysis of data from the 2023 American Community Survey included in KFF's 2025 Employer Health Benefits Survey published October 22, 2025. See KFF. Health insurance coverage of the population ages 0–64 [Internet]. San Francisco (CA): KFF; [cited 2025 Sep 15]. [Time frame: 2023].

[4] Fulton, Brent D. "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses." *The Commonwealth Fund*, 6 Sept. 2017,

ERIC issued a policy brief, *Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices*, which examines the primary drivers of hospital pricing in employer-sponsored insurance markets.[5] Research conducted by Charm Economics finds 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.

Allowing these 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 Subcommittee can take several important steps to discourage consolidation and unfair pricing practices, including expanding site-neutral payment policies, strengthening transparency and accountability, 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 in order to charge higher rates for the same goods and services, and to take on large "facility fees" despite services not taking place on an actual hospital campus. Congress has addressed a narrow subset of this problem, in the Medicare program, in *the Consolidated Appropriations Act of 2026* (CAA 26). ERIC appreciates all the work Congress did in requiring hospital outpatient facilities to use a unique National Patient Identifier (NPI) for off-campus hospital outpatient departments when billing Medicare. However, broader site-neutral reforms are necessary. Congress should extend site-neutral payment policies to additional services and facilities to fully address the distortions created by differential payment structures. Reforms implemented in the Medicare program can serve as an important catalyst for similar policies in the private sector, helping to curb unnecessary spending and restore fairness in health care pricing.

Transparency and Accountability Reforms

ERIC member companies believe that transparency is essential to reducing health care costs and improving the quality of care. Employer health care spending continues to rise at an unsustainable rate, and greater transparency is necessary to foster competition, improve value, and enhance quality and patient safety.

ERIC applauds the House's work on the *Lower Costs, More Transparency Act* (LCMT, H.R. 5378 – 118th Congress) as an important step toward improving health care transparency. 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. The legislation would codify the requirement that hospitals publicly post negotiated prices for health care items and services in a machine-readable format, and would strengthen compliance and enforcement. In addition, the legislation strengthens group health plan Transparency in Coverage requirements and improves access to critical data for plan sponsors. Access to timely and accurate information allows employers to design better benefits and manage costs more effectively on behalf of their employees.

[5] Beyond Cost Shifting: Market Power as the Key Driver of Hospital Prices. ERIC, May 2025

ERIC also supports the *Patients Deserve Price Tags Act* (H.R. 5582), led by Committee member Congressman John James (R-MI), which provides clear statutory authority requiring hospitals and health plans to disclose key pricing information. Under this legislation, hospitals must 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. Health plans must similarly disclose in-network and out-of-network charges for covered items and services, as well as negotiated prices for prescription drugs. These transparency requirements 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. The more accurate, comprehensive, accessible, and up-to-date this information is when shared with employer-sponsored health plans, the more effectively plan sponsors can comply with existing regulations while improving affordability and quality for millions of workers and their families.

Fairness in Contracting

Provider market power is increasingly reflected in unfair contracting practices that raise costs while limiting competition and choice. The Subcommittee should advance the bipartisan *Healthy Competition for Better Care Act* (H.R. 6248), led by Budget Committee Chairman Jodey Arrington (R-TX) with Committee member Congressman Rick Allen (R-GA) as an original cosponsor. This legislation would improve fairness in contracting by allowing employers and insurers to provide incentives for enrollees to choose high-quality, lower-cost providers. It would also prevent hospitals and health systems from forcing insurers and employers to contract with all affiliated facilities as a condition of participating in a network. These reforms would enable 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.

Conclusion

Thank you for the opportunity to share ERIC's views with the Subcommittee. ERIC remains committed to working with 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 Subcommittee to develop and enact meaningful reforms.

AMERICAN BENEFITS COUNCIL

Statement for the Record

U.S. House of Representatives Committee on Energy & Commerce

Subcommittee on Health

Hearing on

Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

Submitted by the American Benefits Council

March 18, 2026

1250 H Street NW Suite 605 Washington DC 20005 202-289-6700 https://www.americanbenefitscouncil.org

Dear Chair Guthrie, Chair Griffith, Ranking Member Pallone and Ranking Member DeGette:

On behalf of the American Benefits Council ("the Council"), I want to thank you for holding this hearing as part of your important efforts to examine the root causes driving higher health care prices and discuss policies that will lower the cost of care for *all* Americans. 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 180 million Americans, 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.[1] Employers are bracing for even higher costs this year.[2] 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] Kaiser Family Foundation, 2025 Employer Health Benefits Survey (October 22, 2025)

[2] Mercer, "Employers prepare for the highest health benefit cost increase in 15 years" (September 3, 2025)

employers and workers.[3] 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**
- **Ensure greater transparency in the health care system**
- **Restrict anti-competitive contracting provisions**
- **Modernize the 340B drug pricing program**

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.[4] Rising prices for hospital services have contributed to a nearly 50% increase in private health plan spending from 2012 through 2022.[5] 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 alike[6] without higher quality or access.[7]

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[3] U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy* (October 2, 2024)

[4] Rand Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (2020)

[5] U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy* (October 2, 2024)

[6] 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)

[7] The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care*

At the same time, many private hospital systems are becoming vertically 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.[8] 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,[9] 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.

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.

Market, pp. 7 (March 2020)

[8] Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physicianpractices 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)

[9] The Winston Group, *Alliance to Fight for Health Care National Survey* (September 11, 2024)

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 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,[10] 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.[11] 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

[10] Id.

[11] Families USA, *The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs* (April 19, 2023)

be most effective when coupled with quality information, price transparency efforts should proceed apace even if quality transparency will take additional time to realize.

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.[12] 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.

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 paper[13] 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.

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.

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[12] The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* (January 31, 2020)

[13] 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)

The Council urges Congress to work with us on legislation to modernize the 340B program without raising costs for employers, employees and taxpayers.

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.[14] 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.

* * * * *

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,

Ilyse Schuman
Senior Vice President, Health and Paid Leave Policy

[14] Jack Hoadley and Kennah Watts, *Health Affairs Forefront*, "The Substantial Costs Of The No Surprises Act Arbitration Process" (August 25, 2025)

ADA American Dental Association®

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March 18, 2026

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce

Re: Comments for the record for the March 18, 2026 hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chairmen Guthrie and Griffith, and Ranking Members Pallone and DeGette:

On behalf of the American Dental Association (ADA), the nation's leading voice for oral health, we appreciate the opportunity to provide comments for the record for the Subcommittee on Health hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."[1]

Oral health must be part of any serious conversation about health care affordability. Oral disease is common, costly when left untreated, and closely linked to overall health, employability, school attendance, and quality of life. At the same time, the dental care delivery system differs in important respects from other provider sectors often examined in affordability debates. Many dentists practice in small, community-based settings and do not possess the scale, facility fee structures or market leverage associated with large, consolidated hospital systems. Congress should take care not to apply broad provider-side reforms in a manner that unintentionally undermines access to local oral health care.

The ADA respectfully urges the Committee to consider the following principles as it evaluates the provider landscape and options to lower health care costs.

Prevention and early intervention should remain central to affordability policy. Long-term health care cost containment is not possible without prevention. In oral health, preventive and diagnostic services can help patients avoid more extensive and costly restorative, surgical and emergency care later. Policies that reduce financial barriers to preventive dental services can improve health outcomes and lower downstream costs.

1. House Committee on Energy and Commerce, "Chairmen Guthrie and Griffith Announce Third Hearing in Series to Improve Health Care Affordability for All Americans," March 11, 2026. (House Committee on Energy and Commerce)

The ADA has consistently supported coverage of diagnostic and preventive services at 100 percent and without counting those services toward annual maximums.[2]

Patients need meaningful dental coverage, not merely nominal coverage.
For many families, the practical barrier to care is not simply whether they have a dental benefit, but whether that benefit provides meaningful financial protection when care is needed. Low annual maximums, deductibles, waiting periods, coinsurance requirements and service limitations can leave patients exposed to substantial out-of-pocket costs. Affordability policy should therefore focus on whether coverage is understandable, predictable and sufficient to support timely access to needed care.

Administrative burden and inefficiency raise costs for both patients and providers.
Provider affordability cannot be assessed solely by looking at reimbursement levels. Excessive administrative complexity, payment uncertainty and opaque coverage rules can increase costs throughout the system and interfere with timely care. A more affordable system should reduce unnecessary administrative friction and improve clarity and accountability for patients and providers alike.

Independent dental practices should not be conflated with large, consolidated provider systems.
As lawmakers examine provider-side drivers of health care costs, it is important to distinguish among sectors with very different cost structures and degrees of market power. Independent dental practices generally operate as small businesses embedded in local communities. Reforms aimed at addressing hospital consolidation, vertical integration, or other large-system dynamics should be carefully tailored, so they do not impose disproportionate burdens on community-based oral health care providers.

Competition and transparency matter, but policymakers should recognize where market concentration exists.
The Committee's review of affordability should include not only provider consolidation but also concentration in the markets that shape dental coverage and payment. In a report released this month, the U.S. Government Accountability Office found that private stand-alone dental insurance markets vary in concentration by state and that limited available research suggests more concentrated dental insurance markets may be associated with reduced reimbursements to providers. The GAO also reported that some dental industry stakeholders described concentrated markets as limiting providers' ability to negotiate contracts and reimbursement with insurers.[3] These findings reinforce the need for policymakers to promote transparency, competition and fair market functioning across the

2. American Dental Association, *Comments to House Energy and Commerce and Ways and Means on Dental Market Reforms and ERISA Transparency*, Jan. 22, 2026. (ADA)
3. U.S. Government Accountability Office, *Private Dental and Vision Insurance: Market Concentration Varied Among States*, GAO-26-107787, March 9, 2026. GAO found that private stand-alone dental insurance markets vary in concentration by state, identified limited peer-reviewed evidence suggesting reduced reimbursements in more concentrated dental insurance markets, and reported stakeholder observations that concentrated markets can limit providers' ability to negotiate contracts and reimbursement. (GAO)

broader dental care landscape, while preserving patient choice and access to independent community-based providers.

Affordability policy should strengthen access, not weaken it.
A narrow focus on reducing provider payments or adding compliance obligations can have the unintended effect of reducing participation, especially in underserved communities and among smaller practices with limited administrative capacity. True affordability means lowering costs for patients while sustaining the delivery system on which they rely for care.

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The ADA appreciates the Committee's attention to health care affordability and respectfully urges Members to ensure that oral health is part of this work. Dentistry should be included in the discussion, but independent dental practices should not be treated as interchangeable with large, consolidated provider systems. Done properly, affordability reform can promote prevention, improve transparency, reduce administrative waste, and support meaningful patient access to oral health care.

Thank you for your consideration of ADA's views on these important issues. We appreciate the Subcommittee's attention to policies affecting providers and patients, and we stand ready to serve as a resource as you continue this work. If you have any questions, please contact Natalie Hales, Senior Congressional Lobbyist, at halesn@ada.org.

Sincerely,

Richard J. Rosato, D.M.D.
President

Elizabeth Shapiro, D.D.S., J.D., C.A.E.
Interim Executive Director

CONSUMERS FOR
FAIR HO$PITAL PRICING

Statement for the Record

House Energy and Commerce Health Subcommittee
Hearing on "Lowering Health Care Costs for All Americans:
An Examination of the U.S. Provider Landscape"

Prepared by:
Consumers for Fair Hospital Pricing

March 18, 2026

1225 New York Avenue, NW, Suite 800
Washington, DC 20005

Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette:

On behalf of the *Consumers for Fair Hospital Pricing* coalition, organizations representing families and health care consumers across the United States, we want to thank you for holding this important and timely hearing on the role of large hospital corporations driving unaffordable health care, and to offer our sincere appreciation to 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, workers, employers, and clinicians 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 three[1]—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 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 misaligned incentives that are driving up costs for families in order to provide real relief to the American people.**

We urge the House Energy and Commerce Committee to advance an agenda that prioritizes health care affordability for American families and holds corporate health systems accountable for charging excessive prices. Specifically, we call on your committees to advance the following well-vetted, bipartisan, and commonsense policies to remedy some of the most obvious health system failings:

- **Achieve meaningful price transparency in the health care system by requiring all hospitals to disclose negotiated rates in dollars and cents, establish standardization including a machine-readable format, eliminate loopholes, and enforcement of recently required hospital executive attestation along with increased penalties to encourage greater compliance by hospitals.** These efforts should include codifying a strengthened version of the Hospital Price Transparency regulation.

- **Address payment differentials across sites of service that financially incentivize further consolidation and help ensure consumers pay the same price for the same service regardless of where the service is performed by enacting site neutral payments.**

- **Prohibit anti-competitive contracting terms, including between providers and insurers such as "all-or-nothing", "anti-steering," and "anti-tiering" clauses in provider and insurer contracts; and "non-compete" clauses in clinician and health care worker employment arrangements, that, for instance, may interfere with the continuity of the primary care patient-physician relationship.**

These policies would set a critical foundation for reducing inflated and wasteful spending throughout the system and make health care more affordable and value-driven for consumers.[6]

Consumers for Fair Hospital Pricing looks 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 Consumer Health Initiative
Consumers for Quality Care
Families USA
Health Access California
Pennsylvania Health Access Network
U.S. PIRG

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[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).

[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-s-spending-healthcare-changed-time/#Total%20national%20health%20 expenditures,%20US%20$%20per%20capita,%201970-2023

[6] Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services. Congressional Budget Office. 2022. https://www.cbo.gov/publication/58222

AAOS
American Association of Orthopaedic Surgeons

American Association of Orthopaedic Surgeons
Statement for the Record
U.S. House Committee on Energy and Commerce
Subucommittee on Health
Hearing on "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"
March 18, 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 March 18, 2026 hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape," before the U.S. House Energy and Commerce Subcommittee on Health. We share the committee's goal of addressing the core drivers working against health care affordability—namely inadqueate Medicare reimbursement, onerous government interference, administrative burdens, waste, fraud, and abuse, and lack of competition and patient choices.

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 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.

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. A good first step would be to raise the MPFS budget neutrality threshold and index it to inflation going forward, as well as providing statutory guardrails to limit the year-over-year changes to the conversion factor (CF). Congress should permanently rationalize Medicare physician payments by requiring that the

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annual conversion factor update include the full amount of yearly inflation as measured by the Medicare Economic Index (MEI).

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.

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.

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 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.[1] 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

[1] https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext

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.

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. 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.

Congress must continue to incentivize the adoption of value-based care

The shift from fee-for-service (FFS) to value-based care systems of healthcare accelerated when the Center for Medicare and Medicaid Innovation (CMMI) was created by the Affordable Care Act in 2010. Since then, CMMI has generated numerous alternative payment models to spur this shift to paying for care that improves quality and reduces costs, instead of paying based on the volume of services delivered. Some of these models, like the Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced (BPCI-A) have proven successful.

Much work remains to be done as most models have not produced the savings intended. Given the significant volume of orthopedic procedures paid for by Medicare along with the burgeoning Medicare-eligible population, orthopaedic surgery remains at the forefront of Advanced Payment Model development.

AAOS encourages Congress to work with CMS to expand physician-led Alternative Payment Model (APM) opportunities for independent and employed physicians.

AAOS recommends a new generation of physician-led APMs that:

- Focus on Comprehensive Condition-Based Care by encouraging primary care providers to partner with teams of specialty physicians who have expertise in specific conditions, including musculoskeletal care, with the support of CMS, to ensure that patients receive optimal care.
- Accelerate support for physicians, particularly those in private practice, who are eager to participate yet lack the resources to build the infrastructure required to participate in this model.
- Begin with upside incentives and allow progression to downside risk-sharing as experience is accumulated.

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.[2] 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.[3]

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. 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.

[2] https://www.fiercehealthcare.com/providers/more-and-more-physicians-are-working-under-hospitals-corporate-entities-report-finds
[3] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf

Payers needs guardrails to preserve program integrity in Medicare Advantage

The Medicare Advantage (MA) program currently enrolls 54 percent of Medicare-eligible beneficiaries.[4] Physicians and patients appreciate the choices MA plans provide regarding out-of-pocket cost protections and supplemental benefits. However, these MA plans should not be able to manipulate or exploit the risk adjustment system used to determine payment to receive higher payments from the federal government. **AAOS endorses the No UPCODE Act (S. 1105) to create guardrails within the MA program by requiring the Centers for Medicare & Medicaid Services (CMS) to use two years of diagnostic data in its risk adjustment methodology for MA payments.**

Strengthening the integrity of the MA program by prohibiting diagnoses collected from chart reviews or health risk assessments alone when adjusting payments based on health status, as well as requiring CMS to account for differences in coding patterns between MA and traditional Medicare when finalizing MA payment adjustments furthers our shared goals of increasing patient access to care and ensuring a strong and stable physician payment system.

Prudent use of federal dollars is essential to improving healthcare access and quality of care. According to MedPAC, CMS overpaid MA plans by $50 billion in 2024.[5] A Health Affairs study points out that the impact of upcoding by MA plans has a scaling effect on the entire market. Specifically, artificially increased revenue from upcoding leads the MA plan to offer more robust benefits and rewards to its enrollees compared with traditional Medicare or MA plans that upcode with less intensity. This subsequent increase in enrollees, attracted by these benefits, generates higher profits per enrollee and increased market share by these aggressively upcoding MA plans.[6]

Payers must be accountable for unnecessary downcoding

It has come to our attention that several payers are implementing a new reimbursement policy to review professional claims billed with E/M codes 99204-99205, 99214-99215, and 99244-99245. We have seen provider bulletins stating that the policy is in alignment with the American Medical Association (AMA) E/M services guidelines, adjusting services by one level to reflect the appropriate reimbursement when AMA guidelines are not met. This policy is in fact against AMA's E/M service guidelines. We have seen reports that payers including Aetna, Anthem, Cigna, Humana, and Sunshine (Centene) have already begun implementing this policy.

[4] https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/
[5] https://www.medpac.gov/document/chapter-12-the-medicare-advantage-program-status-report-march-2024-report/
[6] https://www.healthaffairs.org/content/forefront/improving-medicare-advantage-accounting-large-differences-upcoding-across-plans

AAOS is concerned this policy implies payers will automatically adjust the E/M CPT code level until medical records are submitted to substantiate the complexity and the medical decision making (MDM) or time associated with the reported E/M visit. However, the policy does not indicate how these coding adjustment determinations are made. For example, what are the criteria which trigger such a denial? Is downcoding of E/M charges based solely on the complexity of the diagnosis codes submitted? These questions raise many concerns as physician notes are not typically sent with E/M visits.

AAOS fears the policy will create an unwarranted burden to physicians and their staff, and barriers to patients' access to quality care. This coding adjustment practice sets out a dangerous precedent and raises several issues regarding the legality of this type of policy. We are also concerned that this policy will lead to under-coding to avoid having claims adjusted. There are several factors accounting for high-level E/M visits, such as the decision for surgery and ordering and interpretation of images. Physicians should be reimbursed appropriately for this work.

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 Provider[7] 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.[8] 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.

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

[7] https://files.providernews.anthem.com/6740/MULTI-BCBS-CM-093315-25-Nonpar-provider-policy_FINAL.pdf
[8] https://www.caqh.org/hubfs/43908627/drupal/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf

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.

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Written Statement for the Record
American Nurses Association
"Lowering Health Care Costs for All Americans:
An Examination of the U.S. Provider Landscape"
U.S. House Energy and Commerce Health Subcommittee

March 18, 2026

The American Nurses Association (ANA) applauds the House Energy and Commerce Health Subcommittee for holding this hearing to examine the role that health care providers and hospitals play in shaping the cost of care for Americans. We are pleased to share the nursing perspective that is vital to policy discussions about ensuring Americans have access to affordable, high-quality care. Nurses are central to care coordination, chronic disease management, prevention, and patient education—services that improve health outcomes while reigning in health care spending. Policies that fully leverage the nursing workforce can expand patients' access to affordable health care while improving care coordination, efficiency, and quality in our health care system. ANA urges this subcommittee to pursue the following policies with those end goals in mind.

ANA is the premier organization representing the interests of the nation's over five million registered nurses (RNs) through its constituent and state nurses associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating for healthcare issues that affect nurses and the public. ANA members also include the four APRN roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). Our nurses serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of healthcare settings.

Remove Outdated Barriers to Care for Medicare Beneficiaries

Patients increasingly depend on APRNs to provide them with timely, high-quality care, particularly in rural and medically underserved communities. Today, Medicare beneficiaries are increasingly receiving affordable, high-quality care from APRNs who have advanced degrees and extensive clinical training and expertise. NPs alone conduct more than one billion patient visits annually and make up just over 40% of the primary care workforce.[1] Yet, Medicare policies continue to constrain APRN practice due to outdated statutory and regulatory barriers, such as unnecessary supervision requirements and payment restrictions for services provided to patients. These provisions run counter to

[1] June 2022 MedPAC Report to Congress

modern health care delivery and reduce access to care, disrupt continuity of care, increase health care costs, and undermine quality improvement efforts.

Not only do APRNs provide critical services in areas experiencing acute and persistent provider shortages, but NPs and CNSs are reimbursed at 85% of the Medicare Physician Fee Schedule rate when performing Part B services, representing a 15% discount when performing the same services as physicians. Removal of these outdated barriers serves as an essential component to improving competition and alleviating our nation's health care affordability crisis. This is why ANA was pleased to see the Centers for Medicare & Medicaid Services (CMS) reward states that confer full practice authority to APRNs through the Rural Health Transformation Program, which aims to support innovative care models that improve access to care and reduce health care costs in rural settings. Several states, including Indiana, Michigan, Vermont, Alaska, and Tennessee, declared their intention to confer full practice authority to APRNs.

Congress can build on this momentum by passing H.R. 1317, the bipartisan *Improving Care and Access to Nurses Act* (ICAN Act), to permanently remove outdated barriers and ensure that Medicare and Medicaid beneficiaries have timely, high-quality, cost-effective access to care without altering any scope-of-practice laws. The legislation is supported by more than 240 organizations, including the National Rural Health Association, AARP, and LeadingAge. As such, ANA urges the House Energy & Commerce Committee to consider and advance this legislation.

Remove "Incident To" Billing

One outdated Medicare policy that undermines transparency and efficiency is the continued use of "incident to" billing. Under this practice, APRNs' and other non-physician providers' (NPP) services are billed under a physician's National Provider Identifier (NPI) and are reimbursed at 100 percent of the physician fee schedule rather than the 85 percent rate typically paid when many NPPs bill directly. This policy does not align with modern, team-based care models in which APRNs frequently lead care coordination and primary care services. It also obscures the contributions of the broader nursing workforce, as services delivered by registered nurses are often captured under physician NPIs, making it difficult to measure the full value of nursing care and understand how care is delivered across the system.

In fact, the Medicare Payment Advisory Commission (MedPAC) has recommended eliminating "incident to" billing and concluded that doing so would not change the quality of care delivered to Medicare beneficiaries.[2] Ending this practice would reduce costs and improve transparency in Medicare claims, ensure services are accurately attributed to the

[2] February 2019 MedPAC News

clinicians who provide them, and support broader efforts by CMS to reduce waste, fraud, and unnecessary spending within the Medicare program. At a minimum, ANA recommends that Congress explore transparency measures surrounding incident to billing to inform congressional and agency efforts to better understand which clinicians are actually performing services.

Conclusion

In closing, the American people deserve access to timely, affordable, and high-quality health care. To make this vision a reality, Congress must enact policies that fully utilize nurses and acknowledge their contributions to health care delivery. ANA thanks the subcommittee for its leadership and for its willingness to consider our perspective on this critical issue. We stand ready to work with you to further examine the policy ideas that we posed today. Please contact Tim Nanof, ANA's Executive Vice President for Policy and Government Affairs, at Tim.Nanof@ana.org with any questions.

Society of Hospital Medicine
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March 18, 2026

Statement for the Record submitted by the Society of Hospital Medicine on the House Energy and Commerce Subcommittee on Health hearing titled *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape*.

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee,

On behalf of the Society of Hospital Medicine (SHM) and the 50,000 hospitalists practicing across the United States, SHM submits this statement for the record. We thank the Subcommittee on Health for the opportunity to submit a statement for the record on one of the most pressing challenges facing American patients and families: the affordability of hospital-based healthcare.

Hospitalists are physicians who specialize in the care of hospitalized patients and who occupy a unique and strategically important position in American healthcare. They are present at the intersection of clinical quality and cost of care in the hospital. Every admission they manage, every discharge they coordinate, and every care transition they navigate has direct implications for what patients pay, what insurers reimburse, and what the Medicare and Medicaid programs spend. This statement will address three broad themes: (1) the current crisis of hospital affordability, (2) how hospitalists contribute to cost reduction and quality improvement, and (3) a legislative and policy agenda to further those contributions.

Hospital care remains the single largest category of healthcare expenditure in the United States, accounting for approximately 31 cents of every dollar spent on healthcare — roughly $1.6 trillion annually, according to the most recent data from the Centers for Medicare and Medicaid Services (CMS).[1] For many patients, this translates to a tangible and often devastating financial burden. Studies consistently show that medical debt is the leading cause of personal bankruptcy in the United States, and hospital bills are a contributor to that debt.

[1] Centers for Medicare and Medicaid Services (CMS). National Health Expenditures 2024 Highlights. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.

Society of Hospital Medicine

Unlike ambulatory or elective hospital care, much hospital care is rarely discretionary. Patients arrive in crisis, and they are physically, emotionally, and often financially unprepared. The power imbalance between a hospitalized patient and the healthcare system is profound. Patients cannot comparison-shop for inpatient services during a medical emergency. They cannot easily evaluate the cost implications of a recommendation to extend a stay, order additional testing, or pursue a certain treatment pathway. This vulnerability demands that the healthcare providers and systems responsible for their care take affordability seriously as an ethical obligation, not merely a regulatory requirement.

The Hospitalist Contribution to Affordability

Hospital medicine is the fastest-growing physician specialty in the United States, and we estimate their number to be well over 50,000. Hospitalists provide comprehensive inpatient care: admitting, managing, and discharging patients; coordinating with specialists; communicating with patients and families; and bridging care transitions to post-acute and outpatient settings. Historically, primary care physicians divided their time between the office and hospital to manage their patients who were hospitalized. Today, hospitalists are continuously physically present in the hospital and solely focused on inpatient care. This specialization enables faster response times, better care coordination, and more consistent quality.

Hospital medicine has been valued for more than two decades for its contributions to quality, efficiency, and ultimately, cost savings. Patient care managed by hospitalists is associated with:

- Shorter length of stay (LOS), typically one-half to one full day shorter per admission compared to non-hospitalist care[2,3]
- Lower total cost per hospitalization, with savings ranging from several hundred to several thousand dollars per case, depending on complexity and setting[4,5]
- Reduced rates of 30-day readmission when robust discharge planning protocols are employed

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[2] Rifkin WD, Holmboe E, Scherer H, Sierra H. Comparison of hospitalists and nonhospitalists in inpatient length of stay adjusting for patient and physician characteristics. J Gen Intern Med. 2004 Nov;19(11):1127-32. doi: 10.1111/j.1525-1497.2004.1930415.x. PMID: 15566442; PMCID: PMC1494784.
[3] Davis KM, Koch KE, Harvey JK, Wilson R, Englert J, Gerard PD. Effects of hospitalists on cost, outcomes, and patient satisfaction in a rural health system. Am J Med. 2000 Jun 1;108(8):621-6. doi: 10.1016/s0002-9343(00)00362-4. PMID: 10856409.
[4] Lindenauer PK, Rothberg MB, Pekow PS, et al. Outcomes of care by hospitalists, general internists, and family physicians. N Engl J Med. 2007;357(25):2589–2600.
[5] David Meltzer, Willard G. Manning, Jeanette Morrison, et al. Effects of Physician Experience on Costs and Outcomes on an Academic General Medicine Service: Results of a Trial of Hospitalists. Ann Intern Med.2002;137:866-874. [Epub 3 December 2002]. doi:10.7326/0003-4819-137-11-200212030-00007

- Higher rates of compliance with evidence-based care protocols, which reduces unnecessary testing and treatment variation

Length of stay is a powerful lever for reducing inpatient costs. Each additional hospital day for a patient can cost between $2,000 and $3,000 on average, and costs are passed on directly or indirectly to payers, employers, and patients. By facilitating appropriate, timely, and well-organized discharges, hospitalists generate substantial savings that flow through the entire system.

A core function of hospital medicine is care coordination, the often-invisible work of ensuring that the right providers, the right information, and the right resources are in place at the right time. Poor coordination in the hospital is extraordinarily expensive. When a specialist consultation is delayed, the patient waits, and the bill grows. When a patient is discharged without clear medication reconciliation and a follow-up plan, they frequently return to the hospital, triggering a new admission and increased costs.

Hospitalists serve as the integrative hub of inpatient care. We communicate with specialists in the hospital, primary care providers, home health agencies, skilled nursing facilities, and insurance case managers. We facilitate transitions of care that, when done well, dramatically reduce the downstream utilization that drives up total episode costs. Under bundled payment models and accountable care organization (ACO) structures, this coordination work is increasingly recognized and rewarded. Under traditional fee-for-service, it remains systematically undervalued and uncompensated.

Another important yet underappreciated contribution of hospitalists to affordability is the elimination of low-value care, including tests, treatments, and interventions that generate cost without commensurate clinical benefit. SHM, in partnership with hospitalist experts, has historically supported hospitalists in these efforts through an educational series known as '*Things We Do For No Reason'*, which highlights diagnostic tests, therapies, or other clinical practices that are commonly performed even though they are of low value to inpatients. Overuse of diagnostic imaging, reflexive laboratory ordering, and routine consultations for conditions that do not require specialist input are among the most prevalent and costly forms of waste in inpatient medicine. Hospitalists systematically apply evidence-based criteria to testing and treatment decisions, and when they have the institutional support and culture to do so, the savings are measurable and meaningful. However, these efforts go uncompensated and often unrecognized.

Telehealth and Coverage Innovation

The scope of hospital medicine has expanded significantly to include tele-hospitalist programs, in which remote physicians provide after-hours coverage or augment care at critical access hospitals and rural facilities. These models have the potential to reduce costs by preventing unnecessary transfers to tertiary centers, expanding access to care in underserved communities, and improving night and weekend coverage without proportionally increasing staffing costs.

Congress and CMS should ensure that telehealth payment policies, including those established or extended through pandemic-era waivers, are continued and adequately supported beyond the current 2027 deadline. The evidence base for tele-hospital medicine is growing, and payment parity and regulatory predictability are essential for these programs to scale.

Workforce Sustainability

A discussion of affordability can't ignore the workforce crisis currently confronting hospital medicine and medicine in general. Burnout rates are high. When experienced hospitalists leave clinical practice or leave hospital medicine altogether, institutions lose care coordination expertise and quality infrastructure that cannot be easily replaced. Indeed, research suggests that experience enhances the efficiencies achieved by hospitalists, as measured by length of stay.[6] The downstream costs of turnover, in recruitment, onboarding, temporary staffing, and quality disruption, are substantial and borne ultimately by the healthcare system overall.

Policies that reduce administrative burden, expand the pipeline of physicians choosing hospital medicine as a specialty, support team-based care models that appropriately incorporate advanced practice providers, and address the systemic factors contributing to burnout will indirectly but powerfully advance health care affordability. A well-staffed, fully engaged hospitalist and hospital medicine workforce is itself a cost-containment asset.

Specific Policy Recommendations

On the basis of the foregoing, we urge the Subcommittee to consider the following actions:

- Reform inpatient transitional care payment: Develop a Medicare payment mechanism that rewards structured, documented, evidence-based discharge planning and care transition execution.
- Establish tele-hospitalist payment parity: Permanently codify payment parity for tele-hospitalist services provided to patients at rural or critical access hospitals and clarify regulatory requirements to support such models.
- Support hospitalist workforce development: Fund graduate medical education slots directed toward hospital medicine and general internal medicine, and support loan repayment programs for hospitalists practicing in rural or underserved settings.
- Incent the identification of and movement away from low-value care, by funding and advancing research into evidence-based care and quality improvement.
- Reduce administrative burden to streamline clinical workflows and maximize efficiency for hospitalized patients:
    - Enact prior authorization reform applicable to inpatient services;

[6] Kuo YF, Goodwin JS. Effect of hospitalists on length of stay in the medicare population: variation according to hospital and patient characteristics. J Am Geriatr Soc. 2010 Sep;58(9):1649-57. doi: 10.1111/j.1532-5415.2010.03007.x. PMID: 20863324; PMCID: PMC2946246.

- Simplify and reduce redundant documentation requirements;
- Reform, simplify, or eliminate burdensome reporting and measurement programs that do not improve cost or quality, including the Quality Payment Program (QPP); and
- Expand safe harbor protections for evidence-based care standardization initiatives.

The Subcommittee has asked the right question. Hospitalizations are a large driver of healthcare expenditures in the United States, and the affordability crisis it generates falls most heavily on the patients least able to absorb it: the elderly, the chronically ill, the uninsured, and the underinsured. Hospitalists are not a panacea, but we are a powerful and underutilized resource for achieving the health care affordability, quality, and efficiency goals that are of interest to this Subcommittee.

Hospitalists care for patients at their most vulnerable. They sit at the center of every hospitalization, every length-of-stay decision, every care coordination challenge, and every transition of care. When they are supported with appropriate incentives, infrastructure, and payment design, hospitalists generate measurable cost savings and increased clinical quality. When they are ignored in payment policy, buried in administrative burden, or burned out from unsustainable workloads, the savings potential will go unrealized.

SHM and hospitalists stand ready to be partners in this work. Thank you for the opportunity to provide this statement.

Sincerely,

Eric Howell, MD, MHM
Chief Executive Officer
Society of Hospital Medicine

APhA
American Pharmacists Association

March 18, 2026

The Honorable Morgan Griffith
Chairman
House Energy and Commerce Health Subcommittee
U.S. House of Representatives
2125 Rayburn HOB
Washington, DC 20515

Dear Chairman Griffith:

The American Pharmacists Association (APhA) appreciates the opportunity to submit a statement for the record for the House Energy and Commerce Health Subcommittee's hearing, *"Lowering Healthcare Costs for All Americans: An Examination of the U.S. Provider Landscape."* This hearing appropriately highlights the urgency of addressing escalating national health expenditures and reexamining how all healthcare providers can contribute to more affordable and accessible care.

On behalf of more than 330,000 pharmacists nationwide, APhA thanks you for your leadership in addressing the rising cost of healthcare in the United States. According to the Subcommittee, U.S. healthcare spending rose to $5.3 trillion in 2024—representing 18% of GDP—with hospital and physician spending alone accounting for more than half of national health expenditures. This reality underscores the urgent need to leverage every component of the healthcare workforce—including pharmacists—to meaningfully reduce costs while expanding access for patients.

Pharmacists Expand Access to Care and Reduce System Strain

With spending concentrated heavily in hospital and clinical services, pharmacists offer an immediate opportunity to shift appropriate care into lower-cost settings. Although many Americans struggle to access a physician in a timely manner, more than 90 percent of the U.S. population lives within five miles of a pharmacist. APhA has repeatedly urged Congress to remove regulatory barriers that limit pharmacists and pharmacies from providing lower-cost patient care services. As CMS Administrator Dr. Mehmet Oz recently stated, pharmacists should be able to practice "at the height of their licensure," and he has consistently asked, "Why don't we use pharmacists better?"[1]

[1] Dr. Mehmet Oz on Fixing American Healthcare + Fraud | Live from Davos, All-In Podcast 23:55 (Jan. 24, 2026). Available at: https://www.youtube.com/watch?v=b5p40OuTTW4&t=1435s.

Pharmacists practice in a wide range of settings—including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory care clinics, managed care organizations, hospice settings, and government facilities. Across these diverse environments, pharmacists optimize medication use, improve patient outcomes, and advance public health. State-authorized pharmacist services—such as furnishing routine care, triaging minor conditions, and managing chronic therapies—can reduce unnecessary physician visits and emergency department utilization.

A substantial body of evidence shows that integrating pharmacists into interprofessional healthcare teams improves health outcomes and reduces overall healthcare costs.[2] Removing unnecessary barriers that limit patient access to pharmacist-provided patient care services is essential as policymakers examine strategies to strengthen the healthcare workforce and expand access to care.

Pharmacist-Led Chronic Disease Management Improves Outcomes and Reduces Spending

Chronic diseases account for the majority of U.S. healthcare expenditures. Pharmacist-led medication therapy management (MTM), hypertension and diabetes management, and adherence interventions consistently improve health outcomes and reduce total cost of care.[3] Given the Committee's focus on how provider roles influence year-over-year spending growth, maximizing pharmacist-led chronic disease management is a practical, evidence-based strategy with a strong return on investment.

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[2] *See* Susi Afrianti Rahayu, et al., *Role of Pharmacists in the Interprofessional Care Team for Patients with Chronic Diseases*, 14 Journal of Multidisciplinary Healthcare 1701 (2021). Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC8275864/. *See also* Heeyoung Lee, et al., *Impact on Patient Outcomes of Pharmacist Participation in Multidisciplinary Critical Care Teams: A Systematic Review and Meta-Analysis*, 47 Critical Care Medicine 1243 (2019). Available at: https://pubmed.ncbi.nlm.nih.gov/31135496/.

[3] *See* Mrinmayee Joshi, et al., *Cost-Effectiveness of a Pharmacist-Led Medication Therapy Management Clinic for Management of Type 2 Diabetes*, 65 Journal of the American Pharmacists Association 102253 (2025). Available at https://pubmed.ncbi.nlm.nih.gov/39322027/. *See also* Amanda Wojtusik Orabone, et al., *Pharmacist-Managed Diabetes Programs: Improving Treatment Adherence and Patient Outcomes*, 15 Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy 1911 (2022). Available at: https://pubmed.ncbi.nlm.nih.gov/35757195/. *See also* Viktoria Gastens, et al., P*harmacist Interventions to Improve Hypertension Management Among Patients with Diabetes: A Systematic Review and Meta-Analysis of Randomized Controlled Trials*, 25 BMC Health Services Research 1268 (2025). Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC12487230/. *See also* Anthony Uche Umeh, et al., P*harmacist-Led Medication Therapy Management: Impact on Healthcare Utilization and Costs*, American Journal of Pharmacotherapy and Pharmaceutical Services (2025). Available at: https://ajpps.org/content/127/2025/4/1/pdf/AJPPS-4-4.pdf. *See also* Zachary A. Marcum, et al., P*harmacist-Led Interventions to Improve Medication Adherence in Older Adults: A Meta-Analysis*, 11 Journal of the American Geriatrics Society 3301 (2021). Available at: https://pubmed.ncbi.nlm.nih.gov/34287846/.

Pass ECAPS

APhA urges the Subcommittee to advance H.R. 3164, the Ensuring Community Access to Pharmacist Services (ECAPS) Act, legislation supported by many members of this Subcommittee and the full Committee. ECAPS would allow Medicare Part B reimbursement for pharmacist testing and treatment of common respiratory conditions—services pharmacists have already demonstrated they can provide safely and effectively.

Despite broad state authority and recognition of pharmacists by many Medicaid programs, Medicare Part B still does not cover many state-authorized, impactful, high-value patient care services pharmacists are trained and authorized by their states to provide. Ensuring Medicare beneficiaries—one of our nation's most vulnerable and costly populations—can easily access lower-cost pharmacy-provided services is critical to improving outcomes and reducing spending.

The Subcommittee has previously expressed a commitment to advance ECAPS. Doing so would help patients receive the care they need, when they need it. This bipartisan, commonsense legislation will expand access, improve outcomes, and reduce overall Medicare spending.

Pharmacists Help Prevent Waste and Optimize Medication Use

Medication misuse, nonadherence, and therapeutic duplication significantly contribute to preventable medical spending. Pharmacists—particularly those embedded within value-based care models—play a frontline role in identifying cost-saving therapeutic alternatives, reducing adverse drug events, and ensuring optimal medication use.[4] These interventions directly support the Committee's priority of lowering overall expenditures and reducing system inefficiencies.

Thank you for considering our comments. Our nation's pharmacists stand ready to partner with the Committee to advance meaningful, cost-saving reforms that improve affordability, expand access, and strengthen care for all Americans.

Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org, if you have any questions or would like to meet with APhA and pharmacists from your states.

Sincerely,

[4] *See* Armando S. Almodovar, et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 Research in Social and Administrative Pharmacy 321 (2025). Available at: https://www.sciencedirect.com/science/article/pii/S1551741125000129.

Michael Baxter

Michael Baxter
Vice President, Federal Government Affairs
American Pharmacists Association (APhA)

cc: The Honorable Diana DeGette, Ranking Member

Statement for the Record
From the Society of General Internal Medicine
For the House Committee on Energy and Commerce
Subcommittee on Health
Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape
Held on March 18, 2026

The Society of General Internal Medicine (SGIM) thanks the House Committee on Energy and Commerce Subcommittee on Health ("the Committee") for holding this hearing to examine the role that providers play in health care access and affordability and explore how payment policies, competition, transparency, and other incentives shape patient access and the cost of care. We appreciate the opportunity to submit this statement for the record. SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internal medicine physicians, who are dedicated to ensuring that all patients have affordable access to the highest quality of care possible.

Robust evidence shows that access to comprehensive primary care, which includes prevention and effective chronic disease management, improves quality while lowering overall health care spending. For instance, between 2017 and 2022, primary care-focused accountable care organizations (ACOs) consistently generated greater savings and delivered high-quality care in the Medicare Shared Savings Program (MSSP), producing more than twice the savings of less primary care-oriented ACOs.[1] Yet, our health care system consistently falls well short of the required investment in primary care to fully realize the benefits. To achieve better outcomes for patients, payers, and the American taxpayer, health systems must invest more in primary care, reduce utilization of low-value services, and structure value-based models around team-based comprehensive primary care. However, in many cases the current Medicare Physician Fee Schedule (MPFS) incentivizes physicians to provide specialty care services over primary care, or to provide more services than are necessary, contributing to the rising healthcare costs in the U.S.[2]

We urge Congress to prioritize reforms that place primary care at the center of Medicare payment policy and realign reimbursement incentives to support a primary care workforce that can meet beneficiaries' health care needs and improve healthcare affordability.

While the Centers for Medicare & Medicaid Services (CMS) has implemented policies to support primary care in recent years, additional changes must be made in short order to build the primary care workforce necessary to support prevention and elimination of chronic diseases. The services provided by general internal medicine physicians and other primary care practitioners continue to be undervalued. The first step to doing this is correcting the longstanding deficiencies in the MPFS. Such corrections are needed to reverse the decline in the primary care workforce and support innovative payment models, such as hybrid payments and accountable care organizations. Flaws in the current process for valuing physician services must be addressed by ensuring that evaluation and management (E/M) and other high-value

[1] https://thepcc.org/wp-content/uploads/2025/01/Primary-Care-The-MVP-of-MSSP-2024-Evidence-Report.pdf
[2] GAO-25-107465, HIGHLIGHTS OF A FORUM: Reducing Spending and Enhancing Value in the U.S. Health Care System

services are appropriately valued to stabilize and expand access to primary care, the foundation of a high-value health care system that will reduce the burden of chronic disease.

SGIM is also concerned about the unintended consequences of recent changes in CMS's policy that modified the indirect practice expense (PE) methodology under MPFS by halving the indirect PE allocation for facility-based services. The revised approach arbitrarily reduces reimbursement for many facility-based physicians, including general internists and particularly those practicing at academic medical centers when many of these primary care physicians have already faced decades of stagnant payment. Furthermore, this policy change will destabilize primary care clinics that serve as training sites for internal medicine residencies and worsen existing workforce shortages in primary care. Unfortunately, CMS did not present any data to support this policy change and reduction in reimbursement, and **SGIM urges that Congress and CMS work together in improving transparency and ensuring that there is a reliable evidence base to inform any revisions to the payment policies like the indirect PE methodology going forward.**

SGIM shares Congress' and administration's goals to reduce the burden of chronic diseases and improve the health of Americans, while keeping health care costs down, but those goals cannot be achieved without a strong primary care workforce and system that rewards and supports primary care providers. As the population ages, the need for accessible, comprehensive primary care will only grow. We believe that addressing the payment inequities that exacerbate the primary care workforce shortages is essential to ensuring Americans can receive high-quality, affordable care that they need, when and where they need it.

Thank you for holding this important hearing, your continued focus on addressing the most critical drivers of health care costs, and your leadership on important health care issues.

American College of Physicians
Statement for the Record

The U.S. House of Representatives
Energy and Commerce Health Subcommittee Hearing
on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"
March 18, 2026

The American College of Physicians (ACP) is pleased to provide comments in response to the House Energy and Commerce Health Subcommittee's hearing on *"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."* We thank Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette for holding this hearing to discuss bipartisan policies that would make health care more affordable for our patients. **Our policy recommendations include Congress enacting legislation to bolster the primary care physician workforce, provide long-term payment stability for physicians, ensure patients' access to affordable health care coverage, and enhance transparency in the 340B Drug Discount Program (340B program).**

ACP members include 163,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Fund and Reauthorize Programs that Bolster the Primary Care Physician Pipeline

Patients should have access to physicians who can deliver primary, whole-person, comprehensive, and longitudinal care. Congress should invest in federal programs that support and expand the internal medicine and primary care physician workforce. The United States faces a projected physician shortage of up to 187,140 by 2037, including more than 87,000 primary care physicians. Currently, over 77 million Americans live in areas without adequate numbers of health care clinicians, which is a matter for concern as an insufficient primary care practitioner supply is associated with negative outcomes, including higher rates of hospitalization, lower patient-rated health quality, and even higher mortality.

We are pleased that as part of the extenders addition to the recently enacted Consolidated Appropriations Act, 2026, Public Law No: 119-75, funding was authorized for investments in the primary care workforce through the National Health Service Corps (NHSC) and Teaching Health Center Graduate Medical Education (THCGME). ACP appreciates Congress' support in the primary care workforce through the NHSC with the $350 million authorized for Fiscal Year (FY) 2026 (through September 30, 2026) and $88.2 million for the remainder of calendar year 2026. **The NHSC will need to be reauthorized and funded by the end of this year, and it is critically important for NHSC**

funding reauthorization to be at no less than $350 million per year for at least two fiscal years. Congress must act this year to ensure that NHSC funding does not lapse. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities.

Data from the Health Resources and Services Administration (HRSA) shows that in FY 2024, NHSC members provided culturally competent care to a target of over 22 million patients at more than 21,000 NHSC-approved health care sites in urban, rural, and frontier areas. Increased FY 2027 funding will help maintain NHSC's field strength by helping to address the health professionals' workforce shortage and growing maldistribution.

We also greatly appreciate the inclusion of more than $1 billion for the THCGME program funding reauthorization for fiscal years 2026-2029. The THCGME program has over a decade of bipartisan support and is the only federal program investing in the training of future physicians in community settings, rather than hospitals. This long-term investment in THCGME will go a long way in providing stability to these residency programs. **As the Committee examines policy solutions to address the physician workforce shortage, this is an exemplary program to invest in further to ensure patients in rural and underserved areas will have access to physicians in their communities.**

Additionally, the College urges Congress to pass the Resident Physician Shortage Reduction Act, H.R.4731/S.2439. This bipartisan bill is crucial to bolstering the physician workforce and ensuring that patients across the country will have access to well-trained physicians. The bill would invest in the physician pipeline by adding 14,000 new Medicare-supported residency slots over the next seven years. It provides a meaningful and targeted approach that would allow rural and underserved communities to train resident physicians who can provide high-quality health care to patients. Studies show that an overwhelming majority of physicians practice where they are trained, and this bill would direct a significant portion of slots to rural hospitals, hospitals serving health professional shortage areas (HPSAs), hospitals in states with new medical schools, and hospitals that are currently training above the existing resident caps.

Provide Long-term Payment Stability for Physicians

Patient care has been jeopardized as the Medicare Physician Fee Schedule (PFS) fails to provide physicians with the resources to keep up with rising expenses and the cost of caring for patients. ACP appreciates Congress providing additional funds for the PFS for 2026. However, it is important to recognize the longstanding problem that the PFS has not been updated to account for inflation. As a result, payment rates for physicians have actually decreased by a staggering 33 percent from 2001 to 2026, when adjusted for inflation. The lack of inflationary updates, coupled with the PFS statutory budget neutrality (BN) requirement, has led to increased financial instability for physicians. The BN requirement triggers physician payments to be withheld from the PFS when CMS overestimates utilization of new or modified codes in the fee schedule. CMS is not required to return the withheld funds to the fee schedule, resulting in physicians getting unnecessary payment cuts.

The lack of structural, long-term changes to the PFS has resulted in the closure of independent physician practices across the country, followed by a significant uptick in market consolidation. Emerging research shows that health care consolidation leads to worse health outcomes for patients and burnout for physicians. Without federal legislation that provides a payment increase reflecting rising inflationary pressures and changes to fix BN constraints, patients' access will be threatened, particularly in rural and underserved communities. **We urge Congress to pass legislation that would raise the threshold for**

triggering budget neutral cuts within the PFS from $20 million to $53 million. Further, we ask Congress to pass legislation that would return savings from any overestimation of new or modified codes in the PFS back to the PFS.

Ensure Patients' Access to Affordable Health Care Coverage

The College urges Congress to pass legislation that would make health care more affordable by lowering patients' cost-sharing for primary care and preventive health care services and addressing the expired enhanced health insurance premium tax credits. Healthcare affordability can be enhanced through legislative efforts to lower out-of-pocket costs for patients, including co-pays and deductibles for primary and preventive care services. Studies conclude that effective primary care reduces hospitalizations, improves patient health, and extends life expectancy more than other specialties. And yet, the U.S. allocates just 5 cents of every healthcare dollar to primary care. General internal medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple complex chronic conditions. Nearly 95% of older adults in the U.S. have at least one chronic condition and nearly 80% have two or more chronic conditions. Chronic diseases, the leading causes of illness, disability, and death in the United States, are very costly to treat and manage. According to the Centers for Disease Control and Prevention (CDC), 90% of health care expenditures were spent on treating and managing chronic diseases.

We remain concerned that many seniors have failed to access chronic care management services due to a patient cost-sharing requirement associated with this care. Current law mandates that Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive chronic care management services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may avoid the services altogether as a result. Only 4 percent of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

We urge Congress to reintroduce and pass the Chronic Care Management Improvement Act. This legislation would remove the cost-sharing requirement for patients to access chronic care management services. We also support allowing the physician who performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with such services. **Another piece of legislation that ACP supports, which would also lower out-of-pocket costs and cost-sharing for primary care and preventive health services, is the Chronic Disease Flexible Coverage Act, H.R.919.** This bill would provide employers with the option of offering first-dollar coverage of certain chronic disease treatments for employees with high-deductible health plans.

The College also urges Congress to extend the expired enhanced health insurance premium tax credits for the Health Insurance Marketplace or work on a bipartisan policy solution that would bolster health care coverage for people impacted by the expired tax credits. These tax credits made health insurance more affordable for low-income Americans who do not qualify for Medicaid, as well as for small business owners who are not on employer-sponsored health care plans. Since the open enrollment period ended on January 15th for most states, we are seeing lower enrollment in the Health Insurance Marketplace. Patients faced with steep premium increases opted to forgo health care coverage. According to recent data from the Centers for Medicare & Medicaid Services, approximately 1.4 million fewer people have signed up for health coverage in the Health Insurance Exchange this year. With more people opting out of health coverage, this could lead to increased health care costs.

Increase Transparency and Accountability in the 340B Program

The U.S. continues to spend significantly more on prescription drugs than any other country in the world. Prescription drug spending is projected to increase by almost 6% annually from 2024 to 2028 – making it one of the fastest-growing health care spending categories. Prescription drugs are a key part of a physician's comprehensive toolkit and have been crucial in improving the health and well-being of patients. As physicians, we see firsthand what happens when patients cannot get the drugs that they need because the drugs are not affordable. These patients are more likely to skip their medications. This can have negative downstream effects, placing lives at risk and increasing costs throughout the health care system. It is estimated that medication non-adherence results in roughly 125,000 deaths, 10 percent of hospitalizations, increased morbidity rates, and costs the U.S. healthcare system anywhere from $100-$300 billion a year.

ACP strongly supports the 340B program. Created by Congress in 1992, the program allows health care entities that provide outpatient care to uninsured and low-income patients to purchase prescription drugs at steep discounts directly from drug manufacturers. With savings from prescription drug discounts, qualified health care entities can reinvest the money into patient care and expand access to health care services for underserved patient populations. While we strongly support the program and would like to see it continue, we call on Congress to examine policies that would boost transparency and accountability, to ensure that the savings health care entities receive are directed toward patient care.

To enhance program integrity in the 340B program, ACP calls for covered health care entities to publicly report on the benefits received through the program and how the savings are used to expand access to care for low-income and uninsured populations. Additionally, we support the continued option for covered health care entities to contract with specialty or community-based pharmacies to help promote greater access to 340B drugs for eligible patients. However, we urge for oversight and auditing of contract pharmacies to ensure that discounts are going to uninsured and low-income patients, as the program intended. Furthermore, we urge Congress to provide relevant federal agencies with clear statutory authority and dedicated resources to promulgate necessary program regulations to conduct oversight and compliance activities.

Conclusion

Once again, we thank you for holding this important hearing to examine impactful, common-sense policy solutions to the rising cost of health care. We look forward to working with the Energy and Commerce Committee to accomplish these goals. Should you have any questions regarding the recommendations outlined in this statement, please contact Vy Oxman, Senior Associate of Legislative Affairs, at voxman@acponline.org.

Submission for the Record
Alliance to Fight for Health Care
For the
Committee on Energy and Commerce
Subcommittee on Health
Of the
U.S. House of Representatives
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"
March 18, 2026

Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, thank you for the opportunity to submit the following statement for the record in conjunction with the hearing on **"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."**

Americans are calling for more affordable health care. The **Alliance to Fight for Health Care** is offering our 2026 Policy Agenda complete with concrete policy recommendations to lower health care prices for the more than 181 million working Americans covered by employer-sponsored insurance. The Alliance was founded with a vital mission: to **protect and improve employer-provided coverage** and ensure that high-quality, employer-sponsored insurance remains an affordable and accessible coverage option.

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 select policies collaboratively that our coalition views as meaningful steps that improve coverage and address issues in our health care system that increase health care costs for patients without adding value or increasing quality.

The **Alliance** is dedicated to pursuing policies that bring meaningful change — and cost savings — to our health care system and the patients it serves.

Core Legislative Priorities for 2026

The following priorities represent our primary focus for the current legislative session:

Protect Stable Coverage for the American Workforce: We will continue to vigorously defend the tax exclusion for employer-provided health insurance. This is the most effective tool for pooling risk and providing stable coverage to the American workforce. Employer-provided health care coverage efficiently and effectively covers more Americans than all other sources of coverage combined. Employer-provided coverage also produces substantial return on the federal government's investment in it—both economically and when it comes to our health. For every dollar the government invests in the exclusion, employers invest $5.66 into the health care system—that's a return on investment for taxpayers that would be very difficult for any other system to match.

Increase Hospital Price and Billing Transparency: Patients and payers must have access to real, standardized dollar amounts rather than vague estimates. Improved access to transparent pricing, costs, and quality data will empower patients to make informed choices and will drive down costs through competition. Requiring separate National Provider Identifier (NPI) numbers for off-campus outpatient clinics ensures bills reflect the actual location and provider. Honest billing will give patients more insight into whether they are appropriately charged for visits based on location. This

transparency will empower patients to dispute erroneous fees, unfair add-on costs, hospital upcharges generated by artificial intelligence or otherwise, and other junk fees.

Expand Site-Neutral Payments: Building on the 2026 CMS Outpatient Prospective Payment System Final Rule, the **Alliance** supports further site-neutral payment reforms within Medicare. Aligning reimbursement for services across settings—ensuring the same price is paid for the same service, regardless of whether it is performed in a hospital outpatient department or a physician's office—is essential to lowering costs for patients and the federal government.

Limit Anti-Competitive Contracting: To promote high-value care, we champion policies that prohibit "all-or-nothing" or "anti-tiering" and “anti-steering” clauses in hospital contracts. These practices stifle competition and prevent employers from using strategies to steer employees toward higher-quality, lower-cost providers.

Expand Access to Telehealth: We urge Congress to allow providers to practice telehealth across state lines and prohibit unnecessary "facility fees" for virtual visits, ensuring telehealth remains a low-cost, convenient option for all.

Allow Greater Pre-Deductible Coverage in HSA-Eligible Plans: We support expanding the list of "high-value" chronic care services that are allowed to be covered pre-deductible in HSA-qualified plans. These plans ensure that patients can access needed services without the threat of high out-of-pocket costs.

Supporting Policies

In addition to our primary goals, the **Alliance** will lend its voice to efforts that address systemic market failures, including:

Stemming rising costs at freestanding emergency departments through site-neutral practices.

Increasing ownership transparency for hospitals and private equity-backed health facilities.

Workforce expansion in primary care and mental health to address critical provider shortages.

Advancing solutions for preventing end-stage renal disease (ESRD) and improving dialysis markets.

We look forward to working with you to advance these commonsense solutions that prioritize the health and financial security of American workers and work to make health care more affordable for all Americans.

Sincerely,

The Alliance to Fight for Health Care

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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

House Committee on Energy and Commerce
Subcommittee on Health

March 18, 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 Subcommittee 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 patients get better value. However, bringing down health care costs will require the participation and alignment of incentives across the whole health care system. Plans alone cannot solve the affordability pressures for consumers and the government. Together, we can find workable solutions that make health care more affordable for patients and more sustainable for the country.

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 in hospital costs, improve provider participation and modernization of practices while aligning incentives across the system while 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.

Affordability Depends on System-Wide Collaboration

Health plans are ready to be full, accountable partners with hospitals and providers to help drive down health care costs. Health care affordability is a shared responsibility, and patients deserve reforms that lower costs and improve outcomes. Health plans have the tools, data, and incentives to reward value over volume, but hospitals and providers must also be transparent and accountable.

Hospital Pricing is Driving Higher Health Care Costs

Affordability remains out of reach when hospital system practices undermine cost-containment efforts across the system. Hospitals continue to raise their prices at rates that outpace inflation, accompanied by opaque fees that ultimately drive-up costs for patients. 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]

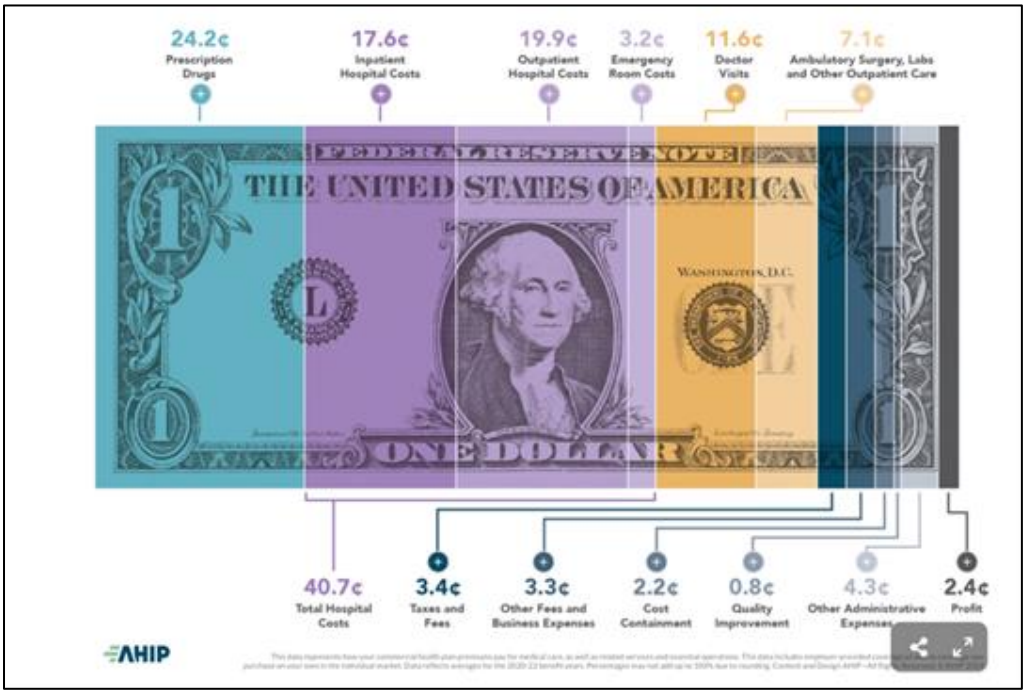

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf.

Hospitals play a central role in driving 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 care reached a staggering $1.6 trillion.[3] This level of 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 acquire independent physician practices, consolidated

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[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

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 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] Most 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 – and ultimately 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] Nonetheless, 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]

Excessive Site-of-Care Price Variation

Hospital consolidation doesn't 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

[4] https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/enviromental-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

prices, often due to facility fees imposed by hospitals. 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.[8] For patients, it is often "the same visit, higher bill." These facility fees and other opaque hospital billing practices mean higher premium costs year after year.

- **Recommendation:** Protecting consumers 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.[9] 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.

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 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.[10] Great 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.[11] Hospitals substantially mark-up drug costs for commercial health plans, charging 50 percent to 103 percent more than specialty pharmacies for the same drug.[12] 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.

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[8] https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings/

[9] https://www.cbo.gov/budget-options/60908

[10] https://www.bcbs.com/news-and-insights/report/ai-boosting-hospital-billing

[11] https://www.axios.com/2026/03/05/disparities-hospital-drug-prices

[12] https://www.ahip.org/news/press-releases/new-research-highlights-premium-impact-of-provider-markups-on-specialty-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.

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.[13] 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 comparable practices across that same time period.[14] Private equity's focus on generating short-term profits often leads to reduced health care staffing, stretching workers further and putting patients at risk.[15] These studies demonstrate how 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.

Provider Partnerships Are Essential to Affordable, High-Quality Care

Plans and providers share the same goal: high-quality, affordable care, and collaboration is essential to modernize prior authorization, expand telehealth, strengthen network adequacy, and eliminate surprise medical billing. Health plans have built and maintained the infrastructure to support these reforms, but meaningful progress requires provider engagement to ensure patients see real improvements in affordability.

Value-Based Care: Aligning Incentives Around Patient Outcomes

Value-based care is the connective tissue of the plan-provider partnership, aligning incentives so providers are rewarded for delivering better outcomes and more efficient care, rather than higher volume or higher prices. Health insurance exists to protect individuals and families from the unpredictable costs of medical care – and value-based care is central to that mission. By shifting away from volume-driven incentives, health plans are working to shield Americans from high

[13] https://hsph harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/
[14] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946
[15] https://www2.nber.org/digest/202104/how-patients-fare-when-private-equity-funds-acquirenursing-homes

and rising health care costs while improving care delivery. This protection depends on a strong, balanced risk pool and payment models that encourage high-quality, efficient care for individuals with diverse health care needs throughout the year.

Patients deserve a health care system focused first and foremost on delivering affordable, evidence-based care that works. By aligning incentives around outcomes, value-based care helps curb avoidable hospital spending and supports a more sustainable cost trajectory across the entire health care system. Health plans are committed to working hand-in-hand with hospitals and provider organizations to advance value-based care and deliver patient-centered, high-quality, coordinated care that is more affordable for Americans.

Health plans continue to invest in value-based care models – such as alternative payment models (APM) – that emphasize quality and patient outcomes while safely reducing costs. Results from the 2025 APM Adoption Survey conducted by AHIP in collaboration with CMS reaffirm the commitment of public and private payers to transition from fee-for-service toward payment models that incentivize quality, efficiency and improved patient outcomes.[16]

The APM Adoption Survey found that 44.9 percent of all health care payments were tied to APMs that hold providers accountable for quality and cost of care, while 28.7 percent of health care payments were tied to APMs with downside risk. The survey also captured perspectives on future trends; 70 percent of respondents expect APM activity to increase over the next 24 months, citing provider readiness, health plan engagement, and health plans' ability to operationalize such models as key facilitators.[17]

While the survey findings demonstrate health plans' continued commitment to value-based care models, wider engagement among hospitals and other provider organizations could help strengthen momentum and grow broad-based participation in value-based care arrangements that improve outcomes – and affordability – for families across the U.S.

Medicare Advantage

Medicare Advantage (MA) illustrates how health plans, through risk-based payment and accountability, have powerful incentives to control costs and improve affordability across the health care system. MA delivers significantly lower total health care costs for beneficiaries than traditional fee-for-service (FFS) Medicare while also delivering better patient outcomes. Research shows that MA beneficiaries experience fewer avoidable hospitalizations, stronger hospital recovery, and lower hospital readmissions.[18,19]

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[16] https://www.ahip.org/resources/2025-apm-measurement
[17] Ibid
[18] https://www.inovalon.com/wp-content/uploads/2025/05/INOV_MA-vs-FFS-Outcomes-Study_5.28.25-v1.0.0.pdf
[19] https://www.thinkbrg.com/insights/publications/black-hispanic-aapi-ma-beneficiaries-receive-primary-care-potentially-avoidable-care/

MA also has a lower improper payment rate compared to FFS Medicare.[20] In 2025, FFS improper payment rate was 6.55 percent, costing the federal government over $28 billion, compared to 6.09 percent for MA plans – all while MA plans are serving more Medicare beneficiaries. This performance reflects the accountability built into MA, where plans are financially responsible for managing care, preventing fraud, waste, and abuse, and ensuring services are medically appropriate. By contrast, FFS Medicare lacks many of these safeguards, underscoring how MA's care coordination, oversight, and utilization management tools protect both beneficiaries and taxpayers while delivering high-quality coverage at scale.

Furthermore, MA can play an important role in supporting rural health system stability and improving care quality, at a time when rural Americans face growing challenges accessing and affording care due to hospital closures and reduced services. In fact, one study that examined rural hospitals in 14 US states, found that an increase in county MA penetration was associated with an increase in hospital financial stability and a reduction in risk of closure. In fact, the study found that every percentage point increase in MA penetration was associated with a 4 percent reduction in risk of hospital closure.[21] Another recent survey found that rural Americans saved $5,500 on MA, compared to FFS, thereby improving affordability in low-access regions.[22]

As policymakers look for ways to address the affordability crisis facing Americans, particularly in rural communities where access to care is already strained, MA remains a proven tool for protecting beneficiaries from the rising cost of medical care. While health plans support reforms to strengthen the program for seniors, flat funding during a period of sharply rising medical costs and high utilization – as is currently proposed in CMS's 2027 MA and Part D Advance Notice – could result in reduced benefits, fewer choices, and increased costs for millions of seniors when they renew coverage in October 2026.

MA's value-based care approach helps reduce unnecessary hospital utilization, strengthen hospital stability and lower overall health care costs for beneficiaries and taxpayers.

Simplifying Prior Authorization

Prior authorization is another value-based tool health plans use to ensure care is safe, evidence-based, and as affordable possible. By applying prior authorization in a targeted and clinically grounded way, health plans help to coordinate care, promote value, reduce unnecessary or duplicative treatments, and avoid complications that drive costs higher.

The targeted, clinically driven use of prior authorization reflects the distinctive role of health plans as the only part of the system that does not benefit from higher utilization or higher prices.

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[20] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet
[21] https://www.ahip.org/resources/ma-increases-rural-health-system-stability-improves-care-quality-2
[22] https://www.ahip.org/resources/medicare-advantage-leads-to-savings-for-seniors-and-taxpayers

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 are structurally motivated to selectively use prior authorization to reduce low-value care, reinforce clinical best practices, and drive better outcomes.

Electronic prior authorization also reduces administrative burden for providers, accelerates patient access to necessary treatments, and minimizes delays in care. Health plans have invested heavily in building electronic prior authorization options. Yet nearly half of prior authorization requests (45 percent for medical services and 47 percent for prescription drugs) are still manually submitted by providers using phone, fax or traditional mail – creating inefficiencies. As plans deploy the next generation of electronic prior authorization that integrates into electronic health records by January 1, 2027, vendors must build and providers must adopt the new technology. Without the greater use of modern technologies, continued reliance on manual processes negates the efficiencies of electronic prior authorization. Looking forward, a coordinated effort from both plans and providers will be essential to fully streamline the prior authorization process.

Last June health plans announced a series of further commitments to streamline, simplify and reduce prior authorization. Building on health plans' existing efforts, these new actions are focused on connecting 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.[23]

AHIP looks forward to working with the Subcommittee and sharing progress on health plans' commitments to improve prior authorization this spring.[24]

Improving Provider Directory Accuracy

Health plans are also committed to ensuring beneficiaries have accurate, reliable provider directories so individuals can easily find in-network providers who meet their clinical needs and are accessible and appropriate for them. Provider directories are a critical consumer protection tool, offering essential information such as contact details, specialties, and board certifications, and enabling patients to maximize the value of their coverage. Health plans invest significant resources to keep this information current through ongoing outreach, validation, and audits.

Despite these efforts, two persistent challenges undermine directory accuracy: some providers do not consistently submit timely or complete updates to their information, and there is no single source-of-truth for provider information that can be utilized. These challenges are compounded by a complex environment of federal and state rules, with different provider directory

[23] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[24] https://www.ahip.org/news/articles/2026-will-bring-progress-on-simplifying-prior-authorization

requirements across different and state-specific rules in nearly all 50 states.[25] The creates fragmentation and operational complexity without necessarily improving accuracy for patients.

Health plans have worked closely with their provider partners for years to improve directory data. These efforts include streamlining processes and leveraging data to flag outdated information. Achieving meaningful and durable improvement requires a shared, system-wide commitment – including stronger provider responsibility for keeping information current and avoid the real-world consequences of inaccurate listings for consumers.

Using Telehealth to Lower Prices and Challenge Anti-Competitive Provider Practices
Plans and providers must also work together to expand high-value telehealth that improves access while reducing unnecessary utilization; modernize prior authorization so it is targeted, data-driven, and focused on patient safety rather than paperwork; ensure network adequacy that gives patients meaningful access to high-quality, cost-effective care; fully eliminate surprise medical billing by honoring clear rules and good-faith contracting; and jointly identify and stop fraud, waste, and abuse that siphon billions of dollars from the system every year.

Expanded access to telehealth can foster greater competition on quality and costs, particularly in regions with monopoly health systems. As health care provider markets become increasingly consolidated, telehealth spurs crucial price competition that would otherwise be limited in or absent from local markets.

Telehealth can also address inflated pricing from hospital systems that acquire physician offices and redesignate them as hospital outpatient departments: charging higher prices even though nothing about the office has changed. Further, telehealth providers compete with each other, not just with local providers. This dual competition benefits individuals and other customers purchasing coverage, such as employers.

- **Recommendation:** To boost telehealth competition, AHIP urges policymakers to allow physicians to deliver care across state lines and modernize network adequacy regulations to reflect the availability of telehealth as an option for patients. Congress should also pursue policies that allow for flexibility in plan benefit and payment design to support value-based care via telehealth, ban distant site facility fees for telehealth services to lower costs for patients, and make permanent the telehealth flexible benefit offerings Medicare implemented that are currently extended through 2027.

Preventing Private Equity-Backed Providers from Exploiting Surprise Billing Protections
A fragmented health care system – combined with the rapid expansion of private equity ownership – has intensified out-of-network billing, balance billing, and opaque pricing that harms consumers.

[25] https://www.ncsl.org/health/health-insurance-network-adequacy-requirements

When private equity and other investment firms focus on extracting short-term profit cost, quality and patient experience can be negatively impacted. When private equity-backed providers game patient protections against surprise billing, policymakers need to take action to hold down wasteful spending.

Private equity-backed provider groups often rely on aggressive billing strategies, including remaining out-of-network or exploiting payment disputes, to maximize their revenue at the expense of American consumers. Private equity firms initiate the vast number of arbitration challenges raised under the *No Surprises Act*: 63 percent of surprise billing arbitrations were filed by just five private equity-linked firms.[26] These investment groups are flouting the intent of the Federal Independent Dispute Resolution (IDR) process, filing improper claims to arbitrators who operate without oversight, driving over $5 billion in wasteful spending in just two years.[27] These practices contribute to surprise medical bills, medical debt and financial instability for individuals, families, and employers.

Investment capital can meaningfully improve the performance of the health care system by supporting innovations and scaling capabilities that reduce unnecessary costs, improve experience and drive higher quality. Too often, however, PE-backed investments prioritize short-term returns at the expense of patient care. Transparency and oversight are needed to ensure that private equity investment in the health care sector improves quality at a lower cost.

- **Recommendations:** Common-sense solutions include strengthening enforcement in the IDR process to stop private equity-backed groups from flooding the system with ineligible claims and requiring more stringent oversight of arbitrators, such as greater transparency, audits and penalties for non-compliance These solutions can provide relief to employers and consumers who are still bearing the brunt of private equity's abuse of the surprise billing arbitration system.

Conclusion

AHIP thanks the Subcommittee 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 access to high-quality care. AHIP looks forward to continuing to work collaboratively with the Subcommittee 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.

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[26] https://www.healthaffairs.org/content/forefront/independent-dispute-resolution-process-2024-data-high-volume-more-provider-wins

[27] https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process

American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

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House Energy & Commerce Committee
Subcommittee on Health
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

2123 Rayburn House Office Building
Washington, DC 20515

March 18, 2026

Introduction

Chairman Griffith, Ranking Member DeGette, and members of the Subcommittee, thank you for the opportunity to submit this statement for the record. On behalf of the 69,000 members of the American Association of Nurse Anesthesiology (AANA), I write to you today to thank you for holding this hearing on the important topic of lowering health care costs for Americans. Given the importance of this topic, we appreciate the subcommittee's attention to the issue, but we are disappointed to see that the subcommittee has not invited anyone to provide the advanced nursing perspective, despite nurses making up the vast majority of healthcare providers and often providing care in a more efficient manner. We hope to work with the subcommittee in the future to provide the important perspective that nursing brings to the table.

AANA has long advocated for policies that promote competition and choice in the healthcare marketplace, remove outdated and unnecessary barriers that restrict patient access to care, and promote evidence-based policy solutions that benefit consumers and maintain the highest level of safety and quality for patients. As the subcommittee reviews options for ways to lower costs for consumers, AANA strongly supports the removal of outdated regulatory barriers, such as Medicare's supervision requirement for CRNA services, which increases costs for providers and does nothing to improve outcomes or safety for patients. H.R. 1317, the bipartisan *Improving Care and Access to Nurses* (ICAN) *Act* would remove outdated barriers in Medicare and Medicaid, lower costs and promote competition in healthcare without expanding state scope of practice laws.

Furthermore, as Congress looks to lower costs, we strongly urge Congress to work with the Administration to enforce the provider nondiscrimination provisions of the Public Health Service Act and the *No Suprises Act* that ensure proper competition and choice for consumers. Enforcing these laws represents a critical step towards safeguarding patients and ensuring strong and healthy competition in healthcare.

Finally, the Department of Education's recent proposed changes to federal student loans have the potential to devastate the pipeline of providers at a time when there is already a shortage of both nurses and anesthesia providers. Adding to this shortage is certain to drive up costs and decrease access to care for those who need it most. With this in mind, AANA strongly urges the House Energy & Commerce Committee to express support for appropriately classifying the advanced education of CRNAs and other advanced practice nurses as "*Professional Degrees"* to ensure they have access to the loans needed to complete their education. We also encourage the committee to pass H.R. 3593, the *Title VIII Nursing Workforce Reauthorization Act of 2025*, to protect the pipeline of nursing education and maintain crucial investments in the nursing workforce. Support for Title VIII Programs is as critical as it has ever been given the risks posed by the Department of Education's proposal to significantly limit federal support for advanced nursing education.

Background on AANA and CRNAs

The AANA is the professional association for CRNAs and student registered nurse anesthetists, with membership that includes more than 69,000 CRNAs and student nurse anesthetists representing over 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as acute, chronic, and interventional pain management services. In a majority of states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. CRNAs are highly trained and skilled anesthesia providers who have full practice authority across all branches of the Armed Forces, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals.

CRNAs are highly educated, doctorally prepared nurses, who are required to be board certified, and must participate in continuing education and recertification every 4 years in order to maintain practice. CRNAs have a higher educational requirement than any other advanced nursing professions, and their education requires significant and expensive equipment, on par with their physician anesthesiologist colleagues. This high level of education ensures that CRNAs are able to practice independently, without unnecessary and wasteful supervision requirements.[1]

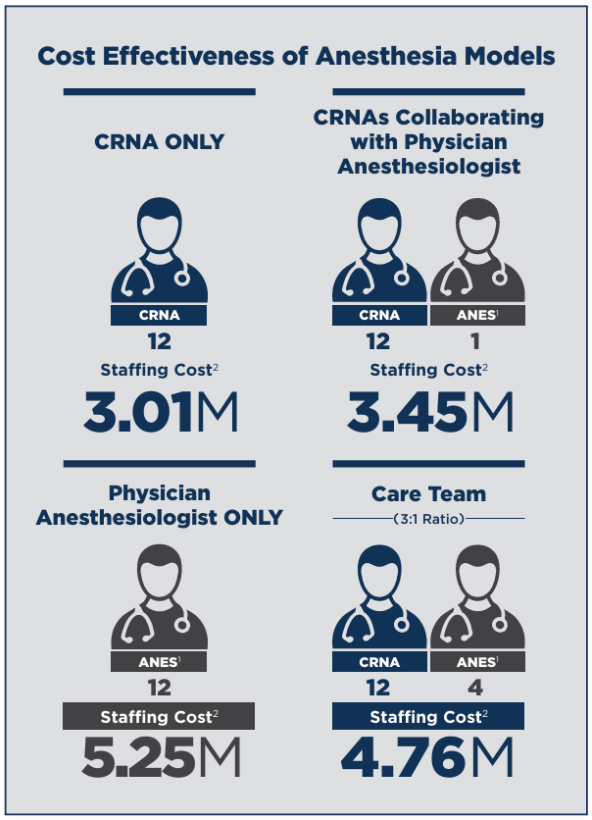
Remove Inefficiencies and Barriers to Optimized Service Delivery

Inefficient and outdated Medicare policies such as Medicare's supervision requirement for CRNA services, only serve to increase costs, without adding any benefit to patients. Not only does Medicare's supervision requirement have no basis in statute, it also ignores state scope of practice laws in forty-five states, where there are no supervision requirements for CRNAs under the state board of nursing, in the Nurse Practice Act, or in their state equivalent. Removing these barriers to care will allow facilities to provide anesthesia and related surgical, obstetrical, and preventative care, at a lower cost. There are significant misconceptions about Medicare's supervision requirement for CRNAs. Multiple studies have spoken to the fact that supervision does not improve outcomes. Furthermore, physician supervision requirements incentivize the use of Medicare Part B anesthesiologist medical direction payment models, which have nothing to do with quality or patient safety. The precursor to the Centers for Medicare & Medicaid Services (CMS), the Health Care Financing Administration stated, "[t]he medical direction requirements are not quality of care standards."[2] The supervision and medical direction models of care utilize two providers, one of whom is not even providing direct patient care, leading to inefficiencies in care and wasted money. Under the medical direction model, where a physician supervises between one and four CRNAs, CRNAs bill for the services they are performing at 50% of the physician fee schedule (PFS), with the physician billing 50% concurrently. This concurrent billing of one to up to four anesthesia cases allows the physician a possible combined total of 200% of the PFS. Permitting a supervising physician anesthesiologist who is not delivering direct patient care to bill up to 200% of the Physician Fee Schedule in concurrent cases is highly inefficient. This approach represents

[1] AANA Code of Ethics for the Certified Registered Nurse Anesthetists, July 18, available at: https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse_?fr=sZGY1YTU2NDAxMjU

[2] 63 FR 58843, November 2, 1998, available at: https://www.govinfo.gov/content/pkg/FR-1998-11-02/pdf/98-29181.pdf.

one of the least cost-effective models of anesthesia delivery possible, and AANA strongly supports legislation like the ICAN Act to increase flexibility and allow for more efficiency.



Multiple peer-reviewed studies have consistently shown that CRNA-provided anesthesia has outcomes that are on par with our physician anesthesiologist colleagues.[3][4][5][6][7][8][9] In addition to providing the same level of quality care as physician anesthesiologists, a recent study shows that allowing CRNAs to practice without supervision, under the QZ modifier, also increases access to care.[10] Similarly, a 2025 study concluded, "that hospital obstetric anesthesia staffing models that rely on CRNAs without medical direction may be more prevalent in areas that lack full access to maternity care services, supporting the idea that CRNAs are vital in areas which would otherwise lack anesthesia providers and obstetric services. Policies that support hospitals allowing CRNAs to practice without medical direction may increase access to obstetric anesthesia services in underserved areas."[11]

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[3] Negrusa, Brighita PhD; Hogan, Paul F. MS; Warner, John T. PhD; Schroeder, Caryl H. BA; Pang, Bo MS. Scope of Practice Laws and Anesthesia Complications: No Measurable Impact of Certified Registered Nurse Anesthetist Expanded Scope of Practice on Anesthesia-related Complications. Medical Care 54(10):p 913-920, October 2016. | DOI: 10.1097/MLR.0000000000000554

[4] "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff

[5] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. Accessed 21 January 2026.

[6] Beissel D. E. (2016). Complication Rates for Fluoroscopic Guided Interlaminar Lumbar Epidural Steroid Injections Performed by Certified Registered Nurse Anesthetists in Diverse Practice Settings. *Journal for healthcare quality : official publication of the National Association for Healthcare Quality*, *38*(6), 344–352. https://doi.org/10.1111/jhq.12093

[7] Needleman, J., & Minnick, A. F. (2009). Anesthesia provider model, hospital resources, and maternal outcomes. *Health services research*, *44*(2 Pt 1), 464–482. https://doi.org/10.1111/j.1475-6773.2008.00919.

[8] Simonson, Daniel C.; Ahern, Melissa M.; Hendryx, Michael S.. Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis. Nursing Research 56(1):p 9-17, January 2007.

[9] Pine, Michael; Holt, Kathleen, Lou, You-Bei. (April 2003). Surgical Mortality and Type of Anesthesia Provider. AANA Journal. Vol 71. No2.

[10] Ghosh PP, Tarazi WW, Ume N, Ferrara EE, Hogan P, Parker ED. Impact of Scope of Practice Laws for Certified Registered Nurse Anesthetists on the Utilization of Anesthesia Services. Health Serv Res. 2025 Oct 15:e70052. doi: 10.1111/1475-6773.70052. Epub ahead of print. PMID: 41091051.

[11] Palmer et al. (April 2025) An Examination of factors contributing to different anesthesia models in underserved areas. (Journal of Nursing Outlook). https://www.nursingoutlook.org/article/S0029-6554(25)00005-3/abstract

The *Improving Care and Access to Nurses Act* (H.R. 1317) is important legislation that would remove barriers on CRNAs and other APRNs, to allow them practice consistent with their state scope, providing more cost-effective care to consumers. AANA strongly encourages the subcommittee to swiftly consider and advance this legislation to help drive down healthcare costs.

Enforce No Surprises Act Rules to Increase Competition and Choice

When Congress passed the bipartisan *No Surprises Act*, it sought to increase competition in healthcare, promote policies that support quality and competition, and hold insurers accountable for practices that drive prices up and deprive consumers of choice. As the Administration continues to implement the rules and policies of the *No Surprises Act*, there has been a glaring omission. Section 108 of the Act requires the Secretaries of HHS, Labor, and the Treasury to issue a proposed rule implementing the provider nondiscrimination protections under section 2706(a) of the Public Health Service Act. These protections state that, "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.[12] Yet, despite the fact that the deadline for issuing a rule is more than four years past, the agencies have failed to properly issue a rule, allowing insurers to act in bad faith and issue policies that unfairly discriminate against entire groups of licensed providers drives up costs and decreases competition.

The lack of rulemaking, or any enforcement at all, has led insurers such as Cigna and UnitedHealthcare to issue policies that cut reimbursement for all independent CRNA provided care, regardless of quality or outcomes. These 15% cuts, which only apply when a CRNA is providing anesthesia independently, do not apply to anesthesia provided through any other model. Not only is this blatantly discriminatory, it is also anticompetitive and incentivizes providers to utilize more expensive models of anesthesia care. While disregarding the law to reduce reimbursement for CRNA-provided services may provide insurers with short-term monetary gains, it provides a long-term disincentive to utilize efficient anesthesia models, which will create increased costs in the long run as provider shortages worsen in the coming years.

AANA strongly encourages the House Energy & Commerce Committee to work with the Administration to enforce the provisions of the *No Surprises Act,* through strong enforcement of the nondiscrimination provision and the promulgation of legally required rulemaking to protect consumer choice and competition.

Protect and Promote the Future Healthcare Workforce

[12] (42 U.S.C. 300gg-5(a) Public Health Service Act. Section 2706(a).

Finally, so long as there are an insufficient number of providers in the healthcare workforce, consumers will continue to face rapidly increasing costs, especially as there are too few providers for the overwhelming demand for care. This leads to delays in care, which in turn leads to increased costs. Congress must make critical investments in our healthcare workforce now, to ensure we have sufficient providers for the future and slow the rising cost of healthcare. Investments in CRNAs and other APRNs are particularly important given they provide high quality care, at a more cost-efficient point, for significantly lower educational costs compared to physicians. AANA strongly supports the passage of H.R. 3593, The *Title VIII Nursing Workforce Reauthorization Act* of 2025, which would reauthorize critical educational programs to protect the nursing pipeline. We appreciate the subcommittee's markup of the bill and advancement to the full committee and hope to work with the committee to move the legislation to the floor for a full vote. We also encourage members of the subcommittee and Congress to work to ensure that CRNAs and other advanced practice nurses are considered to be seeking "professional degrees" under the Department of Education's regulations implementing changes to federal student loan programs. This will ensure Student Registered Nurse Anesthetists (SRNAs) have access to the loans they need to complete their programs.

Unfortunately, the Department has chosen to ignore the definition of "professional degree" dictated by Congress and inappropriately conflates practice as a licensed registered nurse (RN) with practice as APRN despite having distinct roles and licensure. The Department further inappropriately cites supervision requirements that were neither part of statute nor a part of the negotiated rulemaking committee's extensive negotiations and deliberations. By proposing to limit federal support for SRNAs to meaningfully insufficient levels, the Department's proposal will have anti-competitive effects that run counter to much of the work done by the Trump Administration to increase access to APRN care. This is especially concerning as CRNA programs carry much of the same costs as our physician anesthesiologist colleagues due to the fact that both professions are trained to perform the same standards and methods of care but are trained via either the nursing or medicine pathway.

A recent survey of licensed RNs and APRNs interested in becoming CRNAs conducted by the AANA sought to measure the impact of the new, insufficient loan limits. The survey provided deeply concerning results that portend massive disruption to the future workforce. According to the survey, 75% of respondents "reported that CRNA education would no longer be financially feasible under the proposed federal loan limits" and 80% report being very concerned about having to turn to the private loan market to be able to afford their education.[13]

Becoming a CRNA provides a strong return on investment, with programs reporting default rates between one and zero percent from 2024, and programs that overwhelmingly produce 100% employment rates within 6 months of graduation. Additionally, while almost $22 billion is invested annually in various Graduate Medical Education programs to train physicians and pay them during their residency, in stark contrast, only $305 million is provided for all nursing programs combined, covering

[13] American Association of Nurse Anesthesiology. January 2026. Impact of Proposed Federal Loan Limits on the CRNA workforce. https://www.aana.com/wp-content/uploads/2026/01/Impact-of-Proposed-Federal-Loan-Limits-on-the-CRNA-Workforce-1.pdf

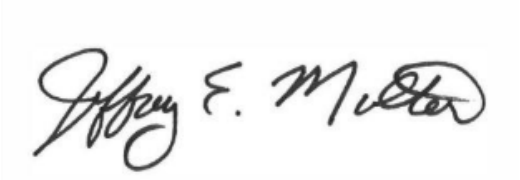
all RNs and APRNs, including CRNAs. Most SRNAs are not paid during their minimum 2,000 clinical training hours requiring them to heavily rely on student loans for their living expenses. The Department's misclassification of CRNA programs as not professional degrees further an anticompetitive environment despite the fact that nurses make up a significantly greater number of healthcare providers than physicians.

Despite the vastly lower federal investment in nursing education, CRNAs are the main providers of anesthesia in rural and underserved communities where higher-cost physicians do not practice. They provide facilities with the most cost-effective model of anesthesia delivery, a CRNA working without unnecessary supervision in coordination with the surgical team. In light of this, it is critical that Congress work with the Administration to ensure that CRNA programs are classified as professional degree programs.

Conclusion

The AANA appreciates the Subcommittee's attention to this important issue. There are many steps Congress can take to lower costs for consumers, including the removal of unnecessary barriers to care under Medicare that have no basis in statute, enforcement of existing laws under the No Surprises Act to curtail insurer policies that harm competition and choice, and support for the future healthcare workforce. We strongly urge Congress to work with the Administration to ensure the inclusion of post-baccalaureate nursing degrees (MSN, DNP, DNAP, Ph.D.) explicitly in the list of professional degrees as the Department of Education finalizes its rulemaking. Should you have any questions, please reach out to the AANA Senior Director of Congressional Affairs Matthew Thackston at mthackston@aana.com.

Sincerely,



Jeff Molter, MSN, MBA, CRNA
President, American Association of Nurse Anesthesiology

The Disability and Aging Collaborative &

March 16, 2026

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, DC 20515

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC 20515

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

RE: The critical role and efficiency of Home and Community-Based Services (HCBS) in the lives of people with disabilities and older adults.

Dear Leader Thune, Minority Leader Schumer, Speaker Johnson, Minority Leader Jeffries, and Members of the United States Senate and House of Representatives,

The undersigned 169 members of the Disability and Aging Collaborative (DAC), the Health and Long Term Services and Supports (LTSS) Taskforces of the Consortium for Constituents with Disabilities (CCD), and allied organizations urge you to oppose actions by the current Administration that would restrict crucial Medicaid home and community-based services (HCBS) and harm people with disabilities and older adults.

CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. DAC is a coalition of national and state organizations that work together to advance long-term services and supports policy at the federal level. DAC and CCD have a longstanding history of advocating for people with disabilities and aging adults to access needed care in their communities, and supporting the family caregivers and care workers who provide that care.

The undersigned organizations write to express deep concern about the Centers for Medicare & Medicaid Services' (CMS) continued attacks on HCBS and drastic responses to concerns about fraud. We strongly disagree with CMS' implication that increased spending on HCBS, including

mental health services, and other integral services for people with disabilities and the increased number of direct care workers alone are indicative of issues with program integrity. The Administration is taking misguided and sweeping actions that put the health, well-being, and independence of people with disabilities and older adults at risk.

People with disabilities and older adults rely on Medicaid HCBS every day, when personal care aides and direct support professionals help a person with a disability find employment and get ready for work or ensure they are able to eat, transport brings a grandmother with Alzheimer's to an adult day center to socialize and combat loneliness, and paid family caregivers fill the gaps in the direct care labor market. More than 1 in 4 people in the U.S. have disabilities, and across the country, more than one in five adults receive ongoing support with these and other everyday functional needs, like bathing, dressing, and taking medications.

Increased overall spending in HCBS reflects the increase in the number of Medicaid HCBS enrollees and is the result of decades of work by families, people with disabilities, and older adults who want to live, work, and age with dignity in their own homes and communities alongside federal and state efforts to rebalance funding to HCBS from institutional facility care. Rebalancing by utilizing Medicaid funding to keep people with disabilities and older adults in their communities instead of expensive institutions both serves more people and can save considerable money.

Family caregivers and direct care workers for older adults and people with disabilities being paid through Medicaid are providing life-saving, essential care that will be compromised by these actions. The increase in direct care workers and in support for family caregivers also reflects the needs of a rapidly aging population and already underpaid workforce. Employment projections from the Bureau of Labor Statistics demonstrate the demand for direct care workers will continue to grow. Today's workforce growth already has not kept pace with the demand for services. Family caregivers' work fills critical gaps in the labor market and looks different from the typical caregiving family members tend to do for each other, and instead can involve fully bathing and grooming a grown adult, transferring someone from a bed to a wheelchair, and even skilled medical care like changing tracheotomies and monitoring ventilators.

The people with disabilities and older adults who rely on Medicaid are harmed, not protected, when the funding for their services is frozen. During debates over Medicaid spending during 2025, we heard repeatedly that Members of Congress promise to protect Medicaid for people with disabilities and older adults. Freezing hundreds of millions of dollars that pay for Medicaid HCBS does not protect people with disabilities and older adults.

More funding, not less, is needed for care. There are real crises facing the aging and disability care system. The US population is older today than it has ever been, and people turning 65 have a nearly 70 percent chance of needing long-term care. There is a drastic shortage of direct care workers across every state. Care is not affordable – paying out of pocket for care costs tens or hundreds of thousands of dollars each year. Family caregivers are being pulled to their breaking points. Several states, including Idaho, Colorado, Utah, Missouri, and Washington are proposing eliminating or reducing funding for some or all HCBS following the drastic Medicaid cuts from H.R.1. Measures such as targeted audits, data-driven oversight, and strengthened safeguards that would actually address fraud are being discounted and dismantled.

Access to Medicaid HCBS is a matter of life, death, and independence for millions of Americans with disabilities, older adults, and their families and loved ones. **We strongly oppose the overly broad actions CMS is taking to freeze funding for Medicaid HCBS services in Minnesota and the threats to freeze funding for services across the country**. The result is the same: taking away critical services from people with disabilities and older adults who have nowhere else to turn. If you have any questions, contact Tory Cross, (tory@caringacross.org) and Natalie Kean (nkean@justiceinaging.org).

Sincerely,

National Organizations

Access Ready Inc.
ADAPT National
AFSCME
AFT: Education, Healthcare, Public Services
American Association of Service Coordinators
American Association on Health and Disability
American Civil Liberties Union
American Friends Service Committee
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
Autism Society of America
Autistic People of Color Fund
Autistic Self Advocacy Network
Autistic Women & Nonbinary Network
Bazelon Center for Mental Health Law
Brain Injury Association of America
Care in Action
Caring Across Generations

Center for Public Representation
Clinician Task Force
Coalition on Human Needs
Community Catalyst
Disability Belongs
Disability Rights Education and Defense Fund (DREDF)
Diverse Elders Coalition (DEC)
Easterseals, Inc.
Epilepsy Foundation of America
Falling Forward Foundation
Family Values @ Work
Family Voices National
Gerontological Society of America
Hand in Hand: The Domestic Employers Network
International Association for Indigenous Aging
Justice in Aging
Kaiser Permanente
Lakeshore Foundation
Little Lobbyists
MEAction
Medicare Rights Center
MomsRising
Muscular Dystrophy Association
National Adult Protective Services Association
National Alliance Caregiving
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Social Workers (NASW)
National Association of the Deaf
National Consumer Voice for Quality Long-Term Care
National Disability Rights Network (NDRN)
National Domestic Workers Alliance
National Down Syndrome Congress
National Health Law Program
National Low Income Housing Coalition
National Multiple Sclerosis Society
National Partnership for Women & Families
National PLAN Alliance
National Respite Coalition
National Women's Law Center Action Fund
NETWORK Lobby for Catholic Social Justice

NHCOA
Our Mother's Voice
Paralyzed Veterans of America
PHI
Protect Our Care
Public Advocacy for Kids (PAK)
Rogan's List
SAGE
Samaritas
Service Employees International Union
TDIforAccess
TechTonic Justice
The Arc of the United States
Transitions Clinic Network
Triage Cancer
Union for Reform Judaism
Unitarian Universalists for Social Justice
United States International Council on Disabilities
Village to Village Network
Voices of Health Care Action
Well Spouse Association
World Institute on Disability
Youth Law Center

State and Local Organizations

Alabama

New Disabled South

North Alabama Area Labor Council, AFL-CIO

Arizona

The Arc of Arizona

William E. Morris Institute for Justice

Arkansas

Arkansas Advocates for Children and Families

New Disabled South

California

Access Central Coast

All Things Disability Equity

California Long-Term Care Ombudsman Association (CLTCOA)

California PACE Association
Disability Rights California
Disability Services and Legal Center (DSLC)
FREED Center for Independent Living
InSpirit
LeadingAge California
Long Beach Alliance for Clean Energy
Marin Center for Independent Living
PathPoint
The Arc of California

Colorado
ADVOCACYDENVER
Association for Community Living in Boulder & Broomfield Counties
Colorado Consumer Health Initiative
Colorado Cross Disability Coalition
Disability Law Colorado
Integrated Life Choices
Mental Health Colorado
Rocky Mountain Multiple Sclerosis Center
The Arc Arapahoe, Douglas & Elbert Counties
The Arc of Aurora
The Arc of Colorado
The Arc of Southwest CO

Florida
New Disabled South

Georgia
Inspire Positivity Inc
New Disabled South

Idaho
Gem State Developmental Center
Idaho Families of Adults with Disabilities

Illinois
CJE SeniorLife
The Arc of Illinois

Indiana
The Arc of Indiana

Kentucky
Kentucky Voices for Health
New Disabled South

Louisiana
New Disabled South

Maine
Maine Council on Aging

Maryland
Public Justice Center

Massachusetts
The Arc of Massachusetts

Michigan
Detroit Disability Power
Disability Network Mid-Michigan
Michigan Elder Justice Initiative
Michigan League for Public Policy
The Arc Michigan

Mississippi
New Disabled South

Missouri
Community Health Commission of Missouri
KC Rehab Doctors LLC

Montana
ADAPT Montana

Nebraska
Disability Rights Nebraska
South Central Nebraska Area Agency on Aging

Nevada
Bridge To Possibilities

New Hampshire
Disability Rights Center - NH

New Jersey
Disability Rights New Jersey
Family Voices NJ
SPAN Parent Advocacy Network

New York
Center for Elder Law & Justice
Cerebral Palsy Associations of NYS
Medicaid Matters New York
New York Legal Assistance Group (NYLAG)
Person Centered Care Services
The Arc New York

North Carolina
ANCHORNC
Disability Rights North Carolina
New Disabled South

Ohio
The Arc of Ohio

Oklahoma
New Disabled South
Oklahoma Policy Institute
The Arc of Oklahoma

Oregon
Access Care Anywhere

Pennsylvania
Community Legal Services of Philadelphia
Pennsylvania Health Law Project

South Carolina
New Disabled South
South Carolina Appleseed Legal Justice Center
The Arc of South Carolina

Tennessee
Tennessee Justice Center, Inc.
New Disabled South

Texas
Coalition of Texans with Disabilities
Disability Rights Texas
New Disabled South

Utah
Disability Law Center of Utah

Virginia
Blue Ridge Independent Living Center
Legal Aid Justice Center
New Disabled South
Virginia Poverty Law Center

Washington
Kokua
Puget Sound Assisted Living
The Arc of Washington State
Total Living Concept
Vibrant Health Homecare
Village Community Services

West Virginia
New Disabled South

Wisconsin
Center for Caregiver Serenity
Disability Rights Wisconsin

Statement for the Record

Submitted by:
Teresa Miller, JD
National Director of Health Initiatives
Legal Action Center
50 F St NW, Suite 350
Washington, DC 20001
tmiller@lac.org

Before the U.S. House Energy and Commerce Subcommittee on Health

March 18, 2026 Hearing

"Lowering Health Care Costs For All Americans: An Examination of the U.S. Provider Landscape"

The undersigned members of the Coalition for Whole Health, a group of leading national organizations advocating for policies to increase access to quality mental health and substance use care, urge Congress not to make further cuts to Medicaid under the pretext of combating fraud, waste and abuse. Millions of Americans are already bracing for the impact of HR 1's near $1 trillion in cuts to Medicaid, which the Congressional Budget Office estimates will cause 10 million people to lose access to health care coverage, including 7.5 million being forced off Medicaid. Additional cuts to this program would only further harm already vulnerable populations, including the nearly 40% of Medicaid enrollees living with mental health (MH) conditions and/or substance use disorder (SUD).

Congress and CMS have made substantial progress in improving access to MH and SUD care by expanding Medicaid eligibility, SUD treatment coverage, and MH/SUD parity protections, but we are concerned that current actions intend only to further gut Medicaid rather than root out fraud. The Energy and Commerce Committee and CMS have already sent letters to more than 10 states purporting to investigate fraud in their Medicaid programs, and even going so far as to withhold and defer federal funding in one state – an unprecedented action that will only serve to disrupt the provision of lifesaving health care services. Moreover, the content of these letters makes clear that this effort is not about program integrity or surgically rooting out actual fraud, which we all support. Rather, this is about making additional cuts to a lifeline program that hasn't even seen the full impact of HR 1's funding reductions, which represent the largest cuts to Medicaid since the program was first established.

Like HR 1's cuts, the proposed additional cuts would disproportionately stymie people's access to lifesaving MH and SUD services, among several others. We hear story after story of people whose lives were saved because they had Medicaid and were able to access the treatment and services they needed, when they needed them. Medicaid consistently yields the highest rates of treatment access to quality care for MH conditions and opioid use disorder (OUD) compared to other types of insurance. So many people rely on Medicaid in the first place because of pervasive discrimination and stigma in other areas, including employment, education, housing, and commercial insurance, and the federal government's current actions are only reinforcing and extending this stigma and discrimination deeper.

If Congress and CMS are serious about meaningfully addressing fraud in the health care system, they should partner with states who are already doing this work— and are in a better position to continue to do so. As advocates for people with MH conditions and SUD, we agree that program integrity efforts are critical to ensuring limited program resources go to support the people who, without Medicaid, would be wholly unable to

access health care. States already have processes and specialized, multi-agency collaborations to identify, investigate and prosecute fraud. In fact, the letters sent to states highlight high profile fraud prosecutions that were the direct result of such processes in action. Thus, instead of further gutting federal Medicaid funding at large, the more helpful and appropriate actions CMS can take to address fraud and abuse include partnering with states to develop national toolkits to address areas of concern and accelerating the time frame in which CMS responds to reports of fraud raised by state attorneys general and state-based Medicaid Fraud Control Units.

While the drug overdose death rate in this country has somewhat declined recently, we are still losing more than 200 people a day to overdose, and mental health needs continue to rise as we lose nearly 135 people a day to suicide. Ensuring people's access to MH and SUD care couldn't be more important— not only to maintain and escalate the progress made in reducing fatal overdose, but also to better address the ever-growing mental health crisis. We urge Congress not to add to the exorbitant cuts already made to Medicaid through HR 1 by making further cuts under the pretext of combating fraud, waste and abuse. On behalf of the millions of Americans' lives who hang in the balance, thank you for the opportunity to provide this statement for the record.

Addition Professionals of North Carolina
American Academy of Addiction Psychiatry
American Association on Health and Disability
AMERSA
Anxiety and Depression Association of America
California Consortium of Addiction Programs & Professionals
Center for Law and Social Policy (CLASP)
Drug Policy Alliance
Faces & Voices of Recovery
International Society of Psychiatric Nurses
Lakeshore Foundation
Legal Action Center
Medicare Rights Center
NAADAC, the Association for Addiction Professionals
NACoA – National Association for Children of Addiction
National Association of Addiction Treatment Providers
National Disability Rights Network (NDRN)
NHMH – No Health without Mental Health
Partnership to End Addiction
Popular Democracy
Treatment Alternatives for Stronger Communities (TASC)
Treatment Communities of America
WestCare Foundation

March 17, 2026

The Honorable Brett Guthrie
Chairman
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy & Commerce
2323 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Pallone:

AARP, which advocates for 125 million Americans age 50 and older, writes to reaffirm our strong commitment to protecting the integrity of Medicare and Medicaid. We are fully committed to eliminating fraud, waste, and abuse, which drain needed resources that are vital to provide care to older Americans and support family caregivers. Fraud is a crime, and those who commit fraud against Medicare and Medicaid must be held accountable to the full extent of the law. Medicare and Medicaid have robust fraud prevention systems established by Congress, administrative action, and states that help ensure that if fraud happens, funding is recouped and bad actors are prosecuted. We also know the incredible need for essential care and services in the community, and we oppose creating unnecessary barriers to care and coverage for innocent Americans who rely on these critical services.

As the Committee examines these issues, it is important that we work to eliminate fraud while ensuring Americans continue to receive the care they need and deserve. This includes Medicaid home- and community-based services (HCBS), which are vital to the daily lives, health, and well-being of millions of older adults and their family caregivers.

Importance of Long-Term Services and Supports and Home and Community-Based Services

The overwhelming majority of Americans age 50-plus would like to live in their current home (75 percent) and community (73 percent) for as long as possible. People want to be near family, friends, social connections, health care and other service providers, and community they know – this increases their independence and quality of life. Millions of older adults depend on long-term services and supports (LTSS) to live safely and remain in their homes and communities.

These services include hands-on help with everyday activities such as eating, bathing, dressing, using the toilet, getting in or out of a bed or chair, walking, managing medications and finances, meal preparation, household tasks, and transportation. A 2022 analysis for the Department of Health and Human Services estimates that 56 percent of people turning 65 between 2021 and 2025 will need LTSS at some point, and many individuals require these supports before age 65. Most people perform these tasks independently until chronic health conditions, disability,

functional limitations, or cognitive impairment create a need for assistance. LTSS can be provided in a person's own home, through adult day services, in community-based settings such as adult foster care or assisted living, or in institutional settings like nursing homes. LTSS provided in the home or other community-based settings are called home and community-based services (HCBS) and are generally more cost-effective than institutional care. Without essential HCBS—such as help with transferring, bathing, dressing, medications, or meal preparation—a person may face health risks from missing medications or meals, falls, and more.

Family Caregiving: The Backbone of Long-Term Care

When individuals start needing assistance with daily tasks like those noted, they most often turn to family members, friends, and neighbors. These 63 million family caregivers are frequently the first line of assistance and largest provider of services and supports, the backbone of our long term care system. Family caregivers provide billions of dollars annually in unpaid care to their loved ones, reducing costly institutional care, hospitalizations, and emergency room visits, saving taxpayer dollars. Family caregivers help with everything including medications and medical care, meals, bathing, dressing, finances, grocery shopping, transportation, coordinating and arranging care, advocating on behalf of their loved one, and more. On average, caregivers provide 27 hours of care per week.

When individuals need more assistance than family caregivers can provide or family caregivers are unavailable, individuals and their families turn to paid care, such as a home care aide to help with daily activities, adult day services, assisted living, or home-based nursing care. Yet, these services are becoming increasingly unaffordable for middle class families, with costs rising and varying greatly across states.

Importance of Medicaid and Medicaid HCBS

Several million adults age 50-plus, including more than two million people ages 65 and over, utilize Medicaid because they have limited financial resources and significant disabilities or functional limitations that require hands-on assistance. Medicaid also provides important direct support for family caregivers of Medicaid beneficiaries, such as respite care, education, and training on care delivery. While more than 2.5 million adults 65 and older and 4.3 million adults ages 21 to 64 (many of whom are 50 and older) receive Medicaid coverage for LTSS, two-thirds of adults 65 and older with Medicaid LTSS coverage receive HCBS, including from home care aides. More than 1.6 million older adults received Medicaid HCBS in 2023, with older adults making up about one in five Medicaid HCBS recipients. Overall, about 9.7 million people of all ages receive Medicaid LTSS, including 8.4 million people who receive HCBS. Older adults age 65 and older lag behind other age groups in terms of the share of total Medicaid LTSS users receiving HCBS and the share of total Medicaid LTSS spending for HCBS.

Federal law requires states to cover institutional care, such as nursing home care. However, most HCBS are optional, giving states discretion to alter covered services, eligibility criteria, or provider payments in ways that can directly limit access to home care, even though HCBS are generally more cost-effective. Medicaid HCBS costs an average of almost $25,900 per older adult, and Medicaid spends on average about $20,000 less per year per older adult who receives services in HCBS settings rather than nursing home settings. Despite the institutional bias in federal law, state and federal policymakers across parties, branches, administrations, and states—

along with advocates—have spent decades expanding access to home and community-based care for older adults and people with disabilities, a long-term effort often called "balancing" or "rebalancing." As we have a growing aging population and the vast majority of individuals want to live in their homes and communities, it is more important now than ever to protect access to HCBS.

HCBS help individuals maintain independence and choice in the care they receive. This choice is especially evident in Medicaid self-direction programs, a service delivery model that lets individuals or their representatives manage their own services, oversee their own budgets, and hire care providers, including family caregivers whom they know and trust. It is important for individuals to have the option to self-direct their services and select a family caregiver to provide services. This provides family caregivers with financial support they may need to continue providing care, relieves pressure on the paid direct care workforce that is strained and experiencing shortages, and allows those needing services to take control of the care they receive. The Department of Veterans Affairs also offers options for veteran caregivers to receive compensation for providing care, including through veteran-directed care.

Beyond long-term care, importantly, Medicaid helps more than 17 million people age 50 and older afford health care services, easing financial burdens and ensuring continued access to doctors, specialists, and prescription medications. Around 6.5 million of these are seniors ages 65 and older on Medicare who rely on Medicaid to help cover health care expenses either as "dual-eligible" seniors or in Medicare Savings Programs. As the largest payer of LTSS and a significant payer of health care to hospitals and other providers, Medicaid has a strong economic impact in communities supporting employment and financial stability.

Similarly, hospice is an essential component of the care continuum for individuals with serious and terminal illness, allowing people to receive compassionate, person-and family-centered centered care in their homes and communities. However, rising concerns about fraud and abuse threaten both beneficiaries and program integrity. As is true for all forms of LTSS, improving oversight, improving program enrollment safeguards, and ensuring meaningful quality standards are critical to protecting older adults and preserving access to high-quality hospice care.

Targeted Steps to Address Fraud

Even one dollar of fraud is too much, and those committing fraud should be held accountable and prosecuted to the fullest extent of the law. We must simultaneously protect access to program benefits for those who rely on them for care. The goal should be to never have innocent individuals forced to pay the price, whether through broad stroke efforts that withhold or defer state payments, delays in needed care, barriers to HCBS, or burdensome bureaucratic hurdles that jeopardize their well-being. Any savings should be directed back into the program. Existing programs in Medicare, Medicaid, and states to fight fraud and the Center for Program Integrity at CMS have a critical role to play. As the Committee and CMS identify shortcomings within targeted efforts to address fraud, AARP stands ready to work with you on mechanisms and additional safeguards to protect against fraud and enforcement to hold those committing the fraud accountable. We recommend the following to address fraud in Medicaid, including in HCBS and more broadly:

- **Improve data collection and analytics:**
    - Strengthen Medicaid data analytics to identify and prevent fraud, including maximizing use of existing data sources (such as electronic visit verification data), determining if any additional data is needed, investing in the technology/systems that operate Medicaid systems in states which will help catch and prevent fraud, improving transparency and data sharing in Medicaid managed LTSS, and considering whether additional quality measures (including questions in HCBS consumer experience surveys) could help identify patterns of fraud.
- **Invest in increased oversight**
    - Use random and/or targeted audits to identify and uncover potential fraud;
    - Adequately fund Medicaid fraud and abuse units and investigate and prosecute providers in any setting who defraud Medicaid or abuse Medicaid enrollees;
- **Improve provider oversight and case management policies**
    - Prohibit providers with a history of fraud or similar crimes from participating in Medicaid;
    - Ensure conflict-free care or case management to help avoid any inappropriate incentives or conflicts that could lead to fraud or inappropriate payments;
- **Improve provider and beneficiary education and transparency**
    - Increase awareness and education of providers and beneficiaries about how to identify and report fraud and what the requirements are for providers of services.

Similar actions can be taken in Medicare. Further steps that strongly promote Medicare program integrity without sacrificing access to care include:

- Adequately fund existing programs that combat fraud, such as the Senior Medicare Patrol, the Healthcare Fraud Prevention Program, and the Health Care Fraud and Abuse Control Program.
- Use technology and data analytics to identify abusive billers, including Durable Medical Equipment (DME) suppliers – without adding prior authorization barriers that could impede consumer access to needed equipment and supplies.
- Ensure background checks of providers, hospice agencies, and DME suppliers are done before they participate in Medicare and Medicaid and data is shared across both programs.
- Requiring prompt claims filing by providers.

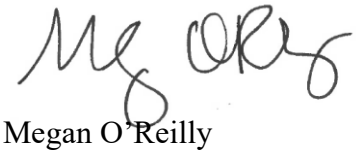
Separately, we urge Congress to make permanent the:

- **Money Follows the Person Rebalancing Demonstration Program** that helps individuals transition out of institutional settings to certain home and community-based settings; and
- **Medicaid HCBS spousal impoverishment provisions** that provide important financial protection for the spouses of individuals receiving Medicaid HCBS.

Without action by Congress, both will expire September 30, 2027. These are important provisions that help address Medicaid's bias toward institutional care.

AARP looks forward to working with the Committee to protect and strengthen the health and long-term care programs that enable millions of older Americans to age in their homes and communities. We support efforts to address fraud in ways that protect taxpayer dollars while ensuring uninterrupted access to needed health care and Medicaid HCBS for older adults and people with disabilities. If you have any questions, please feel free to contact me, or have your staff contact Rhonda Richards of our Government Affairs Staff at rrichards@aarp.org.

Sincerely,



Megan O'Reilly
Vice President, Health & Family
Government Affairs

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Statement for the Record

Energy and Commerce Oversight & Investigations Subcommittee

Hearing on "Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud"

March 17, 2026

Prepared by *Families USA*

1225 New York Avenue, NW
Suite 800
Washington, DC 20005
(202) 628-3030

Chair Joyce, Vice Chair Balderson, Ranking Member Pallone, and Ranking Member Clarke, on behalf of Families USA, we thank you for holding this important and timely hearing. We strongly support efforts to identify and address waste, fraud and abuse in our health care system, including within the Medicaid and Medicare programs. At the same time, we must stress how essential it is for oversight efforts to strengthen, rather than undermine, the programs' ability to serve the millions of Americans who rely on them for health coverage.

Nearly 80 million Americans, including more than 36 million children, across all 50 states and the District of Columbia are currently enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[1] These programs provide essential health coverage and affordable access to care for low-income individuals and families, safeguarding the financial stability and well-being of households at a time when health care costs are rising and the nation faces a growing chronic disease burden.[2] Similarly, the Medicare program provides affordable, high-quality health care for nearly 70 million older adults and people with disabilities, protecting some of our nation's most vulnerable adults from having to make impossible tradeoffs between accessing health care or paying for basic necessities like food and rent.[3]

Fraud within Medicaid and Medicare is obviously unacceptable. Identifying, addressing, and resolving cases of fraud is essential to protecting program integrity and ensuring that taxpayer dollars are used appropriately and efficiently. Yet we urge the subcommittee to exercise caution as it conducts its investigation, ensuring that existing state and federal program integrity efforts are appropriately considered and efforts to enhance program oversight and accountability do not disrupt access to care. **For example, recent actions by the Centers for Medicare & Medicaid Services (CMS) to intensify fraud enforcement through unprecedented measures—such as deferring $259.5 million in Medicaid funding to Minnesota—jeopardize the entire program by disrupting critical health care services and harming seniors, people with disabilities, and low-income families.[4]**

Recklessly withholding broad swaths of federal matching funds for the Medicaid program does nothing to target isolated sources of fraud or abuse, but it does serve as an attack on the health and wellbeing of people with disabilities, older Americans, and the workers who deliver their essential care – workers who are disproportionately women, people of color, and immigrants.[5]

Any additional oversight efforts should build upon existing structures and support effective investigations rather than weakening critical health coverage programs. This is particularly important given the strain already placed on state budgets and families' access to care by H.R. 1, which significantly undermined health insurance marketplaces and made the largest cuts to Medicaid funding in the program's history. **We particularly recommend that the Committee focus its efforts on areas of well-documented waste and abuse in**

the health care system, including within the Medicare Advantage program, where unchecked corporate profiteering has resulted in significant wasteful spending that undermines Medicare's promise to seniors and taxpayers.

Existing Role of CMS in Fraud Oversight

Over their 60-year history, there have been discrete instances of fraud committed against Medicare and every state Medicaid program. That is why there are existing federal and state oversight structures in place to investigate and prosecute fraud, including through the Medicaid Fraud Control Units (MFCUs) run in all states by the U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG), and through the work of state and independent auditors.[6,7]

Federal oversight findings from HHS OIG, the U.S. Government Accountability Office (GAO), and the U.S. Department of Justice make clear that the most significant threats to Medicare and Medicaid program integrity come from organized provider fraud and market-based schemes, not from individual beneficiaries. These investigations have uncovered networks in which marketers, brokers, telemedicine platforms, laboratories, and equipment suppliers collaborate to generate medically unnecessary claims.[8,9] These examples are evidence that the misaligned financial incentives of our health care payment and delivery system are a far greater vulnerability for fraudulent billing schemes than the need for low-income children and seniors to get health insurance coverage.

Addressing fraud within the Medicaid system can take years of collaborative work between CMS and a state Medicaid agency. For a timely example, look to Minnesota's recent program integrity efforts to root out fraud.[10] When the Minnesota Department of Human Services identifies a case of fraud, officials turn it over to the MFCU for prosecution. Since 2020, the Department has "conducted over 3,000 investigations and referred over 500 cases to law enforcement." Through these efforts, officials have identified "more than $50 million for recovery."[11] These ongoing program integrity efforts in Minnesota demonstrate the extensive work already underway to detect and address fraud. **As Congress and the administration consider additional actions, it is critical to ensure that oversight efforts support, rather than disrupt, ongoing investigations and existing program integrity structures.** While Minnesota and other states may need more resources or tools to effectively investigate fraud and hold bad actors accountable, blunt actions that strip Medicaid funding from the vulnerable Americans who need it do nothing to support program integrity.

It is also important to distinguish mechanisms that detect genuine instances of fraud from other kinds of program integrity efforts. For instance, CMS's Payment Error Rate Measurement (PERM) measures improper payments in Medicaid, such as underpayments or overpayments, but it does not measure fraud.[12] Most Medicaid improper payments

result from documentation or administrative errors rather than fraudulent activity. Recent findings involving Medicaid payments associated with deceased beneficiaries should be viewed in this broader context. Audits by the HHS OIG have identified situations in which capitation payments continued briefly after an enrollee's death due to delays in updating eligibility and death-record data across systems.[13] These audits point to administrative and data coordination challenges, not widespread beneficiary fraud, and represent a very small fraction of total program spending.

These findings suggest two things: first, states need resources and tools to improve administrative systems to reduce human error. Second, tackling true fraud in the system will require targeted investments in oversight, auditing, and investigative capacity.[14] **Strengthening eligibility systems, improving data sharing, and modernizing program integrity safeguards are important steps to protect taxpayer dollars and should be advanced. Broad funding restrictions that risk disrupting care for beneficiaries do not reduce administrative error or build system capacity to uncover fraud.**

Impact of Recent CMS Actions on States and Communities – A Closer Look at Minnesota

In February 2026, CMS deferred approximately $259.5 million in federal funding to Minnesota following a review that identified "unusually high spending and rapid growth in certain services areas, including personal care services and home- and community-based services (HCBS)."[15] **Of course, growth in the use of HCBS is not in and of itself evidence of fraud.** After all, these services are critical to allowing seniors and people with disabilities the freedom and opportunity to remain in their communities and receive care, rather than in institutional settings.[16] In Minnesota, approximately 15 percent of Medicaid beneficiaries experience a disability, many of whom rely on HCBS for daily supports and long-term care services.[17] And as America's baby boom population ages, so too does the demand for HCBS.[18]

Providers and patients have fought hard for these services to become available in their communities because, for many people, HCBS offers higher quality care.[19] States have also supported HCBS growth as a means of reducing Medicaid program expenses–CMS reports that community-based services offer care at less than half of the cost of institutional care[20]–and most states deploy one or more mechanisms to rein in HCBS spending (for example, by caping enrollment or spending per participant).[21] Bad actors who seek to defraud Minnesota and CMS out of HCBS funding need to be identified and prosecuted. However, the fact that Minnesota has seen growth in demand for HCBS is not a function of fraud, but a function of consumer preference.[22]

Deferring Minnesota's Medicaid funds risks disrupting the state's ability to sustain these critical services and may force challenging budget decisions about how to allocate limited HCBS funding and resources across the Medicaid program (in ways that could result in greater use of more expensive institutionalized care). In addition, as HCBS programs are

not delivered in a silo, restricting HCBS funding impacts broader access to care for Minnesotans who rely on Medicaid coverage to attain and maintain their best possible health.[23] While CMS' decision to defer federal funding was intended to encourage Minnesota to address HCBS fraud within the program (which the state is and has been actively pursuing) its impact will be to limit access to care for all Medicaid recipients without offering Minnesota additional tools or resources that it may need to target and rectify any true HCBS fraud.

Prior to this hearing, this Committee sent letters to ten states to request information about their current program integrity efforts.[24] While these letters seek additional information, they may also signal the potential for expanded federal oversight actions. CMS has already issued program integrity inquiry letters to states including California, Maine, and New York, which could precede the planned next step of implementing a funding deferral similar to the recent action taken in Minnesota.[25]

Before Congress or CMS initiates Medicaid funding deferral actions in these or any other state, it must take stock of what, if anything, has been achieved in Minnesota. Medicaid beneficiaries depend on federal leadership to ensure that program dollars are spent honestly and appropriately on their care needs; these communities deserve better than blanket, indiscriminate approaches that strip Medicaid funding broadly and disrupt their access to care.

Addressing Waste and Abuse in Medicare Advantage

There are areas within federal health programs where stronger oversight could meaningfully reduce waste and protect taxpayer dollars. One clear example is the Medicare Advantage (MA) program — now covering more than 33 million older adults[26] — which was created to deliver higher-quality, more coordinated care at a lower cost. But Medicare Advantage has failed to deliver on its core promise. Since 2007, MA overpayments have drained nearly $600 billion from the Medicare program.[27] In 2025 alone, taxpayers will spend $84 billion more to cover people in MA than if they were in traditional Medicare — an average 20% overpayment per enrollee.[28] These excess payments drive up Part B premiums for all Medicare beneficiaries and push the Medicare Hospital Insurance Trust Fund closer to insolvency, projected as soon as 2033.[29] And all that spending fails to deliver better care, with MA plans demonstrating inconsistent performance on health care quality and access compared with traditional Medicare.[30]

MA insurers have built a business model that prioritizes profits at the expense of patients. Through systematic upcoding, deceptive marketing of supplemental benefits, and wrongful care denials, corporate health plans exploit flaws in the system to inflate their payments. Seniors are promised better care, but instead often face barriers, delays and denials. For example, there were nearly 90,000 inappropriate denials in 2019 alone, with

83% of appeals overturned in 2023.[31] These practices hurt patients and drain taxpayer dollars.

One well-documented and clear-cut abuse within MA is systemic upcoding practices which have resulted in significant overpayments to insurers. The intent of the MA payment system is to incentivize insurers to compete on the cost, quality, and efficiency of the coverage they offer to enrollees relative to other MA insurers and to Traditional Medicare.[32] Under this system, CMS adjusts payments to MA plans using a risk adjustment model to increase or decrease payments to MA insurers based on the characteristics and diagnoses of each enrolled patient to account for differences in health care costs between healthier and sicker enrollees.[33] However, this model is vulnerable to gaming. MA plans can use certain billing and coding practices to make their enrollees appear sicker and more expensive relative to Traditional Medicare beneficiaries in order to generate a higher reimbursement from the federal government.[34]

This systematic "upcoding" occurs despite the fact that MA enrollees actually tend to be healthier and less costly to cover overall than those in Traditional Medicare.[35] Since MA plan payments are risk-adjusted primarily by the numbers and types of diagnoses reported by MA plans on behalf of their enrollees (e.g. plans are paid more to cover enrollees with relatively more diagnoses or diagnoses linked to higher care and treatment costs), MA plans have a strong financial incentive to identify and record as many diagnoses as possible among their enrolled beneficiaries - often without delivering additional care or coverage to beneficiaries.[36] Most concerningly, some MA plans go as far as assigning patient diagnoses that are not even supported by the patient's medical record, relying on sham health risk assessments and chart reviews.[37]

These coding abuses of the risk adjustment system further inflate Medicare payments to MA plans, costing Medicare an additional $40 billion every year.[38] If Congress' goal is to root out waste and fraud in the health care system, there is no clearer starting place than the abuse being done by these MA insurance companies. Strengthening the risk adjustment system would help protect against this industry gaming. The Congressional Budget Office estimates that if Congress were to enact the policies put forward under the bipartisan *No UPCODE Act*, it would save Medicare $1.5 billion over 10 years.[39]

Conclusion

State and federal oversight efforts must continue to investigate and prosecute occurrences of fraud within the Medicare and Medicaid programs, but the policies designed to address fraud should be carefully targeted to avoid inadvertently undermining access to care. We appreciate the efforts of this subcommittee to highlight the critical role that the Medicare and Medicaid play in the lives of individuals, families, and communities across the nation, and look forward on continuing to work with you to improve affordable and accessible health care.

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AAPD
American Association of People with Disabilities

March 16, 2026

The Honorable Brett Guthrie
Chairman
House Energy & Commerce Committee

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee

The Honorable John Joyce
Chairman
Oversight & Investigations Subcommittee
House Energy & Commerce Committee

The Honorable Yvette Clarke
Ranking Member
Oversight & Investigations Subcommittee
House Energy & Commerce Subcommittee

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Joyce, and Ranking Member Clarke,

On behalf of the American Association of People with Disabilities (AAPD), I write regarding the recent congressional investigations into Medicaid fraud and program integrity.

AAPD is a disability-led and cross-disability rights organization that advocates for full civil rights for over 70 million Americans with disabilities. We accomplish this by promoting equal opportunities, economic empowerment, independent living, and political participation for disabled people.

AAPD strongly supports responsible stewardship of taxpayer resources and efforts to ensure that Medicaid funds are used appropriately. At the same time, we urge Congress to approach these investigations with care to ensure that efforts to address fraud do not inadvertently harm people with disabilities who rely on Medicaid for essential health care and long-term services and supports.

Medicaid is the primary source of health coverage and community-based services for millions of people with disabilities across the United States. For many individuals, the program is the difference between living independently in the community and being forced into institutional settings. Medicaid also supports access to personal care services, home and community-based services (HCBS), durable medical equipment, behavioral health services, and other critical supports that are not widely available through private insurance.

AAPD recognizes the importance of preventing provider fraud, waste, and abuse within Medicaid. Ensuring program integrity protects both beneficiaries and taxpayers and helps maintain public confidence in the program. However, it is important that discussions of fraud accurately reflect the reality of Medicaid service provision. The overwhelming majority of Medicaid expenditures go toward legitimate services provided to eligible beneficiaries. When fraud occurs, it most often involves billing practices or provider misconduct rather than wrongdoing by beneficiaries themselves.

AAPD
American Association of People with Disabilities

We are concerned that broad or poorly targeted anti-provider fraud policies could have unintended consequences for people with disabilities. Policies that impose additional administrative burdens, restrict access to providers, or delay payment for legitimate services can disrupt care for individuals who depend on consistent, reliable supports to live safely and independently. Providers delivering home and community-based services, who already operate on thin margins, may face additional strain if new program integrity requirements are not carefully designed.

As Congress continues its oversight of Medicaid, we respectfully urge policymakers to ensure that program integrity measures do not create barriers to accessing home and community-based services and other essential disability supports. AAPD stands ready to work with Congress to ensure that Medicaid oversight efforts strengthen the program while safeguarding the health and independence of people with disabilities.

Medicaid plays an indispensable role in enabling people with disabilities to participate fully in their communities, pursue employment, and live independently. Protecting the integrity of the program should go together with protecting access to the services that make this possible.

Sincerely,

Michael Lewis
Vice President of Policy
American Association of People with Disabilities

Statement for the Record

Submitted to the House Energy and Commerce Subcommittee on Health hearing titled *Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape*.

March 18, 2026

The Partnership to End the HIV, STI, and Hepatitis Epidemics, a coalition that includes NMAC, the AIDS Institute, the National Coalition of STD Directors, the National Alliance of State and Territorial AIDS Directors (NASTAD), and AIDS United, urges Congress and the Administration not to use fraud and abuse investigations as a pretext for further cuts to Medicaid. Medicaid is the single largest source of health coverage for people living with HIV in the United States and remains a cornerstone of the nation's efforts to end the HIV epidemic.

This concern arises in the wake of the $1 trillion in Medicaid cuts in H.R. 1, which the Congressional Budget Office estimates will cause approximately 10 million people to lose health coverage, including 7.5 million individuals projected to lose Medicaid coverage due to onerous work requirements. Additional actions framed as fraud and abuse investigations risk compounding these coverage losses while failing to identify the true sources of fraudulent activity.

For people living with HIV, roughly 40 percent[1] of whom rely on Medicaid for their health coverage, the consequences would be particularly severe. Medicaid and the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program operate as complementary pillars of the nation's HIV care system. Medicaid provides primary health coverage for many people living with HIV, while the Ryan White Program serves as the payer of last resort for those who are uninsured or underinsured.

If Medicaid coverage is reduced, many people living with HIV will be forced to rely more heavily on the Ryan White Program for medications, medical care, and insurance assistance. However, the Ryan White Program has been operating under significant fiscal pressure for several years. As more people living with HIV rely on the program due to rising medication costs, insurance premiums, and growing client demand, resources have become increasingly stretched. Ryan White Programs will not have the resources to absorb all those who will lose their Medicaid services, leaving many people living with HIV at risk of losing access to critical care and treatment services that help keep them healthy and virally suppressed.

Medicaid does far more than cover lifesaving medication; it provides the care infrastructure that allows people to remain healthy and engaged in treatment and maintain viral suppression. This includes non-emergency medical transportation, home- and community-based services (HCBS), and long-term services and supports for the growing number of people aging with HIV, all of

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which are essential for individuals managing complex health needs. Disrupting these services would destabilize the systems that allow people living with HIV to consistently access care, adhere to treatment, and maintain their health. Interruptions in treatment not only harm individual health outcomes but also increase the likelihood of HIV transmission, undermining national efforts to end the HIV epidemic.

An additional and urgent concern is the growing number of people aging with HIV in the United States. Today, more than half of people living with HIV are age 50 or older, and this figure continues to rise as advances in treatment allow people to live longer, healthier lives. But aging with HIV often comes with complex health challenges, particularly because older adults living with HIV frequently experience age-related symptoms earlier than the general population, even when their virus is well-managed by medication. These symptoms can include cardiovascular disease, cognitive decline, mobility limitations, and other chronic conditions that require sustained care and support.

For these individuals, Medicaid is not simply a source of health insurance. It is the primary payer for long-term services and supports, including HCBS, that allow people aging with HIV to remain safely in their homes while receiving assistance with medication management, daily activities, and ongoing care coordination. Without these supports, many individuals would face unnecessary hospitalizations or premature placement in institutional settings, outcomes that are both more costly to the health system and significantly more disruptive to people's lives.

Moreover, when older adults with HIV are forced to enter nursing homes, they often encounter significant disparities in quality of care. Studies have shown[2] that residents living with HIV are more likely to be admitted to lower-quality facilities with higher rehospitalization rates as compared to those without HIV, even while living in similar areas. Many facilities lack adequate experience managing HIV care, and one study[3] has shown that only about 36 percent of eligible long-stay nursing home residents living with HIV receive appropriate antiretroviral therapy, while routine HIV monitoring, including CD4 and viral load testing, occurs far less frequently than recommended. These gaps highlight the importance of maintaining community-based services that allow individuals to remain engaged in high-quality outpatient HIV care.

Transportation services are another essential component of care for people aging with HIV, many of whom experience mobility limitations or live on fixed incomes. Non-emergency medical transportation ensures individuals can attend regular HIV care visits, obtain routine laboratory monitoring, and remain adherent to antiretroviral therapy. Interruptions in access to care can lead to viral rebound and serious health complications, undermining decades of progress in HIV treatment and prevention.

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Cuts to Medicaid that weaken transportation services or HCBS would place significant strain on a rapidly growing population of older adults living with HIV. At a time when the United States is striving to end the HIV epidemic, policies that destabilize the long-term care infrastructure supporting people aging with HIV risk reversing hard-won gains in treatment adherence, viral suppression, and quality of life.

Protecting Medicaid's role in providing transportation and HCBS is therefore essential, not only for maintaining the health of people aging with HIV, but also for sustaining the public health progress that has been achieved over decades of investment in HIV care and treatment.

There is a long tradition of the Centers for Medicare and Medicaid Services (CMS) working in partnership with the states to identify and prosecute fraud, which strengthens the program's accountability and integrity. These investigations benefit all Medicaid beneficiaries by ensuring they are receiving their essential services in a timely fashion. However, weaponizing such investigations to cut benefits or punish certain states s benefits no one.

Medicaid remains one of the most effective public health investments in the United States, particularly for people living with HIV. Protecting Medicaid, and the essential services it provides, is fundamental to sustaining progress against HIV and ensuring that people living with HIV can live healthy, stable lives in their communities.

Thank you for allowing us to submit this statement for the record.

Sincerely,

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History Repeats? Faced With Medicaid Cuts, States Reduced Support For Older Adults And Disabled People

Editor's Note

This article is the latest in the Health Affairs Forefront *featured topic, "Health Policy at a Crossroads," produced with the support of the Commonwealth Fund and the Robert Wood Johnson Foundation. Articles in this topic will offer timely analysis of regulatory, legislative, and judicial developments in health policy under the Trump-Vance Administration and the 119th Congress.*

As Republicans in Congress continue to flesh out their plan to cut $880 billion in health care spending – most of it from Medicaid – two things are clear: historic cuts to Medicaid are looming and the ripple effect of these cuts will spread across state programs. Much has been written on their ideas to impose work requirements on low-income adults (the vast majority of whom are already working), reduce federal funding levels for Medicaid, and "tackle Medicaid fraud, waste, and abuse." These ideas are often presented as "commonsense" changes needed to preserve the program for seniors and people with disabilities —those who need it "the most." But in reality, these ideas, if acted upon, are anything but commonsense. They will have devastating effects on the most vulnerable populations who will experience loss of coverage, cuts to their benefits, and lower quality of care.

Medicaid is a critical source of coverage for older adults and people with disabilities, serving as the primary payor for long-term care, including the home and community-based services (HCBS) that help people remain in their own homes and communities. With nearly 21 million enrolled through disability and aging eligibility pathways, or about 25 percent of total Medicaid enrollment, over half of Medicaid spending is on these populations. In some states, like Alabama, Florida, Kansas, Mississippi, and North Dakota, the share of care dedicated to disabled people and seniors accounted for *at least* two-thirds of overall Medicaid spending. (These percentages are even higher when disabled people and older adults eligible through other pathways are included.)

Cutting federal Medicaid spending would have such negative consequences on older adults and people with disabilities because reductions in Federal reimbursements to states would leave states with tough choices: use more state dollars to pay for Medicaid (hard to do if the use of provider taxes is eliminated or severely cut), or cut Medicaid spending. If they cut Medicaid spending, that means covering fewer people, reducing covered benefits,

cutting provider payment rates, or a combination of these. For each of these choices, Home and Community Based Services (HCBS) is a highly threatened area, despite assurances otherwise from Republicans in Congress.

HCBS In The Crosshairs

How can seniors and people with disabilities be harmed if assurances have been made to protect them? The answer is simple: HCBS are optional services and likely to be the first to see cuts if states receive less federal Medicaid spending. To be sure, many Medicaid benefits, such as nursing home services, are required by Federal law. But there are also a whole host of other benefits, including HCBS, that are available only at the discretion of the states. Because states have the *option* to cover HCBS, they can make changes based on available funding, meaning that they can easily limit enrollment, reduce benefits, or get rid of them entirely if they face spending pressures. To say it bluntly: States *must* pay for nursing home care, but they do not *have to* pay for HCBS.

This puts HCBS squarely in the cross hairs. In 2017, MACPAC found that just over half (51%) of state spending on optional Medicaid services goes to HCBS. Optional services for older adults and people with disabilities, including HCBS, comprise the vast majority (86%) of all optional Medicaid spending and nearly one-third (32%) of total Medicaid spending.

It's not just benefits either. States also have the *option* to cover people who need HCBS but would not otherwise qualify for Medicaid, such as children whose parents work but still need help to pay for HCBS. The so-called Katie Beckett waiver provides exactly that kind of support in many states. But just like with *optional* benefits, states can reduce the number of people who qualify for HCBS programs, increase eligibility levels, or eliminate these

optional eligibility pathways altogether.

Past Spending Cuts Foreshadow What's To Come

When states have faced budgetary pressures in the past, they respond by cutting Medicaid eligibility, benefits, and provider payments. These cuts affect all facets of the Medicaid program, particularly HCBS programs. In 2009, Congress responded to the Great Recession with a stimulus package that included a large increase in Medicaid matching funds to help states balance their budgets in the face of sharply reduced revenues. In 2011, even though the economies of many states had not fully recovered, Federal funding returned to its pre-recession level and many states struggled to cope with large increases in their share of Medicaid spending.

Exhibit 1. Number of states reducing HCBS spending between 2010 and 2012 and average reduction.

	Spent less per person*		Served fewer people		Either/both
	# States	Average reduction	# States	Average reduction	# States
IDD Waiver programs	33	10.8%	8	2.2%	36
Other Waiver programs / PCS	35	11.8%	20	8.3%	41
Home health	23	22.2%	29	15.1%	40
Cuts to any program	**47**		**40**		**51**

Notes:

**After adjusting for inflation using the Consumer Price Index for Medical Care.*

IDD = Intellectual and Developmental Disabilities, PCS = Personal Care Services

Source: UCSF analysis of HCBS expenditure and participant data.

An analysis of HCBS expenditure and participant data, conducted by the third author at the University of California San Francisco, indicates that every single state and the District of Columbia cut spending to one or more of its HCBS programs between 2010 and 2012, either by reducing inflation-adjusted, per-beneficiary spending or by reducing the number of beneficiaries (Exhibit 1). States were more likely to cut per-beneficiary spending, sometimes by capping or cutting benefits, than to limit enrollment, such as by reducing the number of "slots" for HCBS waiver services. Spending cuts averaged 11 to 12% for waiver and personal care services programs and 22% for home health, and reductions in the number of people served ranged from 2 to 15%, depending on the program.

While serving fewer people, or otherwise halting program expansion, many states saw large increases in waiting lists for HCBS Waiver programs. For services for people with intellectual and developmental disabilities, 23 states (out of the 34 that both maintain waiting lists and supplied data to researchers) saw a median 54% increase in the number of people on the waitlist. For waiver programs targeting other populations, 12 states (of 20 with available data) saw increased waiting lists, with a median growth of 138%.

If Republicans in Congress move forward with their plans to cut federal Medicaid funding, states will once again have to make hard choices on who to cover under their HCBS programs, what to cover, and how much to pay providers. For example, nearly every state has expanded optional income eligibility for people who use HCBS, covering about 7 million seniors and people with disabilities who would lose coverage if states eliminated these eligibility pathways.

States would also face pressure to eliminate coverage of specific optional services, such as home modification, adult day care, home-delivered meals, and transportation. Other optional services that play a key role in helping people with significant disabilities to live outside of institutions, such as support for family caregivers and services in assisted living facilities, would also likely be on the chopping block.

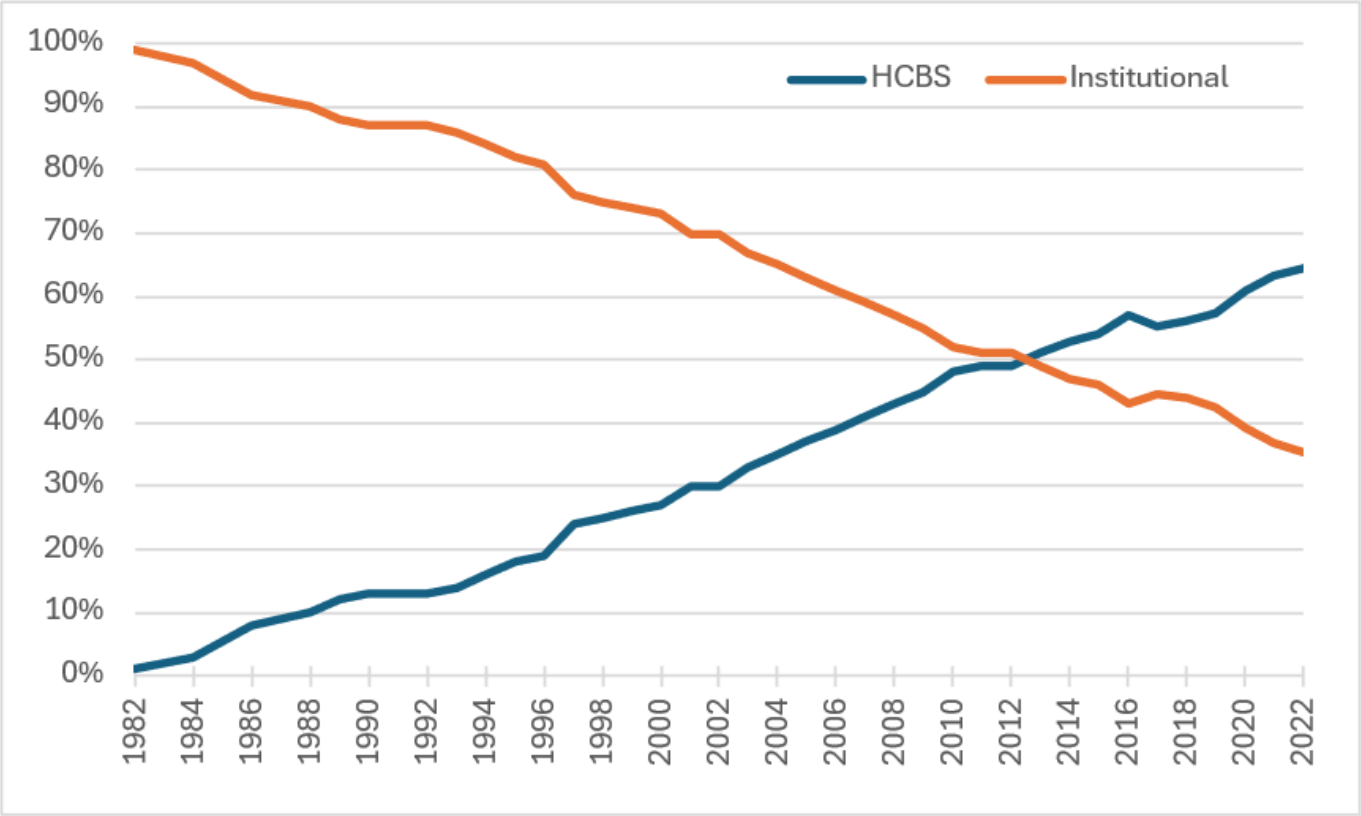
Rounding out the trifecta of harmful reductions are cuts in provider rates, which are already so low that states are facing a workforce crisis, with providers declining referrals and closing down services despite high demand. States would face pressure to cut payment rates for HCBS providers, in part because over the last five years, states have used extra federal funds from the American Rescue Plan to increase payment rates for HCBS providers. The exhaustion of the extra federal funding will put pressure on payment rates even in the absence of new federal cuts, so any additional spending cuts would further exacerbate state spending burdens.

Finally, it is notable that the HCBS provider community is less well-funded and organized than other provider types, making payment rate cuts more likely for this group.

Sliding Backwards: Pressure To Move Back To More Nursing Home Care

Despite the optional nature of HCBS, we have seen a significant shift in the funding of long-term care away from nursing homes and towards HCBS; HCBS not only is more cost effective, but the vast majority of older adults and disabled people strongly prefer to remain in their homes and communities and age in place. As shown in Exhibit 2, HCBS spending exceeded institutional care spending in 2013, with 65 percent of all long-term care spending going towards HCBS in 2022.

Exhibit 2. National Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, 1982–2022



Source: *Centers for Medicare and Medicaid Services*

If Republicans in Congress ultimately cut federal Medicaid spending, we're likely to see a reversal of the significant progress made over the last decade in the use of HCBS. Helping people stay in their homes and communities has been a bipartisan issue for decades: in fact, it was President Reagan who established the Katie Beckett option, allowing children in middle class families to afford HCBS for their children. But according to a recent analysis by the fourth and fifth authors at the LeadingAge LTSS Center @UMass Boston, federal Medicaid cuts could force up to three million people aged 50 or over to seek institutional care rather than being able to get the HCBS they would otherwise receive in their homes.

The LTSS Center's recent analysis shows how critical HCBS are to keeping people out of institutional care. In 2020, people over 50 who met criteria for nursing home level of care but did not receive HCBS were nearly five times more likely to have a nursing home stay and spend nearly five days more in a nursing home than similar individuals who did receive HCBS. The researchers estimated that even a 15% reduction in HCBS spending would result in over 1.5 million additional nursing home days and $467 million in additional costs. This jumps to more than three million additional days and $943 million in additional costs if HCBS spending is cut by 30%, and more than 5.6 million additional days and $1.7 billion in additional costs if spending is cut by 45%.

Progress At Risk

Medicaid is the primary payor of long-term care in this country, making it a critical source of coverage for seniors and people with disabilities. States have steadily provided more HCBS over the last decades, but this progress is at risk given the optional nature of HCBS, the potential for significant cuts to federal Medicaid funding, and states' struggle to finance their Medicaid programs. Despite assurances that older adults and disabled people will not be harmed, the plan that the Republicans in Congress have put forward will do just that, and the so called "savings" will actually be experienced as *real* costs to the most vulnerable Americans.

Authors' Note

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Federation of American Hospitals

Charlene MacDonald
President and CEO

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

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

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

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

The Role of Tax-Paying Hospitals

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

Medical Loss Ratio (MLR) Oversight and Patient Affordability

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

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

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

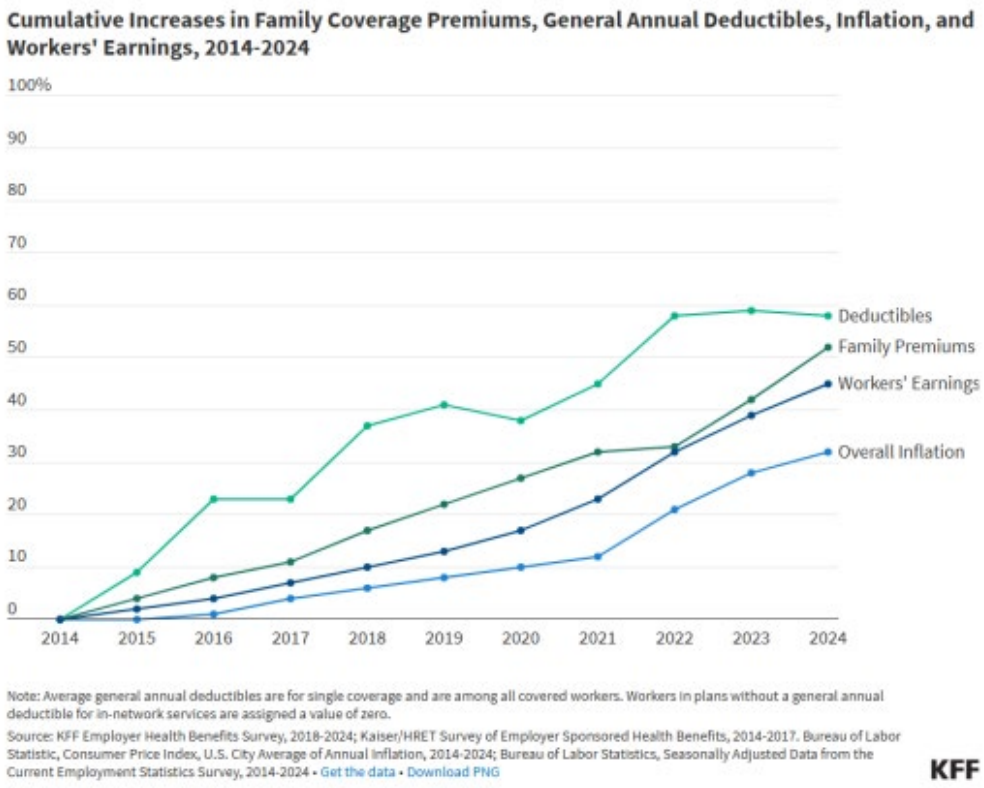
- **Require issuers to separately report payments counted as medical spending that are made to affiliated entities**, including provider organizations, pharmacy benefit managers, utilization management vendors and other subsidiaries.
- **Require issuers to disclose corporate relationships** between the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

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

Benefit Design and Patient Out-of-Pocket Cost Growth

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

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



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

These costs cannot be dismissed as aberrations. American workers are facing higher out-of-pocket exposure at the very moment they are required to pay more just to maintain coverage, reducing disposable income and creating real affordability challenges for middle-class households. As Congress focuses on lowering health care costs, it is critically important to understand the impact of benefit design, denial trends and growing patient out-of-pocket costs, which have far outpaced inflation. Voters consistently report that insurers and pharmaceutical companies are primarily responsible for rising health care costs[9] — a perception that reflects the real-world experience of patients and providers alike.

Hospitals as Cost Aggregators

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

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

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

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

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

Conclusion

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

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

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

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American College of Physicians
Statement for the Record

The U.S. House of Representatives
Energy and Commerce Health Subcommittee Hearing
on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"
March 18, 2026

The American College of Physicians (ACP) is pleased to provide comments in response to the House Energy and Commerce Health Subcommittee's hearing on *"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."* We thank Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette for holding this hearing to discuss bipartisan policies that would make health care more affordable for our patients. **Our policy recommendations include Congress enacting legislation to bolster the primary care physician workforce, provide long-term payment stability for physicians, ensure patients' access to affordable health care coverage, and enhance transparency in the 340B Drug Discount Program (340B program).**

ACP members include 163,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Fund and Reauthorize Programs that Bolster the Primary Care Physician Pipeline

Patients should have access to physicians who can deliver primary, whole-person, comprehensive, and longitudinal care. Congress should invest in federal programs that support and expand the internal medicine and primary care physician workforce. The United States faces a projected physician shortage of up to 187,140 by 2037, including more than 87,000 primary care physicians. Currently, over 77 million Americans live in areas without adequate numbers of health care clinicians, which is a matter for concern as an insufficient primary care practitioner supply is associated with negative outcomes, including higher rates of hospitalization, lower patient-rated health quality, and even higher mortality.

We are pleased that as part of the extenders addition to the recently enacted Consolidated Appropriations Act, 2026, Public Law No: 119-75, funding was authorized for investments in the primary care workforce through the National Health Service Corps (NHSC) and Teaching Health Center Graduate Medical Education (THCGME). ACP appreciates Congress' support in the primary care workforce through the NHSC with the $350 million authorized for Fiscal Year (FY) 2026 (through September 30, 2026) and $88.2 million for the remainder of calendar year 2026. **The NHSC will need to be reauthorized and funded by the end of this year, and it is critically important for NHSC**

funding reauthorization to be at no less than $350 million per year for at least two fiscal years. Congress must act this year to ensure that NHSC funding does not lapse. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities.

Data from the Health Resources and Services Administration (HRSA) shows that in FY 2024, NHSC members provided culturally competent care to a target of over 22 million patients at more than 21,000 NHSC-approved health care sites in urban, rural, and frontier areas. Increased FY 2027 funding will help maintain NHSC's field strength by helping to address the health professionals' workforce shortage and growing maldistribution.

We also greatly appreciate the inclusion of more than $1 billion for the THCGME program funding reauthorization for fiscal years 2026-2029. The THCGME program has over a decade of bipartisan support and is the only federal program investing in the training of future physicians in community settings, rather than hospitals. This long-term investment in THCGME will go a long way in providing stability to these residency programs. **As the Committee examines policy solutions to address the physician workforce shortage, this is an exemplary program to invest in further to ensure patients in rural and underserved areas will have access to physicians in their communities.**

Additionally, the College urges Congress to pass the Resident Physician Shortage Reduction Act, H.R.4731/S.2439. This bipartisan bill is crucial to bolstering the physician workforce and ensuring that patients across the country will have access to well-trained physicians. The bill would invest in the physician pipeline by adding 14,000 new Medicare-supported residency slots over the next seven years. It provides a meaningful and targeted approach that would allow rural and underserved communities to train resident physicians who can provide high-quality health care to patients. Studies show that an overwhelming majority of physicians practice where they are trained, and this bill would direct a significant portion of slots to rural hospitals, hospitals serving health professional shortage areas (HPSAs), hospitals in states with new medical schools, and hospitals that are currently training above the existing resident caps.

Provide Long-term Payment Stability for Physicians

Patient care has been jeopardized as the Medicare Physician Fee Schedule (PFS) fails to provide physicians with the resources to keep up with rising expenses and the cost of caring for patients. ACP appreciates Congress providing additional funds for the PFS for 2026. However, it is important to recognize the longstanding problem that the PFS has not been updated to account for inflation. As a result, payment rates for physicians have actually decreased by a staggering 33 percent from 2001 to 2026, when adjusted for inflation. The lack of inflationary updates, coupled with the PFS statutory budget neutrality (BN) requirement, has led to increased financial instability for physicians. The BN requirement triggers physician payments to be withheld from the PFS when CMS overestimates utilization of new or modified codes in the fee schedule. CMS is not required to return the withheld funds to the fee schedule, resulting in physicians getting unnecessary payment cuts.

The lack of structural, long-term changes to the PFS has resulted in the closure of independent physician practices across the country, followed by a significant uptick in market consolidation. Emerging research shows that health care consolidation leads to worse health outcomes for patients and burnout for physicians. Without federal legislation that provides a payment increase reflecting rising inflationary pressures and changes to fix BN constraints, patients' access will be threatened, particularly in rural and underserved communities. **We urge Congress to pass legislation that would raise the threshold for**

triggering budget neutral cuts within the PFS from $20 million to $53 million. Further, we ask Congress to pass legislation that would return savings from any overestimation of new or modified codes in the PFS back to the PFS.

Ensure Patients' Access to Affordable Health Care Coverage

The College urges Congress to pass legislation that would make health care more affordable by lowering patients' cost-sharing for primary care and preventive health care services and addressing the expired enhanced health insurance premium tax credits. Healthcare affordability can be enhanced through legislative efforts to lower out-of-pocket costs for patients, including co-pays and deductibles for primary and preventive care services. Studies conclude that effective primary care reduces hospitalizations, improves patient health, and extends life expectancy more than other specialties. And yet, the U.S. allocates just 5 cents of every healthcare dollar to primary care. General internal medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple complex chronic conditions. Nearly 95% of older adults in the U.S. have at least one chronic condition and nearly 80% have two or more chronic conditions. Chronic diseases, the leading causes of illness, disability, and death in the United States, are very costly to treat and manage. According to the Centers for Disease Control and Prevention (CDC), 90% of health care expenditures were spent on treating and managing chronic diseases.

We remain concerned that many seniors have failed to access chronic care management services due to a patient cost-sharing requirement associated with this care. Current law mandates that Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive chronic care management services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may avoid the services altogether as a result. Only 4 percent of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

We urge Congress to reintroduce and pass the Chronic Care Management Improvement Act. This legislation would remove the cost-sharing requirement for patients to access chronic care management services. We also support allowing the physician who performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with such services. **Another piece of legislation that ACP supports, which would also lower out-of-pocket costs and cost-sharing for primary care and preventive health services, is the Chronic Disease Flexible Coverage Act, H.R.919.** This bill would provide employers with the option of offering first-dollar coverage of certain chronic disease treatments for employees with high-deductible health plans.

The College also urges Congress to extend the expired enhanced health insurance premium tax credits for the Health Insurance Marketplace or work on a bipartisan policy solution that would bolster health care coverage for people impacted by the expired tax credits. These tax credits made health insurance more affordable for low-income Americans who do not qualify for Medicaid, as well as for small business owners who are not on employer-sponsored health care plans. Since the open enrollment period ended on January 15th for most states, we are seeing lower enrollment in the Health Insurance Marketplace. Patients faced with steep premium increases opted to forgo health care coverage. According to recent data from the Centers for Medicare & Medicaid Services, approximately 1.4 million fewer people have signed up for health coverage in the Health Insurance Exchange this year. With more people opting out of health coverage, this could lead to increased health care costs.

Increase Transparency and Accountability in the 340B Program

The U.S. continues to spend significantly more on prescription drugs than any other country in the world. Prescription drug spending is projected to increase by almost 6% annually from 2024 to 2028 – making it one of the fastest-growing health care spending categories. Prescription drugs are a key part of a physician's comprehensive toolkit and have been crucial in improving the health and well-being of patients. As physicians, we see firsthand what happens when patients cannot get the drugs that they need because the drugs are not affordable. These patients are more likely to skip their medications. This can have negative downstream effects, placing lives at risk and increasing costs throughout the health care system. It is estimated that medication non-adherence results in roughly 125,000 deaths, 10 percent of hospitalizations, increased morbidity rates, and costs the U.S. healthcare system anywhere from $100-$300 billion a year.

ACP strongly supports the 340B program. Created by Congress in 1992, the program allows health care entities that provide outpatient care to uninsured and low-income patients to purchase prescription drugs at steep discounts directly from drug manufacturers. With savings from prescription drug discounts, qualified health care entities can reinvest the money into patient care and expand access to health care services for underserved patient populations. While we strongly support the program and would like to see it continue, we call on Congress to examine policies that would boost transparency and accountability, to ensure that the savings health care entities receive are directed toward patient care.

To enhance program integrity in the 340B program, ACP calls for covered health care entities to publicly report on the benefits received through the program and how the savings are used to expand access to care for low-income and uninsured populations. Additionally, we support the continued option for covered health care entities to contract with specialty or community-based pharmacies to help promote greater access to 340B drugs for eligible patients. However, we urge for oversight and auditing of contract pharmacies to ensure that discounts are going to uninsured and low-income patients, as the program intended. Furthermore, we urge Congress to provide relevant federal agencies with clear statutory authority and dedicated resources to promulgate necessary program regulations to conduct oversight and compliance activities.

Conclusion

Once again, we thank you for holding this important hearing to examine impactful, common-sense policy solutions to the rising cost of health care. We look forward to working with the Energy and Commerce Committee to accomplish these goals. Should you have any questions regarding the recommendations outlined in this statement, please contact Vy Oxman, Senior Associate of Legislative Affairs, at voxman@acponline.org.

Statement for the Record

Alliance for Fair Health Pricing

Submitted to the
United States House Committee on Energy and Commerce
Subcommittee on Health

Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

March 18, 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] 31% of small businesses offer employer-sponsored insurance to their employees, with 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]

When hospitals merge, evidence shows that prices increase from 3% to a whopping 65% with no changes in quality or outcomes.[9] Furthermore, when large hospital systems buy independent

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[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] Environmental Scans on Consolidation Trends and Impacts in Health Care Markets, RAND.

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.[10] 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.[11] 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 profitable, 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.[12]
- **Northwell Health** built its own Hollywood-style studio to make promotional content.[13]
- 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.[14]

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 are often cut in favor of higher-revenue specialties like cardiac surgery and intensive care.[15] 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.

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[10] Site-Neutral Payment Reform Medicare Growth Differential Report, Arnold Ventures and Actuarial Research Corporation.

[11] Hospital Cost Tool, National Academy for State Health Policy (NASHP). March 2026 Report to Congress: Medicare Payment Policy, MedPAC.

[12] Nonprofit Hospital Draws Backlash for Super Bowl Ad, Axios. NYU Langone Hospitals Full Filing, ProPublica.

[13] Northwell Health creates film studio to promote the system's brand, Healthcare Brew.

[14] Key Facts About Hospitals, KFF. Estimation of Tax Benefit of US Nonprofit Hospitals, JAMA. Making Hospital Tax Breaks Work for Communities, Lown Institute.

[15] Foisted: The Spillover Effects of Hospital Mergers on Costs and Utilization. Brown University.

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.[16] 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.

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.

[16] 2025 Affordability Polling, Families USA.

Voters are exhausted by rising costs, they're frustrated by inaction,[17] 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.

[17] 2025 Affordability Polling, Families USA.

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March 18, 2026

The Honorable Morgan Griffith
Chair
Energy and Commerce Subcommittee on Health

The Honorable Diana DeGette
Ranking Member
Energy and Commerce Subcommittee on Health

Statement for the record Re: Energy and Commerce Health Subcommittee hearing on "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chair Griffith and Ranking Member DeGette -

On behalf of the more than 1.5 million Americans living with a blood cancer diagnosis, Blood Cancer United (previously The Leukemia & Lymphoma Society) appreciates the opportunity to provide this statement for the record regarding addressing the nation's rising healthcare costs and the impact these costs have on patients and their families.

As the largest nonprofit organization dedicated to blood cancer patients and their families, we advocate for policies that ensure access to affordable, comprehensive, and high-quality healthcare without compromising patient outcomes. Patients living with blood cancers face not only the physical burden of disease but also financial toxicity – the cumulative cost burden of treatment, care, and survivorship that can threaten patients' ability to continue therapy or maintain financial stability. Blood Cancer United launched our Cost of Cancer Care initiative in 2017 to address this growing issue, and we continue to advocate for aggressive but feasible cost-cutting policy solutions that would not sacrifice quality of care.[i] We offer the following policy recommendations for the Committee to consider to help lower healthcare costs, incentivize high-quality care, and ensure patients can access the care they need when they need it.

Addressing market consolidation

Today, a handful of large health systems increasingly dominate several U.S. markets. This allows those systems, hospitals, and providers to demand higher reimbursement from commercial payers through concentrated market power. Market consolidation directly impacts patients' ability to afford care and services.[ii] When markets are highly concentrated, insurers and employers have reduced leverage to negotiate with providers to keep prices down and ensure that care is affordable for their members. Ultimately, insurers and employers pass the burden of provider price increases onto consumers through higher premiums, out-of-pocket costs, and reduced wages.

Despite the promises of efficiency gains by healthcare systems,[iii] mergers and market consolidation come at a cost to patients and consumers—literally. Research on hospital mergers uniformly finds that mergers raise hospital prices for both for-profit and non-profit hospitals.[iv] Post-merger, hospital prices have been estimated to increase by as much as 54 percent.[v] This finding also holds true for physician practices, with practices charging higher prices after merging with other practices, as well as practices in more concentrated markets charging higher prices than those in less concentrated markets.[vi,vii]

Blood Cancer United urges Congress and states to lower the statutory acquisition threshold for healthcare mergers and acquisitions and to mandate more reporting. This would allow the Federal Trade Commission (FTC), Department of Justice (DOJ), and state enforcement agencies the opportunity to review a larger number of mergers and acquisitions in healthcare.[viii] Congress should also evaluate policies that would expand and enhance existing premerger notifications and reviews,

and increase funding for enforcement activities to expand regulatory agencies' capacities to investigate a wider range of anti-competitive consolidation and enhance market surveillance.

Additionally, Congress, the Administration, and states should direct regulatory and oversight agencies to develop and use a robust patient-, consumer-, and equity-focused framework to guide merger and anti-competitive practice evaluations. Unlike many other sectors of our economy, healthcare is a resource that all people will use at some point in their lives; yet it suffers from a chronic lack of transparency and accountability to the patients and consumers who use it. To ensure that patients, including those in medically underserved communities, are not harmed by mergers or market consolidation, we urge policymakers to include patient health and outcomes as key components of healthcare merger review policy, reflecting empirical research that shows reduced competition results in worse outcomes for patients and consumers.[ix]

Prohibiting anti-competitive contracting

Blood Cancer United supports banning 'gag clauses' that prohibit plans from sharing information about provider costs and quality. This information is incredibly valuable to consumers as they consider their treatment options. Yet, particularly in areas where provider consolidation increases the leverage of a hospital or specialty group practice, a clear prohibition on this type of contract clause is the only way to ensure consumer access to this type of information. While the Consolidated Appropriations Act of 2021 formally banned this practice, enforcement of these provisions should be a priority.

Similarly, anti-competitive contracting terms such as non-compete clauses and all-or-nothing clauses drive up healthcare costs for consumers. We urge policymakers to respond to provider consolidation trends by banning or significantly restricting the use of anti-competitive contracting terms that harm patients and consumers, and to focus hospitals and clinicians on providing quality care rather than protecting or increasing revenue through vertical consolidation. Given the monopolistic nature of large hospitals and specialty group practices in certain regions, plans have little leverage to dispute the inclusion of anti-competitive contract clauses that protect the financial interests of providers without incentivizing quality care. We are confident that such efforts will save money for taxpayers and plan participants.

Expanding site-neutral payments

Pricing dynamics can incentivize anticompetitive consolidation and exacerbate the price increases associated with already consolidated markets. The incentive for provider consolidation is largely driven by unchecked pricing practices, allowing providers and hospitals to amass outsized market power and effectively set their own prices with employers and issuers that are divorced from value. For instance, under current law, providers are allowed to charge higher Medicare rates for many services provided by off-campus hospital outpatient departments than for services in the same type of outpatient setting not affiliated with a hospital. This incentivizes hospital acquisition of provider groups and can significantly drive-up prices and consumer costs post-consolidation.

Blood Cancer United strongly supports legislation that would advance recommendations from MedPAC and other experts to implement site-neutral reforms. Such reforms would lower out-of-pocket costs for patients by implementing site-neutral reforms for comparable services in targeted settings and promote transparency in facility billing to understand where a service has been provided. In a study commissioned by Blood Cancer United, patients with chronic and life-threatening conditions – including blood cancer, breast cancer, Crohn's disease, rheumatoid arthritis, and more – could save thousands per year under these reforms.[x] For example, a patient with multiple myeloma, a type of

blood cancer, would save more than $1,100 in out-of-pocket costs annually if site-neutral payments were implemented across the variety of services included in a typical treatment regimen.

Congress must get the details right and limit site-neutral methodology to payments for services that can be safely and effectively provided in any setting. Evidence suggests that some hospitals providing specialty cancer care, specifically NCI-Designated Comprehensive Cancer Centers, routinely deliver higher-quality cancer care that leads to better outcomes than similar care provided in community settings.[xi] As such, we recommend that Congress exempt payments for care provided at these facilities from site-neutral reforms.

Reining in facility fees

In the commercial market, higher patient and consumer costs manifest as facility fees. Facility fees are charges assessed by a healthcare facility in addition to professional service charges. While facility fees were historically used by hospitals to recoup additional overhead costs associated with complex round-the-clock operations, they are increasingly assessed at off-campus sites such as primary care offices, local clinics, and even, in some cases, for telehealth visits. These fees are often not covered by insurance and, as a result, are typically directly billed to patients.

Blood Cancer United supports state and federal legislation that would address financial harm to patients from facility fees. States such as Colorado, Connecticut, Indiana, and Maine have recently taken strong steps toward regulating and curtailing these fees. These measures include prohibiting fees for:

- Routine services, such as "evaluation and management" or E&M codes, regardless of their site of service,
- Care delivered at a facility located separate from a main hospital campus, or
- Fees sent directly to a patient, without being based on the patient's insurance's contracted rates and subject to plan cost-sharing.

Blood Cancer United supports efforts that benefit consumers by limiting or eliminating the direct financial harm from these fees and promoting proper patient financial protections.

Aligning provider payment incentives to rein in prescription drug costs

Over the past several decades, the U.S. healthcare system has developed perverse incentives that reward healthcare providers for prescribing higher-cost drugs when lower-cost alternatives are available and clinically appropriate. Although we have seen some progress in value-based initiatives that better align incentives, too often patients with costly conditions treated in whole or in part by prescription drugs are being prescribed the higher-cost option. These incentives increase patient out-of-pocket costs while simultaneously raising healthcare costs for consumers, employers, and taxpayers.

Although biosimilars have been available as lower-cost, clinically appropriate alternatives to some costly drugs since 2015, provider adoption has been slowed by the fact that reimbursement methodologies typically penalize providers with lower payments when they prescribe lower-cost biosimilar drugs. As one expert recently put it, "This fundamental misalignment between what is best for the provider's bottom line and what is best for the payer's budget is the single greatest barrier to biosimilar adoption for drugs covered under the medical benefit."[xii] To address this perverse incentive in Medicare, in 2022, Congress established a new payment methodology that currently provides a small payment *bonus* (2 percent of the reference product's average sales price) when the provider delivers a biosimilar versus a reference biologic. This bonus payment is intended to apply for the first

five years after biosimilar entry, in order to promote more widespread adoption among prescribers. Policies like this one – aimed directly at removing perverse incentives – are critical to addressing high drug costs. In fact, a recent study found that those Medicare patients who pay coinsurance for their biologic medication saw a significant reduction in their individual out-of-pocket costs after biosimilar competition.[xiii] Congress should consider mechanisms to build on this policy to further adjust provider payment in ways that lower drug costs for patients and taxpayers while promoting access to appropriate care.

Critically, direct reimbursement is not a providers' sole incentive to prescribe higher-priced drugs. The 340B program provides a financial opportunity for participating hospitals that can maximize 340B-related rebate revenue by prescribing higher-priced drugs over lower-priced drugs.[xiv] These incentives have been shown to increase drug spending at 340B-participating hospitals and throttle 340B-participating hospitals' adoption of lower-cost biosimilar drugs.[xv,xvi] Congress needs to thoughtfully address such perverse incentives.

Enforcing and expanding cost transparency

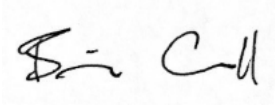
Transparency is essential for accountability and informed policymaking. While federal rules require hospitals to disclose pricing information, compliance with these requirements remains uneven and incomplete, limiting the ability of patients, researchers, and policymakers to understand true costs. Enhancing enforcement and oversight, in addition to expanding data reporting requirements, will make price data more accurate and usable.

In addition to price transparency, policymakers should take steps to improve ownership transparency of health care facilities, particularly as private equity (PE) continues to play an ever-larger role in our health care system. Greater transparency regarding ownership and provider performance information has the dual benefit of allowing regulators – and, to a lesser extent, consumers – to track patient access and outcomes as well as costs stemming from market forces such as consolidation and PE investment.

Blood Cancer United stands ready to work with you and your colleagues in Congress to advance the solutions we have outlined above and other proposals that would achieve savings without sacrificing patient access to appropriate cancer care. We share your belief that we are at a crucial juncture in our healthcare system, and we urge you and your colleagues to capitalize on this real opportunity to make the reforms necessary to promote patient access to appropriate care while eliminating incentives that drive unnecessary spending. We are grateful for your leadership.

If you have any questions or would like to discuss our comments further, please contact us at brian.connell@bloodcancerunited.org.

Sincerely,



Brian Connell
Executive Director of Federal Affairs

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Blood Cancer United

High prices, higher stakes:

Policy solutions to tackle rising healthcare costs

2025

Contents

Introduction

The cost of care for patients in the United States continues to rise at an alarming and unsustainable rate. High costs associated with providing and receiving care are forcing patients to delay—or entirely forgo—necessary treatments. **Today, more than 100 million Americans struggle with medical debt.**[1] Patients and consumers, including those with serious and chronic health conditions like blood cancer, frequently experience "financial toxicity," where the enormous cost associated with their treatment becomes nearly as threatening to their lives as their diagnoses.

Rising costs strain not only individual patients but also our overall healthcare system. The annual cost of cancer care in the United States is projected to exceed $245 billion by 2030 — nearly double the cost in 2010.[2] As prices for services increase for issuers and employers, they shift these costs onto consumers and employees through higher out-of-pocket expenses, such as premiums, deductibles, co-pays, and co-insurance. Studies suggest that higher employer healthcare costs also suppress wage growth, exacerbating already significant affordability issues. It is essential that we address the underlying causes of soaring healthcare costs and do so without sacrificing the quality of care.

Higher prices are a major contributor to rising costs for patients. Americans do not use more healthcare services or have better health outcomes than other industrialized nations, yet we spend almost twice as much on care.[3] While the high prices associated with care in the U.S. cannot be solely attributed to a single stakeholder, accelerating provider consolidation significantly impacts patients and our healthcare system.

Blood Cancer United recognizes the urgency of this issue. Since launching our Cost of Cancer Care initiative in 2017,[4] we continue to advocate for aggressive yet feasible cost-cutting policy solutions that do not sacrifice quality care. In response to these trends and the experiences of the patients we serve, Blood Cancer United has developed the following policy recommendations that will help lower healthcare provider prices and alleviate the financial burdens for patients.

> "Americans do not use more healthcare services or have better health outcomes than other industrialized nations, yet we spend almost twice as much on care."
> — N. N. Levey

Promoting competition and accountability to constrain costs

Patients stand to benefit from a healthcare marketplace that promotes healthy competition. This includes robust standards to prevent anti-competitive behaviors that drive up prices and endanger patients' ability to afford high-quality care. However, system complexity combined with concentrated provider markets creates opportunities for major stakeholders to engage in anti-competitive practices. Blood Cancer United urges states, Congress, and the Administration to empower regulatory bodies to enforce laws governing anti-competitive behaviors and other market trends that harm patients and consumers. Policymakers should also work to strengthen rules that address health sector incentives that are not aligned with patients' health and financial well-being.

Anti-Competitive Contracting

Low-transparency, highly consolidated markets can contribute to the use and abuse of anti-competitive contracting terms between providers and issuers — exacerbating price hikes that are already associated with provider consolidation.[5] Without the market-driven leverage needed to challenge anti-competitive contract terms, issuers and employers are able to pass these price hikes onto patients and consumers in the form of higher premiums, out-of-pocket costs, and reduced wages.[6]

Commonly used anti-competitive contracting terms include the following:

All-or-Nothing Clauses: All-or-nothing stipulations require that an insurer seeking to engage with a specific provider within a system (e.g., a hospital offering specific services) must also engage with all other providers in that system.

Anti-Tiering Clauses & Anti-Steering Clauses: Anti-tiering and anti-steering provisions prohibit an insurer from assigning a particular provider to a non-preferred tier within its provider network or from using other incentives or strategies to direct patients to competing providers. This arrangement can encourage patients to use that provider, even if higher-value options are available elsewhere within the network.

Most Favored Nation Clauses: Most favored nation clauses mandate that a provider must extend to an insurer the lowest rates among all insurers with whom it has agreements. While the previous examples favor providers in their dealings with insurers, most favored nation clauses enable provider-insurer collusion in setting higher prices for healthcare services.[7]

Gag Clauses: Gag clauses prevent insurers and providers from disclosing negotiated rates. However, they have been prohibited by the Consolidated Appropriations Act of 2021.[8]

Additional policies frequently employed by provider employers, such as non-compete clauses, contribute to consolidation. While these are not generally used between issuers and providers, physician groups and hospitals routinely employ non-compete clauses to reduce competition within their local markets. Non-compete clauses prevent an employee of a particular provider from accepting employment with a competing provider or establishing a new practice within a specified proximity for a certain period. In May 2024, the Federal Trade Commission (FTC) approved regulations banning most non-compete clauses in employment contracts, citing their harm to competition and workers' mobility.[9] Importantly, the FTC ban does not apply to non-profit entities, including the majority of hospitals organized as non-profits.

Recommendation

Ban Anti-Competitive Contracting Terms in Healthcare Settings
State and federal policymakers should take steps to ban or significantly restrict the use of anti-competitive contracting terms that harm patients and consumers, particularly by providers and hospitals in highly concentrated markets. Policymakers should consider explicitly prohibiting anti-competitive contracting terms that enable dominant providers and insurers to distort market competition and inflate prices. Reforms would empower insurers and employers to provide secure savings for their employees by allowing greater flexibility in selecting high-value providers, promoting price transparency, and reducing the artificial barriers that entrench provider monopolies.

Merger and Acquisition Oversight

Today, a handful of large health systems dominate several major U.S. markets. Data indicates that provider mergers and market consolidation are accelerating. Between 1998 and 2021, more than 1,800 hospital mergers resulted in approximately 2,000 fewer hospitals operating across the country. Furthermore, more than half of all physicians working in the United States were employed by a hospital in 2020—an increase of nearly 20% since 2012.[10]

Despite the promises of efficiency gains by healthcare systems[11], mergers and market consolidation come at a cost to patients and consumers—literally. Research on hospital mergers uniformly finds that mergers raise hospital prices for both for-profit and non-profit hospitals.[12] Post-merger, hospital prices have been estimated to increase by as much as 54 percent.[13] This finding also holds true for physician practices, with practices charging higher prices after merging with other practices, as well as practices in more concentrated markets charging higher prices than those in less concentrated markets.[14, 15]

Antitrust protections are critical yet underutilized tools against anti-competitive practices and harmful provider consolidation. At the federal level, the FTC and the Department of Justice (DOJ) work collaboratively to enforce a range of federal antitrust laws. Due to resource and regulatory constraints, federal regulators investigate a very small number of hospital mergers each year.[16]

Current antitrust rules require entities to report mergers to the FTC and the DOJ involving a transaction of at least $119.5 million in 2024 (this amount is adjusted annually with

inflation). Many mergers, especially those across provider groups, do not meet that threshold for a single acquisition, although they may reach it over time as acquisitions accumulate. Additionally, purchasers often use a tactic known as "roll-ups," in which the acquiring company buys multiple smaller companies in quick succession to avoid antitrust scrutiny.[18] As a result, many mergers go unnoticed by regulators until they are already consummated.[19] This can mean that to execute consolidation strategies, private purchasers such as private equity firms sell their amassed holdings for a profit and exit before antitrust enforcers can intervene to prevent harm to patients.[20]*

State attorneys generals (AGs)[21] also have the authority to monitor markets and engage in robust antitrust oversight and review. However, the extent of this authority and current practices vary significantly by state.[22] State and federal lawmakers should consider implementing or expanding antitrust laws to ensure that state regulators have the tools, resources, and mandate necessary to monitor and intervene in healthcare mergers.

Recommendations

Lower the Acquisition Threshold and Include Roll-Ups

Recognizing the acceleration of consolidation within the healthcare sector, Blood Cancer United urges Congress and states to lower the statutory acquisition threshold for healthcare mergers and acquisitions and to mandate more reporting. This would allow the FTC, DOJ, and state enforcement agencies the opportunity to review a larger number of mergers and acquisitions in healthcare.[23]† Revisions to federal laws and regulations should include policies that account for the use of roll-ups and other anti-competitive strategies aimed at circumventing antitrust scrutiny. For example, the Hart-Scott-Rodino (HSR) premerger notification law could be amended to require purchasers of hospitals and other medical facilities to disclose the cumulative value of their proposed and recently completed acquisitions within a specific market or geographic area, similar to how the FTC and DOJ have proposed to change the HSR filing rules to understand acquirors' roll-up strategies.[24]

Expand and Enhance Premerger Notification and Review

In addition to lowering the premerger notification threshold for healthcare mergers and acquisitions, Congress and states should evaluate policies that would expand and enhance existing premerger notifications and reviews. Enforcers should have adequate time and information to review and evaluate mergers before their approval. For example, the 30-day waiting period required before consummation may have been appropriate in 1976 when Congress passed the HSR Act, but today's healthcare transactions are larger and more complex, necessitating more time for antitrust enforcement agencies to scrutinize potentially anti-competitive deals. Additionally, legislators should ensure that agencies receive all the information they need in HSR filings to adequately assess the potentially anti-competitive effects of healthcare transactions, especially those involving private equity firms.

* This recently played out in *FTC v U.S. Anesthesia Partners*, in which a federal court dismissed a private equity firm that executed a roll-up consolidation of anesthesia practices across Texas. The judge reasoned that federal antitrust law provides no cause of action against the private equity firm because it no longer held a controlling interest in the anesthesia practice after divesting its shares.

† For example, federal law could mirror California's new Health Care Quality and Affordability Act, which requires qualifying healthcare entities to notify the Office of Health Care Affordability of certain proposed mergers and acquisitions and prevents transactions from closing until after any market impact review.

Provide Robust Resources for Antitrust Oversight and Enforcement
Policymakers at the state and federal levels should increase funding for enforcers to expand the capacity of the DOJ, FTC, and State AGs to investigate a wider range of anti-competitive consolidation and enhance market surveillance, consistent with the Merger Filing Fee Modernization Act of 2022.[25] As the head of the Antitrust Division has pointed out on numerous occasions, the DOJ has fewer employees today than it did in 1979, despite monitoring an economy three times as large.[26] Additional dollars should support updating data collection and reporting systems, investigations, and expert personnel to bolster agency monitoring, oversight, and enforcement activities.

Enhance Scrutiny of Non-Profit Healthcare Providers
Both for-profit and non-profit organizations have engaged in monopolistic and anti-competitive practices that negatively impact patients and consumers. While a trio of federal antitrust laws governs anti-competitive practices, two laws—the Clayton Act and the Sherman Act—apply to both for-profit and non-profit entities.[27] Blood Cancer United has become concerned about the lower level of scrutiny applied to non-profit provider entities due to their charitable status. Regulators must apply the same degree of scrutiny to all providers, regardless of their charitable status, to ensure that patients and consumers are not adversely affected.

Empower States to Challenge Anti-Competitive Mergers
States should be empowered to scrutinize or challenge mergers and acquisitions, even in the absence of federal action. Ensure that states have the authority to engage in the necessary scrutiny and oversight of healthcare mergers and acquisitions. Empower state enforcers to review mergers that fall below existing federal thresholds and smaller cumulative or consecutive mergers ("roll-ups"). Enhance state regulatory authority so that patient and community impacts, such as the potential for impaired, diminished, or delayed access to care, are included when assessing mergers.

Develop a Pro-Patient Framework for Evaluation of Prospective Mergers
Congress, the Administration, and states should direct regulatory and oversight agencies to develop and use a robust patient-, consumer-, and equity-focused framework to guide merger and anti-competitive practice evaluations. Unlike many other sectors of our economy, healthcare is a resource that all people will use at some point in their lives; yet it suffers from a chronic lack of transparency and accountability to the patients and consumers who use it. To ensure that patients, including those in medically underserved communities, are not harmed by mergers or market consolidation, we urge policymakers to include patient health and outcomes as key components of healthcare merger review policy, reflecting empirical research that shows reduced competition results in worse outcomes for patients and consumers.[28]

Align incentives to drive value for patients

Costs associated with cancer diagnosis, treatment, and survivorship continue to balloon.[29] However, higher prices rarely correlate with better patient outcomes or improved quality of life. Patients are not the only ones impacted: taxpayers also bear the price for inefficient and inflationary practices through public programs such as Medicare.

Because of this, Blood Cancer United urges policymakers to address the drivers of systemic costs that contribute to financial toxicity for patients and consumers. This includes continuously strengthening standards that address health sector incentives misaligned with patients' health and financial well-being.

Site Neutral and Facility Fees

Health system consolidation increasingly contributes to higher patient costs in the form of additional fees for routine care provided in non-hospital settings.

Medicare typically pays more for a service when it is performed at a hospital outpatient department (HOPD) than for the same service when it is performed in a physician's office. This payment discrepancy incentivizes hospitals to acquire small physician practices (e.g., primary care clinics and infusion centers) and reclassify them as HOPDs, thereby receiving higher reimbursement rates, even when these offices exist beyond the hospital's physical campus. Because Medicare enrollees, especially those without supplemental coverage, are often required to pay co-insurance for their care (usually 20 percent of the price of the service paid by Medicare), they are then charged more because their clinic is reclassified as a HOPD—thus their cost-sharing also goes up.

Patients without supplemental coverage are not the only ones impacted by this practice. Those with supplemental coverage, such as Medigap, Medicaid, or plans through former employers, also incur higher costs—though they may not see it directly. While patients may not face additional out-of-pocket expenses, they may experience higher premiums.

Implementing "site-neutral" payments would ensure that Medicare reimburses the same amount for the same service, regardless of where care is provided. Experts have repeatedly identified site-neutral payments as an opportunity to save money for Medicare. More importantly, these policies would reduce cost-sharing for beneficiaries and limit non-clinical incentives to provide services in more expensive settings—without compromising beneficiary access to care or health outcomes.[30] In fact, both Congress and the Administration have taken modest steps to implement site-neutral payments in specific circumstances.[31] However, these provisions do not apply to many routine services that can be safely and effectively provided in all settings.

Implementing site-neutral payments would yield several benefits, including shielding patients from increased out-of-pocket costs, reducing overall Medicare spending, and reducing incentives for hospitals to participate in anti-competitive practices (such as buying up physician practices).

Until recently, policymakers lacked a strong understanding of the specific savings patients would experience if site-neutral payments were implemented in Medicare. A study by Wakely Actuarial, with support from Blood Cancer United, found that beneficiaries across eight different disease states would experience significant out-of-pocket savings if site-neutral reforms were implemented.[32] The analysis was limited to services deemed safe and appropriate to perform in all healthcare settings—such as routine office visit.[33]

The report clearly indicated that patients could benefit significantly if site-neutral reforms were implemented. Under common clinical scenarios, Wakely found that Medicare patients with the following conditions could see dramatic savings in out-of-pocket costs within just one year:

- $1,200 for Multiple Myeloma patients
- $2,024 for Chronic Obstructive Pulmonary Disease patients
- $3,735 for Multiple Sclerosis patients

In the commercial market, higher patient and consumer costs manifest as facility fees. Facility fees are charges assessed by a healthcare facility *in addition* to professional service charges. While facility fees were historically used by hospitals to recoup additional overhead costs associated with complex round-the-clock operations, they are increasingly assessed at off-campus sites such as primary care offices, local clinics, and even, in some cases, for telehealth visits. These fees are often not covered by insurance and, as a result, are typically directly billed to patients.

Recommendations

Advance Targeted Site-Neutral Policies in Congress
Blood Cancer United strongly supports legislation that would advance recommendations from MedPAC and other experts to implement site-neutral reforms. Specifically, Blood Cancer United urges Congress to immediately advance reforms similar to those included in the 118th Congress' H.R. 5378, the Lower Costs More Transparency Act.[34] Such reforms would lower out-of-pocket costs for patients by implementing site-neutral reforms for comparable services in targeted settings and promote transparency in facility billing to allow Works to understand where a service has been provided.

Congress must get the details right and limit site-neutral methodology to payments for services that can be safely and effectively provided in any setting. Evidence suggests that some hospitals providing specialty cancer care, specifically NCI-Designated Comprehensive Cancer Centers, routinely deliver higher-quality cancer care that leads to better outcomes than similar care provided in community settings.[35] As such, we recommend that Congress exempt payments for care provided at these facilities from site-neutral reforms.

Protect Consumers from Burdensome Fees Associated with Care Provided at Hospitals and Hospital-Outpatient Settings
Blood Cancer United supports state and federal legislation that would address financial harm to patients from facility fees. States such as Colorado, Connecticut, Indiana, and Maine have recently taken strong steps toward regulating and curtailing these fees. These measures include prohibiting fees for:

- Routine services, such as "evaluation and management" or E&M codes, regardless of their site of service,
- Care delivered at a facility located separate from a main hospital campus, or
- Fees sent directly to a patient, without being based on the patient's insurance's contracted rates and subject to plan cost-sharing.

Blood Cancer United supports efforts that benefit consumers by limiting or eliminating the direct financial harm from these fees and promoting proper patient financial protections.

Enhance collection and transparency of health system data

To control systemic ***and*** individual costs, policymakers, regulators, researchers, advocates, and other stakeholders must have access to timely, accurate, and complete data about our system of care. Currently, much of this data is siloed and unevenly collected and shared across different markets and actors. As a result, efforts to address issues impacting patients' ability to access and afford their care are frequently limited by a lack of comprehensive and accurate data. Blood Cancer United supports advancing policies that would enhance transparency and support accountability within our healthcare system.

Transparency of Ownership & Private Equity Investment

Healthcare business practices, corporate relationships, and ownership have historically been opaque and difficult to track. Previously, the Biden Administration took steps to improve ownership transparency in the Medicare program by requiring hospitals and nursing homes participating in Medicare to provide detailed information about ownership, enrollment data, practice information, and other identifying information. This data can then be used to identify owners with poor performance records and enhance market surveillance of consolidation and provider mergers.

Ownership transparency has become even more important as private equity (PE) has become a larger player within the healthcare delivery system. According to one analysis, PE invested nearly $1 trillion in almost 8,000 healthcare transactions over the last ten years.[36] Over the last 20 years, PE-driven mergers and acquisitions in the hospital sector grew at four times the rate of non-PE takeovers.[37] Further, PE acquisition has increased across multiple types of providers. For example, the number of PE-acquired physician practices in 2021 was more than seven times that in 2012.[38] An estimated 5 percent of nursing home facilities are now owned by PE[39], and more than 25 percent of Medicare hospice beneficiaries receive care from for-profit providers, with over half of that attributable to PE.[40]

The growing engagement of PE in healthcare has also been directly linked to rising prices. Studies of hospitals and physicians acquired by PE find that total charges increased significantly post-acquisition. For example, a study of hospitals acquired by PE from 2005 to 2017 found that, on average, PE acquisition increased total charges per inpatient day by 7 percent and increased emergency department charge-to-cost ratios by 16 percent compared to matched non-acquired hospitals.[41] Similarly, studies have found that prices charged and allowed for PE-acquired physician practices increased significantly compared to practices that were not acquired.[42, 43]

PE's typical investment timeline of 3 to 7 years raises concerns that PE-acquired hospitals and physician practices will prioritize financial returns over quality patient care—and there is evidence to support this concern. PE-acquired hospitals are associated with significantly worse outcomes for Medicare patients on numerous measures, and patients in PE-acquired hospitals were, on average, younger, in better health, and less likely to be dually eligible for Medicare and Medicaid.[44]

PE investment and market concentration have also been shown to reduce access and availability of key service lines, including primary care, inpatient mental healthcare, outpatient non-emergency visits, and diagnostic imaging.[45, 46] These findings are particularly important in light of arguments supporting rural hospital mergers to improve their financial sustainability and ability to maintain key services.[47]

Given the growing evidence of the negative impacts of consolidation and PE ownership on patient costs, access to care, quality of care, and medical debt, we believe federal and state policymakers and regulators must take comprehensive action. Greater transparency regarding ownership and provider performance information has the dual benefit of allowing regulators—and, to a lesser extent, consumers—to track patient access and outcomes as well as costs stemming from market forces such as consolidation and PE investment.

Recommendation

Build on Existing Efforts to Increase Ownership Transparency in Healthcare

The Administration and state lawmakers should continue to build on recent transparency efforts by expanding existing regulatory transparency requirements to other healthcare entities, including those engaged with PE. Regulators should also monitor significant changes in ownership or controlling interest. Relevant information should be disclosed to the public on a consistent basis to empower researchers and enforcement agencies to analyze data and trends regarding how PE and market consolidation impact costs and consumers.

Unique Identifiers

Payments to providers currently include limited information about where services are provided. For example, codes do not distinguish whether services are delivered on a hospital campus or at an affiliated provider, such as a primary care doctor or infusion center that may be geographically separate from the primary hospital's physical campus. Because Medicare payments for HOPDs are reimbursed at a higher rate than those for physician's offices, hospitals are incentivized to purchase smaller providers and reclassify them as HOPDs.

In addition to site-neutral reforms, several proposals under consideration in Congress would, if passed, require hospitals and providers to report more granular data regarding the location of the services being provided—whether at a hospital's primary facility or at a provider beyond the boundaries of the hospital's physical campus. These simple transparency requirements would provide data that would help policymakers and researchers better understand hospital revenue cycles and consolidation trends, as well as their implications for patients and national budget outlays.

Recommendation

Advance Site of Service Transparency Policies in Congress

Federal and state lawmakers should improve site of service transparency to better understand if healthcare systems are using consolidation and other anti-competitive behaviors to game payments.

All-Payer Claims Databases (APCDs)

All-payer claims databases (APCDs) are flexible data resources that can help policymakers, regulators, researchers, and advocates better understand our healthcare system's performance and how it serves the needs of patients and consumers. The ability to assess and track costs, utilization, enrollment, demographic data, and other key information is essential for accurately evaluating the quality and affordability of healthcare markets, services, treatments, and patient outcomes.

As of 2024, 19 states have already implemented an APCD, with several additional states actively developing programs. Each state has adopted its own approach to implementing its program, including variations in which state agency or non-governmental organization governs and maintains its APCD, data reporting requirements, and frequency of reporting. States typically choose to track individual and population data, insurance product and network details, healthcare service and pricing information (including payer and patient cost-sharing), and provider information (such as specialty and location). Additionally, some APCDs may choose to collect information about partially or fully denied claims, including medical, pharmacy, and dental data, pharmacy rebate information, and non-claims payments.[48]

APCDs offer a unique window into the cost of care, including what is charged to insurance companies and patient cost-sharing responsibilities. The National Cancer Institute, for example, estimated that the U.S. spent $208.9 billion on cancer care in 2020, a nearly 10 percent increase from 2015.[49] Per patient, the average annual cost of initial care across all cancer sites was $43,516 in 2020. As the cost of cancer care rises, more of the cost burden has shifted to patients in the form of out-of-pocket costs and copayments for treatment. APCDs can be instrumental in assessing the cost of care and informing policy actions aimed at reducing these burdens. For example, APCDs may be used for the following:

- Identify variations in prices for medical procedures and imaging across providers.
- Examine differences in the payer mix among patients with chronic or acute care conditions (i.e., the distribution of patients among different types of insurance coverage) and their payer, provider, and patient payment implications.
- Evaluate the effectiveness of policies aimed at controlling costs.
- Monitor the prevalence of denied claims to identify patterns, understand reasons for denials (e.g., lack of coverage, incomplete documentation), and evaluate the potential impact on patients.‡
- Compare different approaches to cost containment and value across states.

‡ Where denied claims are available in the state's APCD.

However, there are some constraints. While state-operated APCDs have the authority to collect claims information from state-regulated payers, they may collect data from ERISA-regulated plans on a voluntary basis only. Data filing and reporting times can also lag by a year or more, creating gaps in APCD's ability to examine developing trends in real-time. APCD data is also inconsistently collected across states, with access requirements varying further still. These challenges lead to gaps in the comprehensiveness and comparability of the data, limiting its effectiveness for informed decision-making and policy development.

To increase the utility of APCDs, state and federal policymakers and health data organizations should engage APCDs to identify and apply emerging best practices and engage local stakeholders to understand and address their health data needs. Additionally, the federal government has the authority and opportunity to enhance APCD utility by providing additional resources, healthcare market oversight, and transparency standards that would facilitate better information exchange.

Recommendations:

States Should Leverage Best Practices to Establish and Maintain Strong State APCDs
States aiming to establish an APCD or enhance an existing APCD function or capacity should consider several practices to maximize its utility for data users, including establishing strong data governance processes, supporting community-informed reporting, expanding and improving upon data collection requirements, and establishing strong data quality controls.

Federal Policymakers Should Leverage Resources and Authorities to Facilitate and Support Strong APCD Systems and Reporting
As state APCDs continue to proliferate nationally, the federal government has the authority and opportunity to enhance their utility and build state capacity for healthcare market oversight and transparency. The federal government, in collaboration with states and payers, can build on the common data layout[50] to establish a national APCD technical data standard that may be employed by states and the federal government in the collection of claims and encounter data. A national standard would reduce the reporting burden for plans and strengthen cross-state analytic alignment. Additionally, federal policymakers should take steps to address state APCD data gaps; the federal government could establish reciprocal data-sharing relationships with state APCD agencies, collecting federally regulated data—including data for individuals covered by private, ERISA-preempted, self-insured plans—by a single standard and exchanging it with available state APCD data to create more complete local and national datasets.

Identify Financial Support for Establishing and Sustaining APCDs
Sustained, predictable funding is key to ensuring APCDs are productive resources for state and federal policymakers and regulators. State and federal governments could support capacity for healthcare market oversight and transparency by working to identify stable and consistent funding for these cost-focused resources. For a more detailed discussion of our APCD recommendations, please see Blood Cancer United' report "Harnessing Claims Data to Address Today's Healthcare Challenges".[51]

Conclusion

The rising cost of care is a tremendous problem for patients with chronic diseases, including those with blood cancer. Today, 42 percent of patients with cancer exhaust their entire life savings within two years of diagnosis.[52] Blood Cancer United acknowledges that resolving financial toxicity for patients will require a multifaceted approach, but studies have shown that patients and our entire system of care could substantially benefit from implementing targeted policies aimed at addressing overpayments and high costs. Patients cannot be expected to bear the dual strain of rapid increases in treatment costs and costs created by inflationary factors such as hospital consolidation and anti-competitive behaviors.

Blood Cancer United strongly believes that policymakers at all levels of government should prioritize policies that will help reduce the cost of care for patients by aligning incentives that drive value, promoting competition and accountability, and enhancing the collection and transparency of health system data. We appreciate the opportunity to share these priority policies which, if implemented, would achieve these objectives. Now, more than ever, patients need relief from the overwhelming financial burden of seeking care and treatment in the United States.

For additional information about the recommendations made in this report, please contact Katie Berge at Katie.Berge@BloodCancerUnited.org.

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CONSUMERS FOR
FAIR HO$PITAL PRICING

Statement for the Record

House Energy and Commerce Health Subcommittee
Hearing on "Lowering Health Care Costs for All Americans:
An Examination of the U.S. Provider Landscape"

Prepared by:
Consumers for Fair Hospital Pricing

March 18, 2026

1225 New York Avenue, NW, Suite 800
Washington, DC 20005

Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette:

On behalf of the *Consumers for Fair Hospital Pricing* coalition, organizations representing families and health care consumers across the United States, we want to thank you for holding this important and timely hearing on the role of large hospital corporations driving unaffordable health care, and to offer our sincere appreciation to 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, workers, employers, and clinicians 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 three[1]—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 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 misaligned incentives that are driving up costs for families in order to provide real relief to the American people.**

We urge the House Energy and Commerce Committee to advance an agenda that prioritizes health care affordability for American families and holds corporate health systems accountable for charging excessive prices. Specifically, we call on your committees to advance the following well-vetted, bipartisan, and commonsense policies to remedy some of the most obvious health system failings:

- **Achieve meaningful price transparency in the health care system by requiring all hospitals to disclose negotiated rates in dollars and cents, establish standardization including a machine-readable format, eliminate loopholes, and enforcement of recently required hospital executive attestation along with increased penalties to encourage greater compliance by hospitals.** These efforts should include codifying a strengthened version of the Hospital Price Transparency regulation.

- **Address payment differentials across sites of service that financially incentivize further consolidation and help ensure consumers pay the same price for the same service regardless of where the service is performed by enacting site neutral payments.**

- **Prohibit anti-competitive contracting terms, including between providers and insurers such as "all-or-nothing", "anti-steering," and "anti-tiering" clauses in provider and insurer contracts; and "non-compete" clauses in clinician and health care worker employment arrangements, that, for instance, may interfere with the continuity of the primary care patient-physician relationship.**

These policies would set a critical foundation for reducing inflated and wasteful spending throughout the system and make health care more affordable and value-driven for consumers.[6]

Consumers for Fair Hospital Pricing looks 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 Consumer Health Initiative
Consumers for Quality Care
Families USA
Health Access California
Pennsylvania Health Access Network
U.S. PIRG

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CMS' New Approach to Federal Medicaid Spending in Cases of Potential Fraud

Authors: Jessica Mathers, Alice Burns, and Robin Rudowitz

Published: Mar 16, 2026

The current administration is placing a new emphasis on potential fraud in Medicaid. The Centers for Medicare and Medicaid Services (CMS') current efforts are focused on Minnesota and three other states with Democratic governors (California, Maine, and New York). The House Committee on Energy and Commerce has also sent requests for information about potential Medicaid fraud to 11 states (the 4 CMS is focused on and 7 others, including 2 with Republican governors). CMS has historically partnered with states to identify and resolve issues of fraud, waste, and abuse, and denied the federal share of Medicaid spending when fraud has been identified by an audit, investigation, or reported by the state. However, CMS has recently announced a new approach to fraud that will rely more heavily on options to pause or withhold significant amounts of federal funding in cases of potential fraud, which could have broad implications for states and enrollees. This issue brief explains the new approach. Key findings include:

- CMS' historic practice has relied on disallowing federal Medicaid payments when fraud is identified (typically through an audit), a process that may take several years to implement.

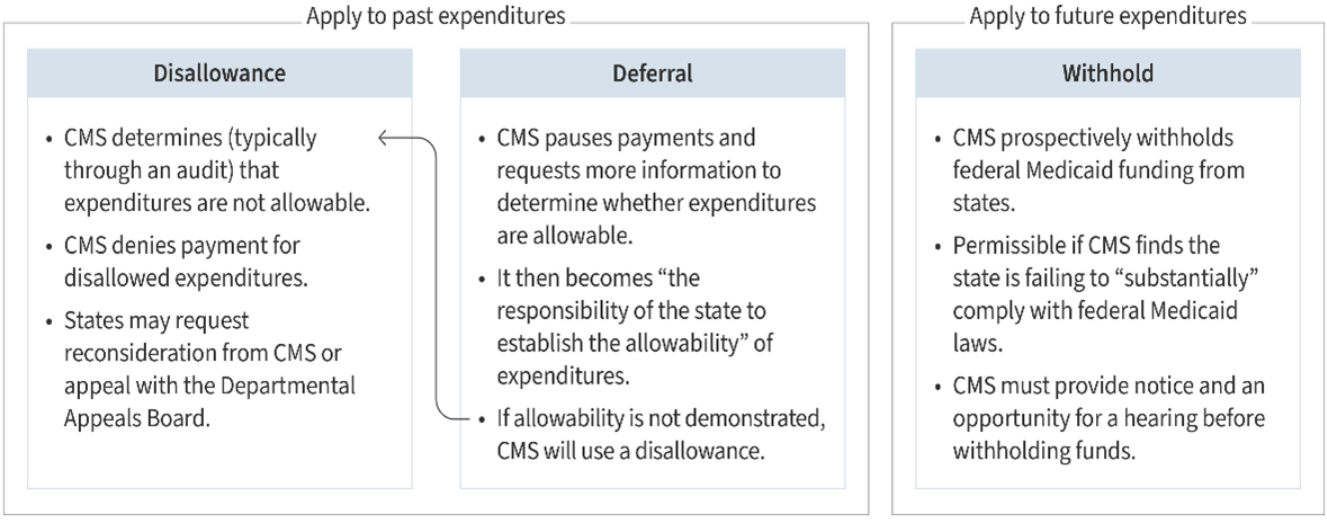
CMS' new approach to potential fraud involves deferring and withholding federal Medicaid payments when fraud is suspected (Figure 1). This approach differs from prior approaches because it can have more immediate consequences, may place a much larger share of federal spending at risk (including spending that pays for services uninvolved in fraud), and proactively shifts the burden of proof to states to obtain federal funds.

While all approaches aim to limit future fraudulent payments using tools such as corrective action plans, the new approach to federal Medicaid spending when fraud is suspected creates uncertainty for state budgets and could have implications for Medicaid enrollees and providers who are not involved in fraud.

Figure 1

The Federal Government Is Changing How It Provides Access to Medicaid Funds for States in Cases of Potential Fraud

Historically, CMS denied payments for **disallowed or deferred expenditures when fraud was identified**. The new approach **defers or withholds federal Medicaid spending** ***when fraud is suspected***. That shifts the burden of proof to states and creates uncertainty for state budgets, which could have implications for enrollees and providers who are not involved in fraud.



Note: CMS is the Centers for Medicare & Medicaid Services.

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What is a disallowance?

The federal and state governments share responsibility for financing Medicaid, and states draw on federal funds to pay health care providers and health plans for providing health care to enrollees. The federal government makes quarterly grant

awards to states to cover the federal share of Medicaid spending. Awards reflect states' estimated expenditures for the upcoming quarter and adjustments from prior quarters' expenses. Adjustments reflect various considerations such as:

- Instances where states' estimated expenditures are higher or lower than actual expenditures
- Changes to accounting practices or federal matching rates
- Reductions in payment resulting from claims where fraud has been identified

Publicly-available data on Medicaid expenditures show the total amount of adjustments each year, reflecting the net impact of all various factors, and do not specifically identify adjustments due to disallowances and deferrals.

Historically, CMS has used disallowances to deny federal matching funds for prior state Medicaid expenditures that are determined to be not allowable. There is limited information available about the frequency and scope of Medicaid disallowances, but an older report by the Government Accountability Office (GAO) suggests that they were not infrequent between 2014 and 2017. Upon receiving a disallowance notice, states may request that CMS reconsider the decision and provide additional information to CMS to demonstrate that the expenditures were allowable or proceed with settling the disallowance. In all cases, once CMS has issued a disallowance, "the state has the burden of documenting the allowability" of the expenditures to overturn the disallowance. When states request a reconsideration, CMS has 60 days to decide, although this timeline may take longer if CMS requests additional information from the state.

States may appeal the disallowance decisions to a Departmental Appeals Board, but the state still has the burden of proof for documenting the allowability of expenditures and the process may take years to resolve. More information is publicly available for cases where states do appeal the decisions than for cases where they settle or request a reconsideration. In such cases, data about the decisions of the Department Appeals Board are available online through the Department's website. Between 2020 and 2025, the Departmental Appeals Board has issued 12

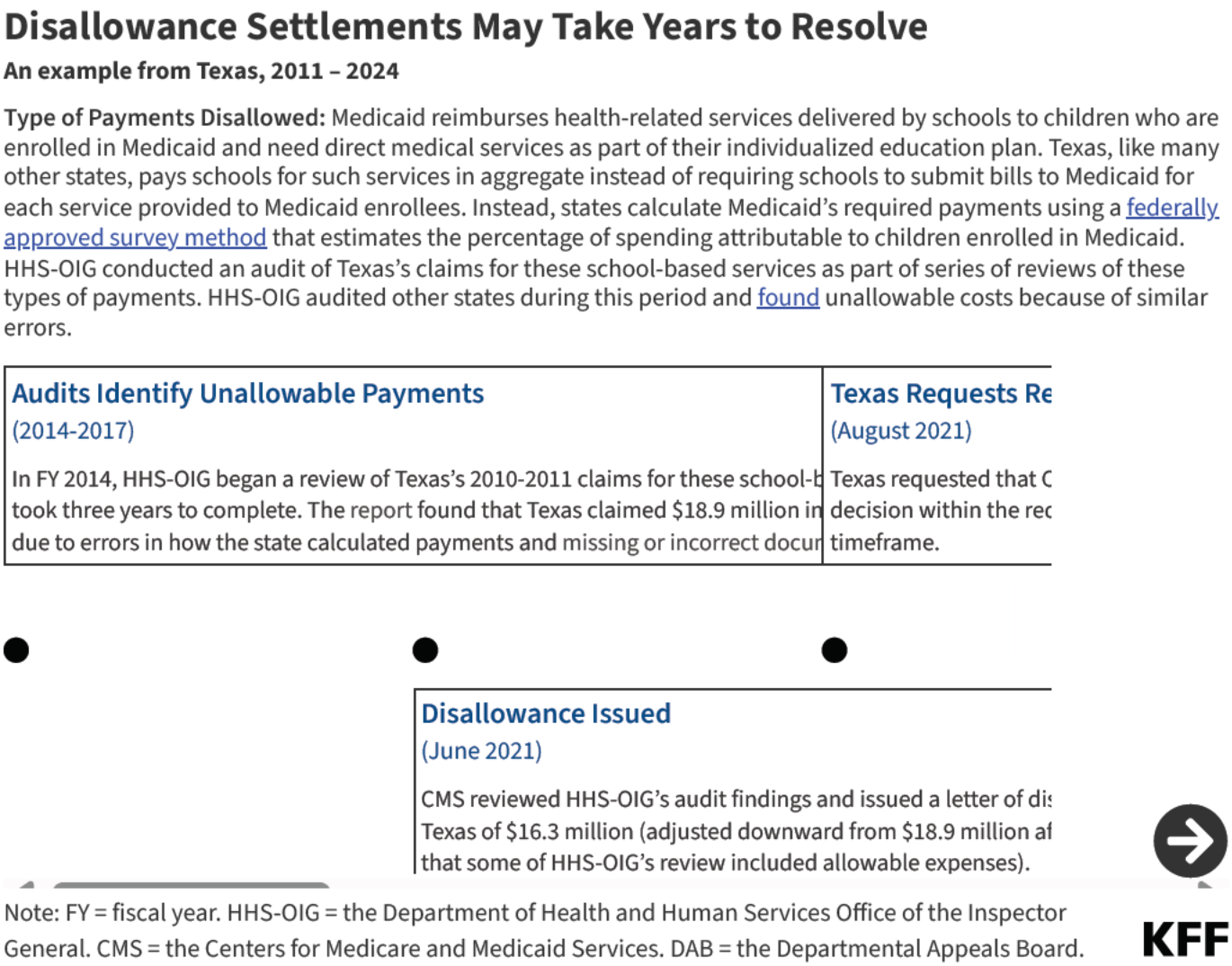
Medicaid disallowance rulings (with 6 rulings being an appeal of a prior case). In all 6 new rulings, there were on average 15 years between the oldest year of disputed expenditures and the final ruling, highlighting how long it takes to resolve these cases (see Figure 2 for an example from Texas). All cases were decided in favor of CMS.

The amount of disputed disallowances where the Departmental Appeals Board issued a ruling between 2020 and 2025 ranged from less than $500,000 to almost $200 million, but these amounts reflect differences in the number of years and scope of services within the disallowed claims. Some of the largest disallowances to be upheld involve disproportionate share hospital (DSH) payments.

The largest disallowance ruling between 2020 and 2025 was $195.7 million in a case involving Michigan's DSH payments between 2001-2009. In that instance, CMS in 2018 determined that the state had made DSH payments to a small number of hospitals that were ineligible to receive them. The Departmental Appeals Board ruling was in 2024.

The second largest disallowance ruling between 2020 and 2025 was for more than $97 million in a case where Florida made DSH payments between 2006-2013 in excess of the limits established for specific hospitals (CMS first issued this disallowance in 2016 and the Departmental Appeals Board ruling was in 2021).

Figure 2



What is a deferral?

With deferrals, CMS pauses payment for prior state Medicaid expenditures and requires the state to provide additional information demonstrating that expenditures are "allowable." Deferrals may be initiated by either federal or state governments and may be used to pause federal funding while the state and federal governments work out the details of a disallowance, and in cases where fraud, waste, or abuse has been identified and the state and federal governments are gauging the extent of the issue. In the past, deferrals were used as temporary measures that

pause funding until CMS either reimburses the expenditures or issues a disallowance. Deferral notices must specify the reason for the deferral and include a request for all documents and materials that CMS believes are necessary to determine whether the expenses are allowable.

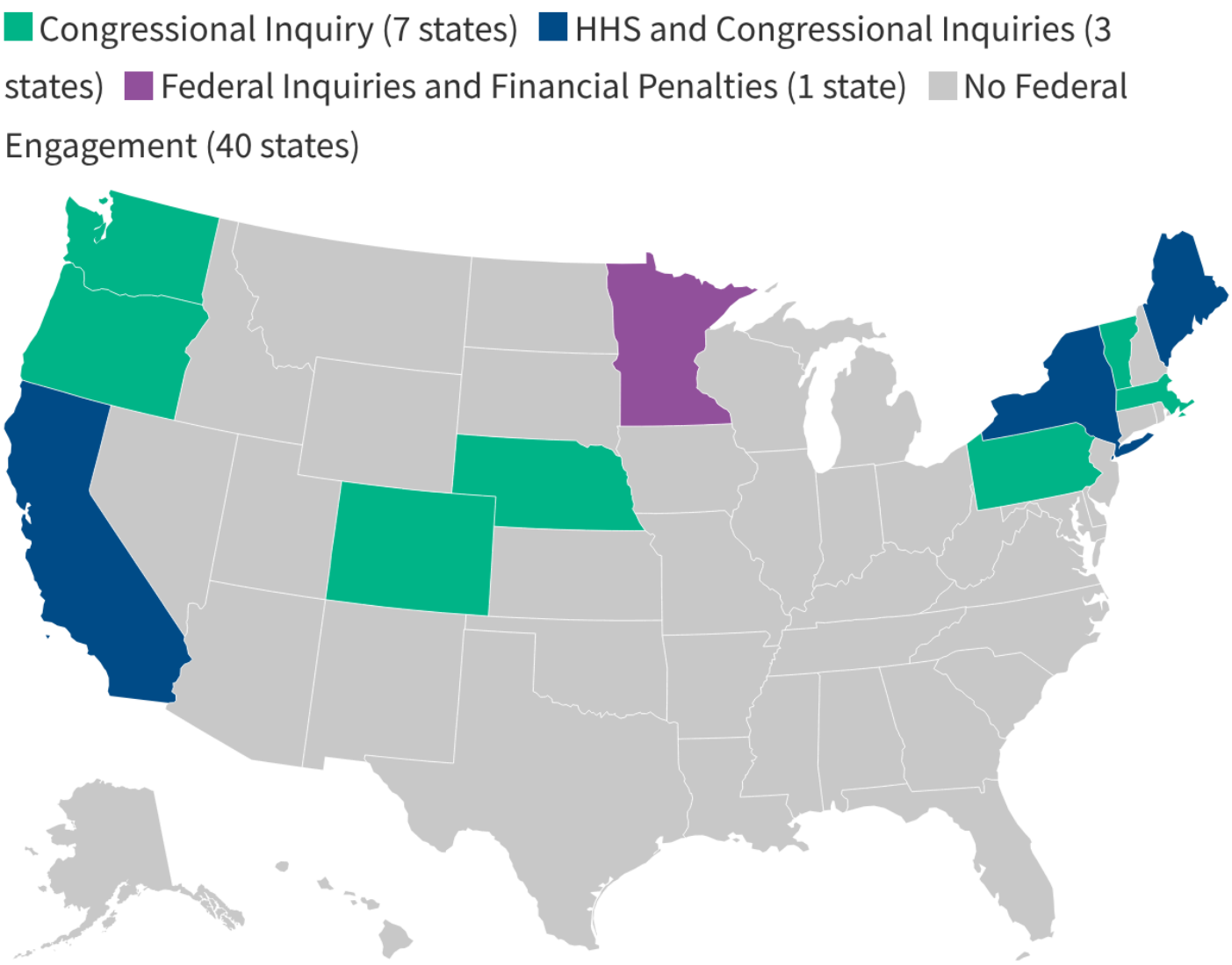
After receiving a deferral notice from CMS, states have 60 days to provide all requested documents and materials unless they request an additional 60-day extension. CMS usually begins document review within 30 days but may request different formats or additional materials from the state. States have 15 days to submit additional materials and if they do not meet that deadline, CMS disallows the expenses. Once all documents are available, CMS has 90 days to review and determine whether expenditures are allowable. If CMS determines expenditures are not allowable, the disallowance process begins.

Deferrals are receiving new attention after CMS announced that it would temporarily defer $259 million in federal Medicaid payments to Minnesota for claims paid in fiscal year (FY) 2025, an unprecedentedly large amount. In the announcement, CMS noted that it may continue to defer federal payments, and that similar announcements for other states would likely be coming soon. As of March 16, 2026, 3 additional states have received formal letters from CMS requesting information about program integrity, and 11 states have received formal letters from the House Committee on Energy and Commerce (Figure 3).

Figure 3

CMS' New Focus on Potential Fraud in Medicaid Focuses on 4 States but Congressional Letters Suggest Effects Could Become Broader

Federal engagement regarding state Medicaid program integrity, as of March 16, 2026.



Note: CMS is the Centers for Medicare & Medicaid Services. "Congressional Inquiry" refers to requests for information issued by the House Committee on Energy and Commerce. "HHS Inquiry" refers to CMS engagement regarding program integrity information and potential corrective action. "Financial Penalties" refers to notices of deferral and withholding issued as program integrity-related compliance actions.

Source: KFF Tracking of Federal Program Integrity Action

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What is a withhold?

In January 2026, CMS notified Minnesota that pending the outcome of a hearing, it would begin withholding $515 million in quarterly federal Medicaid payments moving forward, a process that has seldom been used in prior years. Withholding funds has been referred to as the "compliance process" because it is only permissible in cases where the state is failing to comply with Medicaid law. Prior use of withholding has been limited. When CMS has used withholding as a compliance tool in the past, it withheld between 1 and 10 percent of the federal share of Medicaid spending. Prior withholdings appear to have been used when states incorrectly restricted eligibility or benefits, thus failing to comply with minimum requirements regarding access to coverage or eligibility. Minnesota's case is different because of the scope of the proposed withholding and because the proposed withholding would be to address potential future fraud, rather than state policies that restrict Medicaid eligibility or benefits. The announced level of withholding represents nearly 20% of the federal share of Minnesota's spending on an annual basis.

To withhold federal Medicaid funds, CMS must first provide states with the opportunity for an administrative hearing, and withholding generally ends when CMS is satisfied with states' resolution of the issue. Withholdings may reflect issues with states' Medicaid approved plans or with states' implementation of the plans. Because CMS has authority to approve states' plans, most issues arise regarding implementation of the plan and are resolved using a corrective action plan. Corrective action plans may also be used to address other types of program integrity issues in Medicaid (such as payment error rates or eligibility re-determinations). In general, the plans include a narrative of steps states are planning to take to address issues related to proper implementation of the Medicaid program. On January 13, 2026, Minnesota requested a hearing about the withholding and on January 30, 2026, Minnesota submitted a revised corrective action plan to CMS. If requested, CMS is required to schedule a hearing for Minnesota within 60 days of issuing notice (which would have been March 7, 2026) but CMS has not done so as of

March 16, 2026. It is unclear whether that means CMS has accepted the state's revised corrective action plan or what the next steps might be.

What are the implications of new reliance on deferrals and withholds?

The new approach to federal Medicaid spending when fraud is suspected creates uncertainty for state budgets, particularly given the magnitude of federal funding at stake and the time it takes to resolve administrative disputes. Unlike the federal government, states must generally operate balanced budgets, which is one reason states are able to draw down matching funds to finance ongoing expenditures. The immediate loss of federal funds via withholding could make it difficult for states to maintain current programs while details of the cases are being sorted out. More extensive use of deferrals could have similar destabilizing effects on states' budgets because they reduce the amount of federal funds available to states for several months. Deferrals also place a new administrative burden on states to demonstrate the allowability of expenditures and may increase the likelihood of disallowances. Because disallowances often take years to resolve, increased rates of disallowances would further exacerbate states' budget uncertainty. Other approaches to addressing suspected fraud, waste, and abuse remain available to CMS. The National Association of Medicaid Directors (NAMD) has suggested the following actions to help states to address fraud waste, and abuse in Medicaid:

- Help states identify federal materials about best practices such as recommendations and provider enrollment self-assessments;
- Create rapid methods to share information about provider disqualifications between Medicare, the Veterans' Health Administration, and Medicaid;
- Respond more quickly to fraud reports from state attorneys general and the Medicaid Fraud Control Units;

- Strengthen procedural pathways for states and CMS to work collaboratively on Corrective Action Plans to enhance adherence to provider requirements while maintaining access to Medicaid benefits;
- Conducting additional analysis of Medicaid data through the Center for Program Integrity;
- Strengthening federal data sources and their interoperability; and
- Providing technical assistance to state officials and staff.

New uncertainty about the availability of federal funding could have implications for Medicaid enrollees and providers who are not involved in fraud. If states have inadequate funding to maintain existing Medicaid services, they may face difficult decisions regarding how to limit Medicaid spending. In general, states can reduce Medicaid spending by decreasing payment rates for providers, covering fewer services, or enrolling fewer people. Such actions could affect enrollees and providers who are not using or providing services in which fraud is suspected. There will also be additional disruptions for providers who lawfully provide Medicaid services where fraud is suspected because of new administrative burdens associated with increased audits, delayed payments, and other administrative practices.

CMS' new approach to addressing cases of suspected fraud may exacerbate administrative and financial challenges states face as they implement the 2025 reconciliation law. The 2025 reconciliation law made historic reductions in federal funding for Medicaid and created new administrative requirements for states, particularly those that must implement work requirements for enrollees eligible for Medicaid through the Affordable Care Act Medicaid expansion. As states work to implement those changes and adjust to changes in federal financing, the new approach to fraud creates additional administrative requirements and potential new reductions in federal funding. Combined, these changes may have more significant implications for states' ability to maintain existing levels of Medicaid payment rates, coverage, and eligibility.

American Academy of Physician Associates

AAPA Statement for the Record to the House Energy and Commerce Committee's Subcommittee on Health Hearing: Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape

March 18, 2026

Subcommittee Chairman Griffith, Subcommittee Ranking Member DeGette, Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee on Health:

On behalf of the approximately 190,000 physician associates/physician assistants (PAs) throughout the United States, the American Academy of Physician Associates (AAPA) thanks the subcommittee for holding this hearing and examining ways to improve access to affordable healthcare.

In addition to providing information directly addressing the topic of today's hearing, it is critical for AAPA to clarify for the record misinformed testimony related to PAs that is included in the written statement of the American Medical Association's (AMA.) A portion of testimony submitted by the AMA points to one small study examining PA care in a Mississippi clinic that included fewer than 10 PAs in the analysis and neglects to acknowledge the significant body of well-designed, large case-control studies, retrospective studies; and systematic reviews demonstrating comparable or improved outcomes of PA-provided care compared to physicians.

The study from the Hattiesburg Clinic first published in the Journal of the Mississippi State Medical Association in January 2022 is a highly flawed and limited study that does not meet the standards of basic research methodology. Therefore, it cannot be held up to this committee as evidence against PAs. First, the study is not indexed in PubMed, indicating the study does not adhere to strict Library of Medicine standards for publications. This is evidenced by a lack of reporting of statistical significance of the findings, making interpretations of the results extremely limited, as it cannot be determined if differences are meaningful.

Further, the generalizability of the findings is considerably limited due to the extremely small study population, which only included a single practice in one state. It was also affirmed by the author through direct communication with affiliates of AAPA that outcomes of fewer than 10 PAs were included in the analysis. Not only does this further restrict the population size, and therefore the transferability of the findings, it demonstrates a lack of transparency in the methodology used. This

and other limitations were not included in the article, despite the disclosure of study limitations being an essential component of a scientific paper. Acknowledging the limitations of any research is considered standard practice, demonstrates scientific integrity, and minimizes the risk of bias.

The use of one, single low-quality study that is not representative of the broader PA population and cannot be assessed for statistical significance is disingenuous. This is evident, given the numerous studies that contradict the findings of the Hattiesburg report. For example, the Medicare Payment Advisory Commission concluded, "A large body of research, including both randomized clinical trials and retrospective studies using claims and surveys, suggests that care provided by NPs and PAs produces health outcomes that are equivalent to physician-provided care."[1] Similarly, a systematic review of the quality and cost-effectiveness of PA-provided care concluded, "PAs delivered the same or better care outcomes as physicians with the same or less cost of care."[2]

AAPA urges the committee to critically appraise the quality of evidence presented and to assess the totality of findings related to the outcomes of PA-provided care.

As Congress considers policies to ensure timely access to high-quality care for all patients, AAPA encourages the subcommittee to embrace opportunities to reduce provider barriers and burdens wherever they interfere with optimizing patient care and access. AAPA also encourages Congress to reauthorize current programs to address workforce challenges and enact legislation to ensure all providers can practice to the top of their license and education. While the rapidly growing PA workforce continues to provide high-quality care across the nation and in all medical specialties; they do so despite outdated barriers that remain in state and federal laws. AAPA stands ready to work with the committee as you consider new ideas to ensure quality care is available to all Americans, and particularly those in rural and underserved communities.

Therapeutic Shoes for Patients with Diabetes

PAs diagnose and treat illnesses, manage complex conditions, prescribe medications in all 50 states, and assist in surgery – but the current statute governing Medicare does not authorize PAs to complete the simple task of ordering diabetic shoes. A PA can diagnose diabetes, manage long-term diabetic care including foot conditions, and first-assist in foot amputation surgery but PAs cannot prescribe shoes to prevent the amputation. This is absurd. The Promoting Access to Diabetic Shoes Act (H.R. 1616/S. 1805) will modernize current Medicare policy and authorize PAs to certify a patient's need for diabetic shoes. A study published in the American Journal of Medicine in 2018 found that PAs perform as well as physicians in the management of diabetes at diagnosis and during

[1] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf
[2] https://pubmed.ncbi.nlm.nih.gov/34723999/

four years of follow-up care.[3] PAs are federally recognized primary care providers and frequently manage care for diabetics who may have multiple comorbidities. Outside of the Medicare program, PAs can certify the need for diabetic shoes for their patients. This is an example of the Medicare statute not making common sense or keeping up with how medicine is practiced today. Diabetic foot complications are directly related to poor clinical outcomes and substantial cost, especially among rural Medicare patients.

Medicare Shared Savings Accountable Care Organization (ACO)

PAs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned as beneficiaries in that program. Under current law, Medicare fee-for-service beneficiaries are assigned to an ACO based on their utilization of primary care services furnished by a physician. However, individuals in rural and underserved communities often rely on PAs and other advanced practitioners. As a result, the physician requirement prevents Medicare fee-for-service beneficiaries in these communities from accessing the coordinated care provided by ACOs. It is essential that primary care services furnished by PAs and other advanced care providers count for purposes of ACO assignment. This encourages ACO formation in rural and underserved areas and allows healthcare providers to attain enough ACO beneficiaries to participate in the Medicare Shared Savings Program. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages and encourage the adoption of value-based care principles such as care coordination and population health. The ACO Assignment Improvement Act (H.R. 4773/S. 3350) will improve the way beneficiaries are assigned under the MSSP by also basing such assignment on primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists.

Cardiac and Pulmonary Rehabilitation (CR/PR)

Current law arbitrarily restricts the ordering of cardiac and pulmonary rehabilitation by PAs for Medicare patients. In 2018, Congress rightfully authorized PAs and other advanced practice providers to supervise cardiac and pulmonary (CR/PR) services but with a delayed implementation until 2024. While that change has been implemented and PAs can now supervise these services, PAs are still not authorized to order this critical service for their patients.

CR/PR services are an essential and proven tool in the management of patients with chronic respiratory conditions, those who have survived myocardial infarction (heart attack) as well as patients fighting chronic obstructive pulmonary disease (COPD.) Despite the clinical implications and critical importance of this treatment, CR/PR services remain severely underutilized, especially

[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC5817031/#:~:text=This%20study%20was%20approved%20by,VA%20Research%20and%20Development%20Committee.

among high-risk populations in rural areas.[4] The Increasing Access to Quality Cardiac Rehabilitation Care Act (H.R. 6894/S. 717) would authorize PAs and other qualified providers to order CR/PR programs for their Medicare patients, enabling patients to benefit from these cost and life-saving services sooner and without a disruption in care, while also minimizing unnecessary medical appointments with an additional provider.

Federal Workers Compensation

Currently, all US federal and postal employees receive workers compensation coverage for employment-related injuries and disease through the Federal Employees Compensation Act (FECA). However, FECA does not cover medical care provided by PAs (or nurse practitioners [NPs]) within the current definition of "medical, surgical, and hospital services...," meaning once a federal or postal employee is injured on the job, they can no longer receive healthcare from a PA, even if that PA is their primary care provider (PCP) through their federal health insurance program. This undue and unnecessary restriction negatively impacts our federal workforce, especially those in rural areas where access to any provider, not just physicians, can be challenging. PAs provide high-quality healthcare and are recognized providers in Medicare, Medicaid, and nearly every state and federal healthcare program, including state workers' compensation programs. PAs are included in the definition of an "acceptable medical source" by the Social Security Administration and thousands of PAs are federal employees themselves and practice within the Department of Veterans Affairs, the Department of Defense, the Public Health Service, and Indian Health Services. FECA is the outlying federal program that does not recognize the critical role PAs play in our healthcare system. The Improving Access to Workers' Compensation for Injured Federal Workers Act (H.R. 3170/S. 3296) would authorize PAs to treat their federally employed patients in accordance with state law. This bill is under the jurisdiction of the House Education and Workforce Committee and passed the committee unanimously last June.

If you have any questions or need additional information, please contact Tate Heuer, VP of Federal Advocacy for AAPA, at theuer@aapa.org or at (517) 319-4338.

[4] Fleg JL, Keteyian SJ, et al. Increasing Use of Cardiac and Pulmonary Rehabilitation in Traditional and Community Settings: OPPORTUNITIES TO REDUCE HEALTH CARE DISPARITIES. J Cardiopulm Rehabil Prev. 2020 Nov;40(6):350-355. doi: 10.1097/HCR.0000000000000527. PMID: 33074849; PMCID: PMC7644593.

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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

House Committee on Energy and Commerce
Subcommittee on Health

March 18, 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 Subcommittee 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 patients get better value. However, bringing down health care costs will require the participation and alignment of incentives across the whole health care system. Plans alone cannot solve the affordability pressures for consumers and the government. Together, we can find workable solutions that make health care more affordable for patients and more sustainable for the country.

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 in hospital costs, improve provider participation and modernization of practices while aligning incentives across the system while 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.

Affordability Depends on System-Wide Collaboration

Health plans are ready to be full, accountable partners with hospitals and providers to help drive down health care costs. Health care affordability is a shared responsibility, and patients deserve reforms that lower costs and improve outcomes. Health plans have the tools, data, and incentives to reward value over volume, but hospitals and providers must also be transparent and accountable.

Hospital Pricing is Driving Higher Health Care Costs

Affordability remains out of reach when hospital system practices undermine cost-containment efforts across the system. Hospitals continue to raise their prices at rates that outpace inflation, accompanied by opaque fees that ultimately drive-up costs for patients. 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]

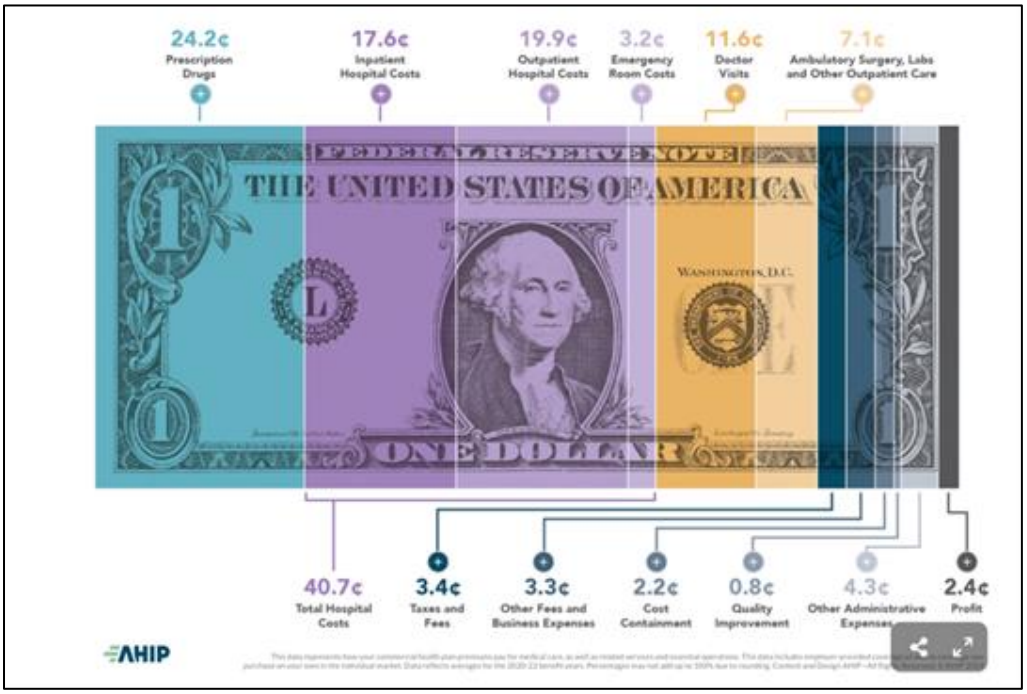

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf.

Hospitals play a central role in driving 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 care reached a staggering $1.6 trillion.[3] This level of 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 acquire independent physician practices, consolidated

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[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

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 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] Most 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 – and ultimately 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] Nonetheless, 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]

Excessive Site-of-Care Price Variation

Hospital consolidation doesn't 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

[4] https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/enviromental-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

prices, often due to facility fees imposed by hospitals. 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.[8] For patients, it is often "the same visit, higher bill." These facility fees and other opaque hospital billing practices mean higher premium costs year after year.

- **Recommendation:** Protecting consumers 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.[9] 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.

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 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.[10] Great 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.[11] Hospitals substantially mark-up drug costs for commercial health plans, charging 50 percent to 103 percent more than specialty pharmacies for the same drug.[12] 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.

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[8] https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings/

[9] https://www.cbo.gov/budget-options/60908

[10] https://www.bcbs.com/news-and-insights/report/ai-boosting-hospital-billing

[11] https://www.axios.com/2026/03/05/disparities-hospital-drug-prices

[12] https://www.ahip.org/news/press-releases/new-research-highlights-premium-impact-of-provider-markups-on-specialty-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.

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.[13] 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 comparable practices across that same time period.[14] Private equity's focus on generating short-term profits often leads to reduced health care staffing, stretching workers further and putting patients at risk.[15] These studies demonstrate how 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.

Provider Partnerships Are Essential to Affordable, High-Quality Care

Plans and providers share the same goal: high-quality, affordable care, and collaboration is essential to modernize prior authorization, expand telehealth, strengthen network adequacy, and eliminate surprise medical billing. Health plans have built and maintained the infrastructure to support these reforms, but meaningful progress requires provider engagement to ensure patients see real improvements in affordability.

Value-Based Care: Aligning Incentives Around Patient Outcomes

Value-based care is the connective tissue of the plan-provider partnership, aligning incentives so providers are rewarded for delivering better outcomes and more efficient care, rather than higher volume or higher prices. Health insurance exists to protect individuals and families from the unpredictable costs of medical care – and value-based care is central to that mission. By shifting away from volume-driven incentives, health plans are working to shield Americans from high

[13] https://hsph harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/
[14] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946
[15] https://www2.nber.org/digest/202104/how-patients-fare-when-private-equity-funds-acquirenursing-homes

and rising health care costs while improving care delivery. This protection depends on a strong, balanced risk pool and payment models that encourage high-quality, efficient care for individuals with diverse health care needs throughout the year.

Patients deserve a health care system focused first and foremost on delivering affordable, evidence-based care that works. By aligning incentives around outcomes, value-based care helps curb avoidable hospital spending and supports a more sustainable cost trajectory across the entire health care system. Health plans are committed to working hand-in-hand with hospitals and provider organizations to advance value-based care and deliver patient-centered, high-quality, coordinated care that is more affordable for Americans.

Health plans continue to invest in value-based care models – such as alternative payment models (APM) – that emphasize quality and patient outcomes while safely reducing costs. Results from the 2025 APM Adoption Survey conducted by AHIP in collaboration with CMS reaffirm the commitment of public and private payers to transition from fee-for-service toward payment models that incentivize quality, efficiency and improved patient outcomes.[16]

The APM Adoption Survey found that 44.9 percent of all health care payments were tied to APMs that hold providers accountable for quality and cost of care, while 28.7 percent of health care payments were tied to APMs with downside risk. The survey also captured perspectives on future trends; 70 percent of respondents expect APM activity to increase over the next 24 months, citing provider readiness, health plan engagement, and health plans' ability to operationalize such models as key facilitators.[17]

While the survey findings demonstrate health plans' continued commitment to value-based care models, wider engagement among hospitals and other provider organizations could help strengthen momentum and grow broad-based participation in value-based care arrangements that improve outcomes – and affordability – for families across the U.S.

Medicare Advantage

Medicare Advantage (MA) illustrates how health plans, through risk-based payment and accountability, have powerful incentives to control costs and improve affordability across the health care system. MA delivers significantly lower total health care costs for beneficiaries than traditional fee-for-service (FFS) Medicare while also delivering better patient outcomes. Research shows that MA beneficiaries experience fewer avoidable hospitalizations, stronger hospital recovery, and lower hospital readmissions.[18,19]

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[16] https://www.ahip.org/resources/2025-apm-measurement
[17] Ibid
[18] https://www.inovalon.com/wp-content/uploads/2025/05/INOV_MA-vs-FFS-Outcomes-Study_5.28.25-v1.0.0.pdf
[19] https://www.thinkbrg.com/insights/publications/black-hispanic-aapi-ma-beneficiaries-receive-primary-care-potentially-avoidable-care/

MA also has a lower improper payment rate compared to FFS Medicare.[20] In 2025, FFS improper payment rate was 6.55 percent, costing the federal government over $28 billion, compared to 6.09 percent for MA plans – all while MA plans are serving more Medicare beneficiaries. This performance reflects the accountability built into MA, where plans are financially responsible for managing care, preventing fraud, waste, and abuse, and ensuring services are medically appropriate. By contrast, FFS Medicare lacks many of these safeguards, underscoring how MA's care coordination, oversight, and utilization management tools protect both beneficiaries and taxpayers while delivering high-quality coverage at scale.

Furthermore, MA can play an important role in supporting rural health system stability and improving care quality, at a time when rural Americans face growing challenges accessing and affording care due to hospital closures and reduced services. In fact, one study that examined rural hospitals in 14 US states, found that an increase in county MA penetration was associated with an increase in hospital financial stability and a reduction in risk of closure. In fact, the study found that every percentage point increase in MA penetration was associated with a 4 percent reduction in risk of hospital closure.[21] Another recent survey found that rural Americans saved $5,500 on MA, compared to FFS, thereby improving affordability in low-access regions.[22]

As policymakers look for ways to address the affordability crisis facing Americans, particularly in rural communities where access to care is already strained, MA remains a proven tool for protecting beneficiaries from the rising cost of medical care. While health plans support reforms to strengthen the program for seniors, flat funding during a period of sharply rising medical costs and high utilization – as is currently proposed in CMS's 2027 MA and Part D Advance Notice – could result in reduced benefits, fewer choices, and increased costs for millions of seniors when they renew coverage in October 2026.

MA's value-based care approach helps reduce unnecessary hospital utilization, strengthen hospital stability and lower overall health care costs for beneficiaries and taxpayers.

Simplifying Prior Authorization

Prior authorization is another value-based tool health plans use to ensure care is safe, evidence-based, and as affordable possible. By applying prior authorization in a targeted and clinically grounded way, health plans help to coordinate care, promote value, reduce unnecessary or duplicative treatments, and avoid complications that drive costs higher.

The targeted, clinically driven use of prior authorization reflects the distinctive role of health plans as the only part of the system that does not benefit from higher utilization or higher prices.

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[20] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet
[21] https://www.ahip.org/resources/ma-increases-rural-health-system-stability-improves-care-quality-2
[22] https://www.ahip.org/resources/medicare-advantage-leads-to-savings-for-seniors-and-taxpayers

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 are structurally motivated to selectively use prior authorization to reduce low-value care, reinforce clinical best practices, and drive better outcomes.

Electronic prior authorization also reduces administrative burden for providers, accelerates patient access to necessary treatments, and minimizes delays in care. Health plans have invested heavily in building electronic prior authorization options. Yet nearly half of prior authorization requests (45 percent for medical services and 47 percent for prescription drugs) are still manually submitted by providers using phone, fax or traditional mail – creating inefficiencies. As plans deploy the next generation of electronic prior authorization that integrates into electronic health records by January 1, 2027, vendors must build and providers must adopt the new technology. Without the greater use of modern technologies, continued reliance on manual processes negates the efficiencies of electronic prior authorization. Looking forward, a coordinated effort from both plans and providers will be essential to fully streamline the prior authorization process.

Last June health plans announced a series of further commitments to streamline, simplify and reduce prior authorization. Building on health plans' existing efforts, these new actions are focused on connecting 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.[23]

AHIP looks forward to working with the Subcommittee and sharing progress on health plans' commitments to improve prior authorization this spring.[24]

Improving Provider Directory Accuracy

Health plans are also committed to ensuring beneficiaries have accurate, reliable provider directories so individuals can easily find in-network providers who meet their clinical needs and are accessible and appropriate for them. Provider directories are a critical consumer protection tool, offering essential information such as contact details, specialties, and board certifications, and enabling patients to maximize the value of their coverage. Health plans invest significant resources to keep this information current through ongoing outreach, validation, and audits.

Despite these efforts, two persistent challenges undermine directory accuracy: some providers do not consistently submit timely or complete updates to their information, and there is no single source-of-truth for provider information that can be utilized. These challenges are compounded by a complex environment of federal and state rules, with different provider directory

[23] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[24] https://www.ahip.org/news/articles/2026-will-bring-progress-on-simplifying-prior-authorization

requirements across different and state-specific rules in nearly all 50 states.[25] The creates fragmentation and operational complexity without necessarily improving accuracy for patients.

Health plans have worked closely with their provider partners for years to improve directory data. These efforts include streamlining processes and leveraging data to flag outdated information. Achieving meaningful and durable improvement requires a shared, system-wide commitment – including stronger provider responsibility for keeping information current and avoid the real-world consequences of inaccurate listings for consumers.

Using Telehealth to Lower Prices and Challenge Anti-Competitive Provider Practices
Plans and providers must also work together to expand high-value telehealth that improves access while reducing unnecessary utilization; modernize prior authorization so it is targeted, data-driven, and focused on patient safety rather than paperwork; ensure network adequacy that gives patients meaningful access to high-quality, cost-effective care; fully eliminate surprise medical billing by honoring clear rules and good-faith contracting; and jointly identify and stop fraud, waste, and abuse that siphon billions of dollars from the system every year.

Expanded access to telehealth can foster greater competition on quality and costs, particularly in regions with monopoly health systems. As health care provider markets become increasingly consolidated, telehealth spurs crucial price competition that would otherwise be limited in or absent from local markets.

Telehealth can also address inflated pricing from hospital systems that acquire physician offices and redesignate them as hospital outpatient departments: charging higher prices even though nothing about the office has changed. Further, telehealth providers compete with each other, not just with local providers. This dual competition benefits individuals and other customers purchasing coverage, such as employers.

- **Recommendation:** To boost telehealth competition, AHIP urges policymakers to allow physicians to deliver care across state lines and modernize network adequacy regulations to reflect the availability of telehealth as an option for patients. Congress should also pursue policies that allow for flexibility in plan benefit and payment design to support value-based care via telehealth, ban distant site facility fees for telehealth services to lower costs for patients, and make permanent the telehealth flexible benefit offerings Medicare implemented that are currently extended through 2027.

Preventing Private Equity-Backed Providers from Exploiting Surprise Billing Protections
A fragmented health care system – combined with the rapid expansion of private equity ownership – has intensified out-of-network billing, balance billing, and opaque pricing that harms consumers.

[25] https://www.ncsl.org/health/health-insurance-network-adequacy-requirements

When private equity and other investment firms focus on extracting short-term profit cost, quality and patient experience can be negatively impacted. When private equity-backed providers game patient protections against surprise billing, policymakers need to take action to hold down wasteful spending.

Private equity-backed provider groups often rely on aggressive billing strategies, including remaining out-of-network or exploiting payment disputes, to maximize their revenue at the expense of American consumers. Private equity firms initiate the vast number of arbitration challenges raised under the *No Surprises Act*: 63 percent of surprise billing arbitrations were filed by just five private equity-linked firms.[26] These investment groups are flouting the intent of the Federal Independent Dispute Resolution (IDR) process, filing improper claims to arbitrators who operate without oversight, driving over $5 billion in wasteful spending in just two years.[27] These practices contribute to surprise medical bills, medical debt and financial instability for individuals, families, and employers.

Investment capital can meaningfully improve the performance of the health care system by supporting innovations and scaling capabilities that reduce unnecessary costs, improve experience and drive higher quality. Too often, however, PE-backed investments prioritize short-term returns at the expense of patient care. Transparency and oversight are needed to ensure that private equity investment in the health care sector improves quality at a lower cost.

- **Recommendations:** Common-sense solutions include strengthening enforcement in the IDR process to stop private equity-backed groups from flooding the system with ineligible claims and requiring more stringent oversight of arbitrators, such as greater transparency, audits and penalties for non-compliance These solutions can provide relief to employers and consumers who are still bearing the brunt of private equity's abuse of the surprise billing arbitration system.

Conclusion

AHIP thanks the Subcommittee 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 access to high-quality care. AHIP looks forward to continuing to work collaboratively with the Subcommittee 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.

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[26] https://www.healthaffairs.org/content/forefront/independent-dispute-resolution-process-2024-data-high-volume-more-provider-wins

[27] https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process

CHILDREN'S HOSPITAL ASSOCIATION

March 18, 2026

Children's Hospital Association Statement for the Record U.S. House Energy and Commerce Subcommittee on Health: "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

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

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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.

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March 18, 2026

The Honorable Brett Guthrie
Chairman
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce

Re: Comments for the record for the March 18, 2026 hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chairmen Guthrie and Griffith, and Ranking Members Pallone and DeGette:

On behalf of the American Dental Association (ADA), the nation's leading voice for oral health, we appreciate the opportunity to provide comments for the record for the Subcommittee on Health hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape."[1]

Oral health must be part of any serious conversation about health care affordability. Oral disease is common, costly when left untreated, and closely linked to overall health, employability, school attendance, and quality of life. At the same time, the dental care delivery system differs in important respects from other provider sectors often examined in affordability debates. Many dentists practice in small, community-based settings and do not possess the scale, facility fee structures or market leverage associated with large, consolidated hospital systems. Congress should take care not to apply broad provider-side reforms in a manner that unintentionally undermines access to local oral health care.

The ADA respectfully urges the Committee to consider the following principles as it evaluates the provider landscape and options to lower health care costs.

Prevention and early intervention should remain central to affordability policy. Long-term health care cost containment is not possible without prevention. In oral health, preventive and diagnostic services can help patients avoid more extensive and costly restorative, surgical and emergency care later. Policies that reduce financial barriers to preventive dental services can improve health outcomes and lower downstream costs.

1. House Committee on Energy and Commerce, "Chairmen Guthrie and Griffith Announce Third Hearing in Series to Improve Health Care Affordability for All Americans," March 11, 2026. (House Committee on Energy and Commerce)

The ADA has consistently supported coverage of diagnostic and preventive services at 100 percent and without counting those services toward annual maximums.[2]

Patients need meaningful dental coverage, not merely nominal coverage.
For many families, the practical barrier to care is not simply whether they have a dental benefit, but whether that benefit provides meaningful financial protection when care is needed. Low annual maximums, deductibles, waiting periods, coinsurance requirements and service limitations can leave patients exposed to substantial out-of-pocket costs. Affordability policy should therefore focus on whether coverage is understandable, predictable and sufficient to support timely access to needed care.

Administrative burden and inefficiency raise costs for both patients and providers.
Provider affordability cannot be assessed solely by looking at reimbursement levels. Excessive administrative complexity, payment uncertainty and opaque coverage rules can increase costs throughout the system and interfere with timely care. A more affordable system should reduce unnecessary administrative friction and improve clarity and accountability for patients and providers alike.

Independent dental practices should not be conflated with large, consolidated provider systems.
As lawmakers examine provider-side drivers of health care costs, it is important to distinguish among sectors with very different cost structures and degrees of market power. Independent dental practices generally operate as small businesses embedded in local communities. Reforms aimed at addressing hospital consolidation, vertical integration, or other large-system dynamics should be carefully tailored, so they do not impose disproportionate burdens on community-based oral health care providers.

Competition and transparency matter, but policymakers should recognize where market concentration exists.
The Committee's review of affordability should include not only provider consolidation but also concentration in the markets that shape dental coverage and payment. In a report released this month, the U.S. Government Accountability Office found that private stand-alone dental insurance markets vary in concentration by state and that limited available research suggests more concentrated dental insurance markets may be associated with reduced reimbursements to providers. The GAO also reported that some dental industry stakeholders described concentrated markets as limiting providers' ability to negotiate contracts and reimbursement with insurers.[3] These findings reinforce the need for policymakers to promote transparency, competition and fair market functioning across the

2. American Dental Association, *Comments to House Energy and Commerce and Ways and Means on Dental Market Reforms and ERISA Transparency*, Jan. 22, 2026. (ADA)
3. U.S. Government Accountability Office, *Private Dental and Vision Insurance: Market Concentration Varied Among States*, GAO-26-107787, March 9, 2026. GAO found that private stand-alone dental insurance markets vary in concentration by state, identified limited peer-reviewed evidence suggesting reduced reimbursements in more concentrated dental insurance markets, and reported stakeholder observations that concentrated markets can limit providers' ability to negotiate contracts and reimbursement. (GAO)

broader dental care landscape, while preserving patient choice and access to independent community-based providers.

Affordability policy should strengthen access, not weaken it.
A narrow focus on reducing provider payments or adding compliance obligations can have the unintended effect of reducing participation, especially in underserved communities and among smaller practices with limited administrative capacity. True affordability means lowering costs for patients while sustaining the delivery system on which they rely for care.

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The ADA appreciates the Committee's attention to health care affordability and respectfully urges Members to ensure that oral health is part of this work. Dentistry should be included in the discussion, but independent dental practices should not be treated as interchangeable with large, consolidated provider systems. Done properly, affordability reform can promote prevention, improve transparency, reduce administrative waste, and support meaningful patient access to oral health care.

Thank you for your consideration of ADA's views on these important issues. We appreciate the Subcommittee's attention to policies affecting providers and patients, and we stand ready to serve as a resource as you continue this work. If you have any questions, please contact Natalie Hales, Senior Congressional Lobbyist, at halesn@ada.org.

Sincerely,

Richard J. Rosato, D.M.D.
President

Elizabeth Shapiro, D.D.S., J.D., C.A.E.
Interim Executive Director

Federal Cuts, State Choices, and the Future of Aging and Disability Care

Protecting Home and Community-Based Services for Older Adults, People with Disabilities, and Family Caregivers

Leela Berman, Kathy Mendes, Tory Cross, and Jaimie Worker

March 4, 2026

State lawmakers across the country are making high stakes budget decisions that will determine whether older adults, people with disabilities, family caregivers, and care workers can access and afford the care they need. These decisions come amid severe fiscal strain after federal legislation passed summer 2025, H.R. 1, cut more than $1 trillion from Medicaid, Medicare, the Affordable Care Act (ACA), SNAP, and other vital services cuts used to bankroll tax giveaways for the wealthy and big corporations and dramatically expand funding for ICE to violently target immigrants, making communities less safe. The consequences are cascading through state budgets, forcing difficult choices about health care, education, housing, and other core services.

Nowhere are the stakes clearer than in Medicaid.

Medicaid is critical across the lifespan and it's the only insurance that truly covers aging and disability care. These cuts would jeopardize coverage and access to care for older adults and people with disabilities at home and in their community, where most people want to receive it, and weaken support for family caregivers and care workers. As state legislators finalize budgets, leaders can protect care programs by prioritizing progressive revenue solutions that fund care instead of eliminating essential services people need to live, age, and work with dignity.

CARING ACROSS GENERATIONS

Medicaid Cuts Threaten Care Across the Lifespan

Medicaid, a state federal partnership, is one of the country's biggest lifelines covering nearly 80 million people nationwide, including two in five children and more than 40 percent of births. It also finances nearly three quarters of home and community based services (HCBS), helping 8.4 million older adults and people with disabilities to live and age in their own homes and communities. But demand far outpaces supply: more than 600,000 people remain on Medicaid waiting lists for HCBS. And for most people, there's no real backup Medicare's long term benefit is limited and private insurance is often unaffordable or inaccessible.

Under federal law, HCBS Medicaid HCBS is optional for states to provide. When states face budget shortfalls, they cannot cap mandatory Medicaid services so they cut optional ones. Historically, when faced with cuts to Medicaid, every state cut HCBS programs older adults and disabled people rely on. With older adults and disabled people accounting for more than half of Medicaid spending, HCBS are often first on the chopping block.

Caregivers and Care Workers Are Directly Affected

Medicaid also sustains the care workforce and supports family caregivers. HCBS programs provide the majority of funding for direct care workers, 37 percent of whom also rely on Medicaid for their own health coverage. Three in ten child care workers rely on Medicaid for health coverage. At least 13 percent of family caregivers depend on Medicaid for coverage. Family caregivers, whose unpaid care totals more than $1 trillion, are also often able to use HCBS programs to receive compensation for the care they provide for their loved ones. Moreover, at least 13% of family caregivers access their own health coverage through Medicaid. This year, the majority in Congress allowed tax subsidies for health insurance through the ACA to end, increasing health care costs for millions including older adults, people with disabilities, family caregivers, and care workers already stretched thin because of the lack of public investment in care. As a result, care is becoming less affordable precisely when families need more support.

States are Already Making Budget Cuts at the Expense of Care Recipients and Caregivers

CARING ACROSS GENERATIONS

Unlike the federal government, states are generally required to maintain balanced budgets. On average, Medicaid accounts for roughly one third of state budgets and federal dollars make up two thirds of state's Medicaid budget. Over half of states are projected to see federal spending reductions exceeding 13 percent over the next decade.

This summer's federal cuts combined with new administrative costs have created significant fiscal strain. This includes costs for states to implement harsh, ineffective work requirements that create barriers to care for caregivers and care recipients who are more likely to work unstable or part time hours because of care needs.

The impacts are well underway. Across the country, hospitals are being forced to close and some states are already eliminating vital Medicaid programs. More than 750 providers are likely to experience financial risk or closures with rural hospitals particularly vulnerable.

Older adults, disabled people, family caregivers, and care workers are paying the price. Even before the federal legislation passed, nearly a third of state Medicaid programs reported they were adopting new strategies to manage the costs of HCBS this year. Since cuts to Medicaid were signed into law in July, at least nine states have already proposed eliminating or reducing funding for home and community based services:

- In Idaho, the Governor proposed funding reductions to Medicaid HCBS programs.
- Colorado recently announced potential cuts to programs that support people with disabilities with services such as cleaning and cooking, as well as outings that promote engagement in community based settings.
- Washington state proposed higher eligibility standards for long term care that could take away support for employment, assistive technology, and skilled nursing services for people with disabilities, and is considering eliminating speech, physical, and occupational therapy services.
- California proposed several cuts to In Home Supportive Services, the state's largest HCBS program, including shifting certain program costs to localities and immediately terminating access to benefits if someone loses Medicaid coverage.
- The governors of Utah and Missouri respectively also proposed cuts to home and community based services.
- In Maryland, cuts were proposed to the Developmental Disabilities Administration, which helps administer Medicaid HCBS waivers including services for people with disabilities and their families to receive caregiver support, transportation, and respite care.

- In Nebraska, the Governor's original budget proposal included capping paid weekly hours for live in family caregivers and in North Carolina the governor initially proposed reducing reimbursement rates for service providers that utilize Medicaid.

However, people with disabilities, older adults, care workers, and family caregivers continue to push back against cuts to HCBS. In Colorado, the Governor proposed caps to family caregiver hours and tried to cut the rates that family caregivers are paid by Medicaid, but temporarily paused the cuts after powerful testimony from impacted families. In Nebraska, advocates successfully stopped the state from cutting the Aged and Disabled Waiver, which supports independent living. In North Carolina, the legislature's refusal to pursue stopgap funding in response to a Medicaid budget shortage resulted in decreased provider rates, which the Governor eventually rolled back after public outcry. These fights won't be one offs without action, states will face similar pressures year after year as federal changes take effect.

States also face ongoing federal threats to care under the current administration, including policies that are unfairly targeting immigrant communities and taking away essential care that allow older adults, people with disabilities, family caregivers, and care workers to live, age, and work with dignity. In February, the Center for Medicare and Medicaid Services (CMS) withheld more than $250 billion in Medicaid funds to Minnesota, including home and community based services, and directed the state to freeze new Medicaid provider enrollments. These threats compound the ongoing budget crisis and further raise the stakes in the fight for care.

Some States are Choosing a Different Path – Strategies for Prioritizing Public Dollars for Care

Despite challenges, several states are advancing solutions to preserve public dollars for care by shifting general funds, ending tax loopholes designed to benefit wealthy corporations, and raise new revenue. In 2025, New Mexico established a Medicaid Trust Fund as a safeguard against federal cuts and approved a $50 million transfer to the state's rural health care fund, providing funding to help people afford health insurance through the state's ACA marketplace. This helped broaden eligibility for state subsidized health care, and increased authority for state officials to protect residents' health care coverage if future federal action were to reduce access to Medicaid or the state's health care exchange.

In response to declining federal funding, Michigan's Governor Gretchen Whitmer proposed new and increased taxes on gaming, nicotine products, and digital advertising, that if approved, would to help close the state's $1.8 billion budget deficit created by H.R. 1 and protect care for people who rely on Medicaid across the state. Other states are considering more progressive revenue options. For example, Washington state lawmakers proposed a tax on annual earnings above $1 million, projected to raise $3.5 billion annually.
In several states, the rapid data center growth paired with unlimited state tax incentives are raising revenue concerns. Lawmakers are weighing reforms to curb subsidies, close loopholes to rein in the development of data centers and raise revenue by requiring corporations to pay their fair share.

The scale of federal cuts makes it difficult to keep communities out of harm's way, such as in Colorado, where lawmakers passed several bills ending tax breaks and loopholes for corporations, but ultimately reversed plans to increase reimbursement rates for health care providers who serve Medicaid patients. However, these measures demonstrate that budget gaps are not inevitable excuses for cutting care they are policy choices.

Families are Struggling to Afford Care and Need More Investments, Not Less.

The federal budget bill delivered substantial benefits to the wealthiest households and large corporations while shifting costs to states and families. Meanwhile, care costs continue to soar: in 2023, the median costs reached $68,640 for full time annual home health aide services and $288,288 for round the clock home health aide services. Family caregivers already spend more than a quarter of their income on caregiving expenses, even as direct care workers remain underpaid. Nursing home care is more expensive than home care, further driving up the costs of care for families struggling to make ends meet.

Federal and state budgets were already insufficient to meet growing care needs. Deepening cuts will only intensify the affordability crisis.

State policymakers face a defining choice. They can reduce life sustaining care to close budget gaps or they can champion new, progressive revenue solutions and protect the care that allows people to live, age, and work with dignity.

Families don t need less care. They need leaders willing to invest in it.

Hospital Medical Debt:
Aggressive Debt Collection Practices in 340B Hospitals Despite Higher Cancer Burdens

Hospital medical debt continues to pose significant challenges for patients across the US, particularly for those facing serious illnesses where medical care is unexpected, intensive, prolonged, and costly. Medical debt often arises from unplanned or unavoidable health needs, leading to substantial financial strain during an already challenging time.

Findings from a 2024 national survey by the National Consumers League (NCL) and Morning Consult show that nearly half of US adults have experienced medical debt, and among those with medical debt, 54% skipped needed follow-up care and 51% depleted most or all of their savings.[1] Research from the American Cancer Society Cancer Action Network similarly found that almost half of patients with cancer and cancer survivors incurred medical debt and that those with debt were three times more likely to fall behind on recommended screenings.[2]

The 340B Drug Pricing Program is a federal program that enables eligible hospitals and clinics serving a high percentage of low-income, uninsured, Medicare and Medicaid patients to purchase outpatient medications at reduced prices, with the expectation that the revenue from these drug sales will be used to improve and expand care for vulnerable populations. Oncology treatments account for a disproportionate share of drug utilization in the 340B Drug Pricing Program, with a Congressional Budget Office study finding that oncology therapies represent roughly 41% of all 340B purchases, nearly three times higher than any other therapeutic class.[3] In 2025, the Health Care Cost Institute published a report showing that close to one-third of infusions for Medicare-fee-for-service patients with blood cancer–related drug administrations between 2018 and 2022 occurred in 340B outpatient settings.[4]

Given the interdependent relationship between the 340B program and patients' access to cancer care, NCL has sought to better understand the extent to which 340B hospitals engage in medical debt practices affecting vulnerable patient populations and identify opportunities for improvement in debt collection processes.

This analysis examines if medical debt practices exist and intensify in hospitals with higher oncology volumes, the differences in debt practice behaviors between 340B and non-340B oncology care sites, and how debt practices may impact patients navigating both cancer treatment and financial hardship.

"Medical debt forced me to use work bonuses, start a GoFundMe, and withdraw from my 401k after cancer treatment. Bills went to collections, damaged my credit, and made it hard to get an apartment—despite care from a hospital meant to use 340B savings to help patients like me. No one should have to decide between choosing to fight for their life or worrying about the debt that comes with fighting for your life."

- Dr. Garrina Ross, Metastatic Breast Cancer Thriver and Tigerlily ANGEL Advocate

340B Hospitals Are More Likely to Adopt Medical Debt Collection Policies

Contrary to the presumption that 340B hospitals will utilize revenue from 340B-discounted drugs to improve the care and services provided to vulnerable populations, **findings from this analysis show that a higher proportion of 340B hospitals have medical debt collection policies compared with non-340B hospitals. These policies include legal actions,[5] such as lawsuits, liens, and wage garnishment, as well as credit reporting and care denial or deferral for unpaid bills.**

Across practices, 340B hospitals show a higher presence of medical debt policies, ranging from 36% to 75% compared with 23% to 62% in non-340B hospitals (Figure 1a).[6] This pattern is consistent when examining the types of legal actions that are allowed by hospitals (Figure 1b). Patients who rely on 340B hospitals tend to be medically and financially vulnerable, meaning that aggressive debt collection environments can heighten financial and emotional strain.

Figure 1a: Hospital Debt Practices for 340B vs Non-340B Hospitals

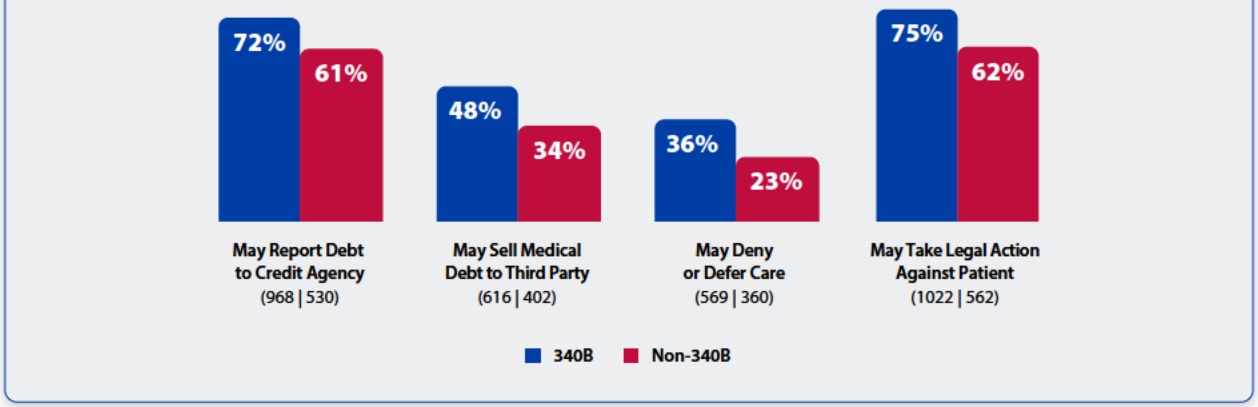
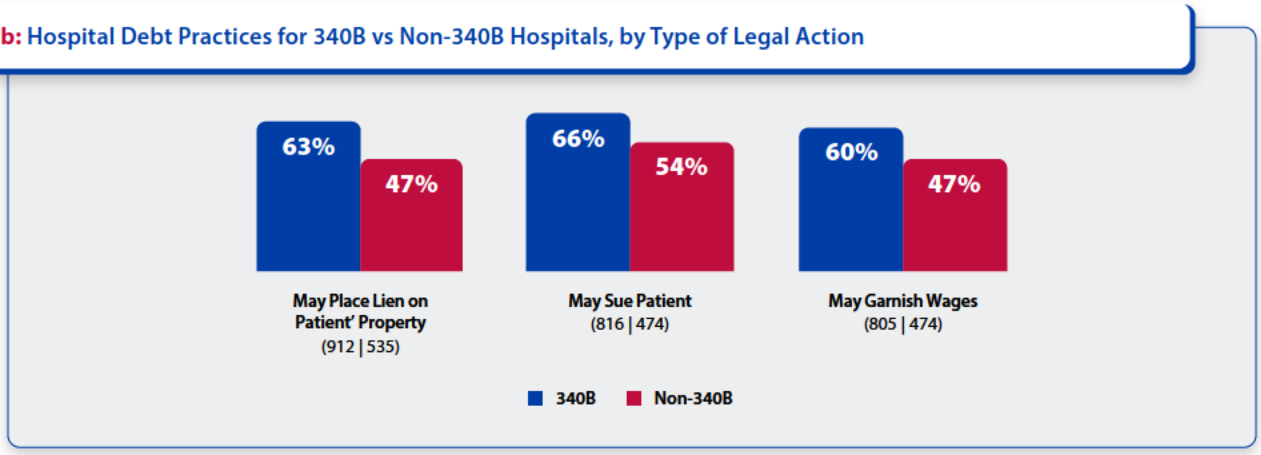


Figure 1b: Hospital Debt Practices for 340B vs Non-340B Hospitals, by Type of Legal Action



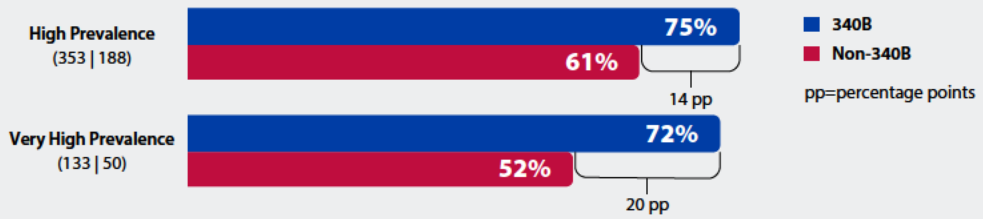
Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

Medical Debt Practices Persist in Hospitals With Higher Cancer Prevalence

Hospitals that treat larger cancer populations care for some of the most medically vulnerable individuals. Yet the analysis shows that medical debt practices do not abate in these settings. Instead, 340B hospitals with high cancer prevalence continue to exceed non-340B hospitals with similar cancer prevalence in the presence of debt collection policies.

Among hospitals with high cancer prevalence and very high cancer prevalence,[7] legal action policies remain notably more common in 340B hospitals. In high cancer prevalence hospitals, 75% of 340B hospitals allow legal action compared with 61% of non-340B hospitals. In very high cancer prevalence hospitals, the proportions are 72% versus 52%, respectively. The difference in the subset of hospitals with policies permitting legal action between 340B and non-340B hospitals is greater among very high cancer prevalence hospitals (20 percentage points) than among high cancer prevalence hospitals (14 percentage points), which shows that disparities in debt collection policies between these types of hospitals intensify at higher cancer burden (Figure 2a).

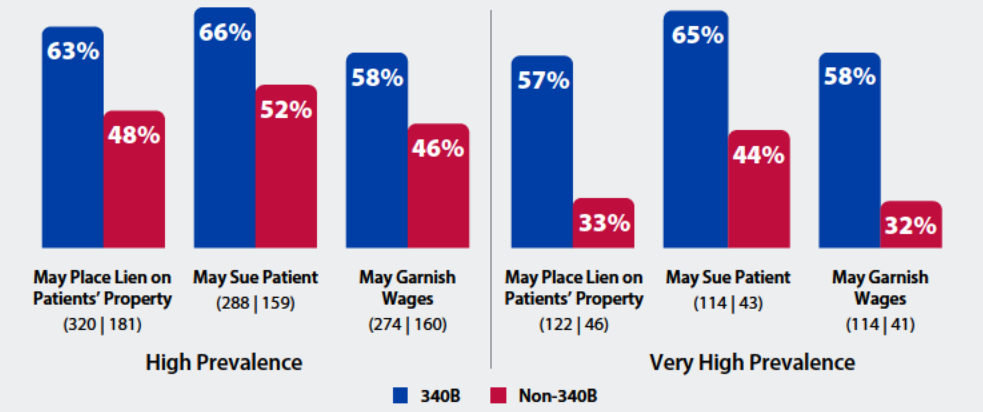
Figure 2a: Comparison of Hospitals That May Take Legal Action by 340B Status and Cancer Prevalence



Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

A similar pattern appears across specific legal actions, including liens, lawsuits, and wage garnishment, with 340B hospitals more likely to allow each practice than non-340B hospitals (**Figure 2b**). Legal action medical debt policies at 340B hospitals were consistent across hospitals with high (58% to 66%) and very high cancer burdens (57% to 65%). In contrast, non-340B hospitals were less aggressive in their legal action policies at hospitals with a very high cancer burden (32% to 44%) compared to those with a high cancer burden (46% to 52%) (**Figure 2b**). This demonstrates a consistent tendency for 340B hospitals to permit these legal actions at higher rates, regardless of cancer prevalence in the communities they serve.

Figure 2b: Comparison of Legal Action Medical Debt Practices by 340B Status and by High and Very High Cancer Prevalence



Hospital counts are displayed in parentheses in the format (340B | non-340B), where the first value represents 340B hospitals and the second represents non-340B hospitals.

Implications

These findings highlight a set of important implications for policymakers and patient advocacy organizations. First, although 340B hospitals are intended to serve as safety-net institutions, many continue to maintain debt collection policies that expose low-income and medically vulnerable patients to financial hardship. This exposure is even more concerning in oncology-heavy settings where continuity of care and timely treatment are essential.

Second, financial strain caused by aggressive collection practices may disrupt care. Patients managing cancer treatment who fear debt, lawsuits, or damaged credit may delay or avoid follow-up appointments and ongoing monitoring, risking poorer health outcomes.

Finally, the evidence points to a structural misalignment within the 340B program. While the program is intended to enhance access and affordability for underserved patients, many participating hospitals continue to have debt collection practices that compound financial hardships and may impede treatment and recovery. This contradiction demands policy attention, including transparent reporting requirements and clearer expectations to ensure that 340B program benefits contribute directly to reducing and not exacerbating the financial burdens of the populations the program is meant to serve.

Policy Recommendations

- Improve and expand provider financial assistance programs, including through enhanced financial assistance screening and transparent billing
- Establish enforceable charity care requirements for 340B hospitals to ensure savings from the program are appropriately reinvested into services that benefit vulnerable patients
- Incentivize Medicaid expansion in states that have not yet expanded
- Support federally qualified health centers rendering no or low-cost services, including preventive care and cancer screenings, to low-income patients
- Prohibit aggressive debt practices at 340B hospitals, including banning care denial subsequent to existing medical debt
- Prohibit the transfer of spousal medical debt
- Consider proposals to reduce medical debt for patients at both the state and federal levels
- Exclude medical debt from credit decisions

Methodology

The following datasets were used for this analysis: Lown Institute Hospital Financial Assistance, Billing, and Collection Policy Dataset (current as of 9/30/25),[8] national open claims database (dates of service from July 1, 2022, to June 30, 2025), Health Resources and Services Administration (HRSA)'s 340B Office of Pharmacy Affairs Information System (OPAIS) database (current as of 7/1/25),[9] Centers for Medicare and Medicaid Services (CMS) Hospital General Information database (current as of 7/16/25),[10] CMS Inpatient and Outpatient Provider Specific Data (last modified July 2025),[11] and CMS Hospital Enrollments File (last modified September 2025).[12]

Medical debt collection information was sourced from the Lown Institute's research on hospitals' financial assistance, billing, and debt collection policies and practices. As of September 2025, this database includes information on 2500 hospitals compiled from publicly available online policy information and verified, when possible, through direct outreach to each hospital. Numbers in this analysis may differ from the first because the dataset was expanded to 2500 hospitals, compared with 1250 in the original analysis. The data have evolved due to a combination of factors, including data completeness, evolving reporting by hospitals, and changing debt collection practices. This study cannot verify the extent to which each of these factors contributed to the updated results. If a hospital has a policy but states that it does not take action, then it was classified as not having the practice. All percentages were rounded to the nearest whole number.

Cancer prevalence for each hospital was estimated using a national open claims database and defined as the proportion of patients treated for cancer within a hospital's overall patient population during the study period. Hospitals with at least 100 patients were included and grouped into four cancer prevalence categories: low, moderate, high, and very high. The very high category represented the top 10th percentile, and the remaining hospitals were evenly distributed among the other three categories.

Limitations

There are several limitations to this study. This analysis includes only approximately 40% of US hospitals.[13] While the initial data collection had been completed, the Lown Institute continuously maintains the database and updates the data as hospital medical debt collection practices change over time. Another limitation is that percentages represent only hospitals with available or verified information for the particular medical debt policy reported. Hospitals missing information for a category were excluded from that calculation, even though they might use specific policies. One important distinction is that the findings indicate whether hospitals maintain policies that allow debt collection actions, not how frequently those policies are enforced. For more information about the Lown Institute's research and data collection methodology, please see the Lown Institute's "Hospital Billing and Collection Practices, a National Data Set" website.[14]

Citation

National Consumers League. January 2026. *Hospital Medical Debt: Aggressive Debt Collection Practices in 340B Hospitals Despite Higher Cancer Burdens*. [Issue Brief].

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1. https://nclnet.org/wp-content/uploads/2025/05/NCL-Medical-Debt-and-340B-National-Survey.pdf **2.** https://www.fightcancer.org/sites/default/files/medical_debt_factsheet_5-9-24_update.pdf **3.** https://www.cbo.gov/system/files/2025-09/60661-340B-program.pdf **4.** https://healthcostinstitute.org/all-hcci-reports/drug-administration-shifted-toward-outpatient-departments-especially-to-340b-hospitals/ **5.** Legal action includes placing liens on homes, filing lawsuits, and garnishing wages. In the Lown Institute research, if a hospital's medical debt policy included taking any legal action, then the follow-up policies around liens, lawsuits, and wage garnishment were reviewed. **6.** Differences in counts and percentages compared with the original issue brief are due to an expanded and updated dataset; the current analysis includes 2500 hospitals, whereas the initial brief was based on 1250. The data have evolved due to a combination of factors, including data completeness, evolving reporting by hospitals, and changing debt collection practices. This study cannot verify the extent to which each of these factors contributed to the updated results. **7.** Cancer prevalence reflects the proportion of patients treated for cancer based on a national open claims database. Hospitals with at least 100 patients were grouped into four tiers; "very high" represents the top 10%, with the rest evenly divided among low, moderate, and high. **8** https://lownhospitalsindex.org/report-hospital-financial-assistance-and-debt-collection-policies **9.** https://340bopais.hrsa.gov/home **10.** https://data.cms.gov/provider-data/dataset/xubh-q36u **11.** https://www.cms.gov/medicare/payment/prospective-payment-systems/provider-specific-data-public-use-sas-format **12.** https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-enrollments **13.** https://www.aha.org/statistics/fast-facts-us-hospitals **14.** https://lownhospitalsindex.org/report-hospital-financial-assistance-and-debt-collection-policies

Analysis conducted by Magnolia Market Access.

Explainer: CMS's Deferral, Disallowance, and Withholding Actions in Minnesota

Steven Schmidt, Senior Attorney, National Health Law Program

I. Introduction

The current administration has set forth its intention to eliminate "Fraud, Waste and Abuse" (FWA) in the Medicaid program. As part of this effort, the Centers for Medicare and Medicaid Services (CMS) has engaged in multiple drastic actions against Minnesota's Medicaid program, including initiating the process to withhold federal Medicaid funding and deferring federal reimbursement for claims the State has submitted. CMS's efforts are an unprecedented and indiscriminate attack on Minnesota's Medicaid program that have put potentially billions of dollars of federal Medicaid funding at risk. The nature of these actions, along with unclear statements from federal officials, have led to confusion as to what has already happened and what could happen to Minnesota's Medicaid funding. This explainer seeks to clarify what has already occurred and how the ongoing disputes may play out.

II. Deferral, Disallowance, and Withholding

Historically, CMS has worked collaboratively with states to identify FWA in the Medicaid program. Nevertheless, federal law provides CMS with various mechanisms to act more aggressively, in particular to deprive states of federal funding if they are not operating their Medicaid programs in accordance with federal law. CMS is using two of these mechanisms in Minnesota: the deferral and disallowance process, and the withholding process.

A. Deferral and Disallowance

CMS may refuse to provide federal financial participation (FFP), which is the funding that the federal government provides to the state for Medicaid, if an expenditure is not allowable under law. CMS accomplishes this through the "deferral and disallowance" process. The "deferral and disallowance" process is used for service claims that have already occurred and that the state has submitted to CMS for federal matching funds.

Under this process, CMS first notifies the State that it is questioning the allowability of a claim and that it needs additional information to determine if the claim should be paid.[1] The burden is then on the State to show that the claim is allowable.[2] The State has 60 days (120 days, if it requests an extension) to submit documentation to CMS to show that the claim is allowable.[3] CMS has 90 days to review the documentation and determine whether to pay or disallow the claim.[4]

If CMS disallows the claim, it must send a proper notice explaining the reasons it believes the claim is improper.[5] Within 60 days of that notice, the State may request that CMS reconsider its decision.[6] If the reconsideration is unsuccessful, the State may file an appeal with the Department of Health and Human Services' Departmental Appeals Board (DAB), which must engage in an independent and impartial review of the decision.[7] If the DAB upholds the disallowance, the State may seek judicial review of the decision in federal district court.[8]

The deferral and disallowance process is a relatively common process that CMS has employed in the past. At least 14 states have contested disallowances proposed by CMS in front of the DAB over the last five years.[9]

B. Withholding

The other process that CMS is using to deny federal funding is known as a withholding, or a compliance action. Under this process, CMS withholds future FFP because of a state's failure to substantially comply with the Medicaid Act.[10] Noncompliance may occur if a State makes an unapproved change to its Medicaid state plan or if fails to "actually comply" with federal requirements, regardless of the contents of the state

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[1] 42 C.F.R.§ 430.40(b)(1).
[2] *Id.* at § 430.40(b)(2).
[3] *Id.* at § 430.40(c)(1).
[4] *Id.* at § 430.40(c)(5).
[5] *Id.* at § 430.42(a).
[6] *Id.* at § 430.42(b). The state may also file an appeal directly to the DAB without going through the reconsideration process. *Id.* at § 430.42(b)(4).
[7] *Id.* at § 430.42(f). *But see Texas v. Brooks-LaSure*, 680 F. Supp. 3d 791, 806 (E.D. Tex. 2023) (holding that the availability of an administrative review process by the DAB did not bar Texas' claim under the Administrative Procedure Act).
[8] 42 U.S.C. § 1316(e)(2)(C).
[9] *See* Andy Schneider, Ctr. for Chil. and Fams., Georgetown Univ., *CMS Weaponize Fraud Against Medicaid in Minnesota*, (Jan. 16, 2026), **https://ccf.georgetown.edu/2026/01/16/cms-weaponizes-fraud-against-medicaid-in-minnesota/**.
[10] 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(a).

plan.[11] In these circumstances, CMS may withhold all or part of the federal payments due to the State until the CMS Administrator is satisfied that the State is in compliance with federal law.[12]

Withholding of payments under this provision of law may only occur after CMS has given the State reasonable notice and opportunity for a hearing.[13] If the State files an appeal, a hearing is conducted by the CMS hearing officer under a specific set of federal regulations.[14] Following the hearing, the CMS Administrator may accept or reject the hearing officer's decision.[15] The withholding does not occur until the Administrator issues his final decision.[16] The State may appeal an adverse decision to U.S. Circuit Court of Appeals for the circuit in which the State is located.[17]

The withholding process is much less common than the deferral process.[18] The regulations themselves note that a hearing under this section is "generally not called until reasonable effort has been made to resolve the issues through conferences and discussions."[19]

III. Actions in Minnesota

The Administration has chosen to use both the deferral and disallowance process and the withholding process in Minnesota. The combined effect of these actions could deprive the State of billions of dollars of Medicaid funding.

A. January 2026 Withholding Notice

Beginning in July 2024, CMS started working with Minnesota to address fraud concerns in its Medicaid program.[20] Between July 2024 and December 2025, CMS and Minnesota

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[11] 42 C.F.R. § 430.35(b)(c).
[12] *Id.* at § 430.35(d)(2).
[13] *Id.* at § 430.35(a).
[14] *See id.* at §§ 430.60 – 430.104.
[15] *Id.* at § 430.102(b).
[16] *Id.* at § 430.35(d).
[17] *Id.* at § 430.38. That appeal may include a requirement that the adverse decision be stayed pending the conclusion of the appeal.
[18] *See* Allison Buffett et al., Bipartisan Policy Ctr., *Medicaid Payment Deferrals: What They Are and How They Work*, (Mar. 4, 2026), **https://bipartisanpolicy.org/explainer/medicaid-payment-deferrals-what-they-are-and-how-they-work/**.
[19] 42 C.F.R. § 430.35(a).
[20] *See* Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act, 91 Fed. Reg. 1539 (Jan. 14, 2026) [hereinafter "*Withholding Notice*"].

worked collaboratively to address these concerns, as is the typical process for these issues. As part of this effort, Minnesota identified 14 Medicaid services as potentially "high risk" for fraud, and eliminated one of those services from its program.[21] In response to a letter from CMS on December 5, 2025, Minnesota submitted a corrective action plan (CAP) to CMS on December 31, 2025, that outlined additional steps that Minnesota intended to take to address fraud issues in its Medicaid program.[22]

Rather than continuing to engage with the State in cooperative federalism to address fraud concerns, CMS chose to pursue an aggressive and direct attack on Minnesota's Medicaid funding. On January 6, 2026, CMS sent the State a notice of its intention to withhold millions of dollars of Medicaid funding. The notice, formally published in the Federal Register on January 14, 2026, states that "CMS has found that Minnesota's policies, practices, and oversight mechanisms violate [42 U.S.C. § 1396a(a)(64)], which requires states to ensure their state plans provide mechanisms to receive reports of alleged FWA and to compile and analyze related data."[23] CMS also concluded that "Minnesota's policies, practices, and oversight mechanisms violate federal regulations at 42 CFR Part 455, Subpart A, which require states to implement methods for identifying, investigating, and referring suspected Medicaid fraud . . . ."[24] The notice states that these findings are "the basis for withholding federal financial participation (FFP) from Minnesota's Medicaid program" and that "[t]he withholding will end when the Minnesota Medicaid agency fully and satisfactorily implements a corrective action plan (CAP) to bring its program integrity operations into compliance with federal requirements."[25] CMS estimated the withholding amount to be approximately $515 million per quarter, or $2 billion per year, which is based on "the federal share for one quarter's amount of the previous calendar year's annual total paid expenditures for the fourteen high-risk services."[26]

In addition, the notice explained that CMS intended to "take additional steps . . . to conduct reviews of state expenditures" of the 14 Medicaid services identified by the State. The notice stated that "CMS intends to issue deferral or disallowance of any FFP claimed by the state that does not meet applicable federal requirements."[27] The review process appeared to occur over the months of January and February 2026, leading to a second notice at the end of February.

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[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 1542.
[27] *Id.*

B. February 2026 Deferral Notice

On February 25, 2026, CMS provided notice to Minnesota "of four deferrals totaling $259,505,491 federal financial participation (FFP)" for "expenditures claimed on Form CMS-64 for the quarter ending September 30, 2025, certified on December 30, 2025."[28] CMS deferred approximately $15.4 million in Medicaid expenditures for services to "individuals lacking a satisfactory immigration status" and approximately $243.8 million in claims related to the 14 "high-risk" Medicaid services.[29] Of the $243.8 million, approximately $164 million involve claims from "other practitioner, personal care, and home and community-based services lines that have questionable variances and raise concerns about allowability of the claimed expenditures," while approximately $79.5 million involve claims "submitted to the state by specific providers that CMS have identified as high-risk for fraud or aberrant billing practices."[30] Thus, it appears that the deferral may be an attempt to work around the withhold process and allow CMS to divest the State of funding without delay. In accordance with federal regulations, Minnesota was given 60 days to provide documents and materials so that CMS can "make a proper determination on the allowability of the claim."[31]

The February 25, 2026, deferral notice is highly unusual for multiple reasons. First, the deferral that Minnesota faces is much larger in amount and scope than other deferrals that CMS has issued in the past. According to the Center on Budget and Policy Priorities' review of decisions of the DAB over the past 10 years, "the deferral amounts leading to disallowances ranged from $2.4 million to $43.7 million."[32] In addition, the deferrals are typically targeted to instances where there is a question of whether a particular claim is allowable under Medicaid, and detailed notice is often provided to the state Medicaid agency on what additional documentation is needed. In this instance, CMS is targeting a broad array of services that Minnesota previously identified, and the only rationale it

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[28] *See* Letter from Dorothy Ferguson, Dir., Div. of Fin. Operations W., Ctr. for Medicaid & CHIP Servs., to John Connolly, State Medicaid Dir., Minn. Dep't of Hum. Servs., (Feb. 25, 2026), **https://www.documentcloud.org/documents/27420090-cms-medicaid-deferral-letter-q4-2025/**) [hereinafter "*Deferral Notice*"].

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *See* Andy Schneider, Ctr. for Chil. and Fams., Georgetown Univ., *CMS Weaponize Fraud Against Medicaid in Minnesota: Part 2*, (Mar. 2, 2026), **https://ccf.georgetown.edu/2026/03/02/cms-weaponizes-fraud-against-medicaid-in-minnesota-part-2/**.

has provided to support the deferral is that the claims at issue have "questionable variances" or are from providers who CMS has "identified as high-risk for fraud."[33]

C. Next Steps

As noted above, both the withholding and deferral and disallowance processes allow states to challenge CMS's determinations, and Minnesota will do so. On January 9, 2026, Minnesota filed an administrative appeal of the January 6, 2026, withholding notice.[34] As of this writing, an appeal hearing has not been scheduled. The regulations governing the appeal process give parties "the right to conduct discovery (including depositions) against opposing parties."[35] We understand that Minnesota does plan to conduct discovery, so it is likely that a hearing may not occur for several months.

With respect to the deferral and disallowance process, Minnesota has until April 26, 2026, to submit its documentation to dispute CMS's claims regarding unallowable expenses. Assuming all documentation is in a reviewable form, CMS would then have until July 25, 2026, to determine the allowability of the claim. This timeline could be delayed if Minnesota requests an extension or if CMS determines that the documentation is not in a reviewable form. If CMS decides to issue disallowances following its review of the documentation, the reconsideration process would push into the later part of 2026, with an appeal to the DAB and potentially further appeal to federal district court to follow.

Minnesota is also challenging the deferral action through affirmative litigation in federal court. On March 2, 2026, the State filed a lawsuit in the U.S. District Court of Minnesota against CMS, HHS, and the heads of both agencies, alleging that the deferral action violates numerous provisions of federal law.[36] Specifically, Minnesota has asserted that the Defendants have violated the procedural due process requirements of the Fifth Amendment, the Administrative Procedure Act, the Spending Clause, and that the action was ultra vires.[37] Minnesota has filed a motion for a Temporary Restraining Order (TRO), which asks the court to enjoin Defendants from immediately deferring over $243

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[33] *See Deferral Notice*.
[34] *See* Letter from John Connolly, State Medicaid Dir., Minn. Dep't of Human Servs. to Mehmet Oz, M.D., Adm'r, Center for Medicaid & Medicare Servs., (Jan. 9, 2026), **https://interactive.kare11.com/pdfs/DHS-appeal-to-CMS-action.pdf**.
[35] 42 C.F.R. § 430.86
[36] Compl., *State of Minn. et al. v. Dr. Mehmet Oz et al.*, 26-cv-01701 (D. Minn., Mar. 2, 2026), **https://www.ag.state.mn.us/Office/Communications/2026/docs/01701_Oz_Complaint.pdf**.
[37] *Id.*

million in Medicaid funding. The TRO motion will be heard on March 12 and is likely to be decided quickly.

It is possible that CMS and Minnesota could resolve the withholding and deferral (and potential disallowance) with a CAP. Minnesota submitted a revised CAP to CMS at the end of January 2026, which is currently under review. The withholding notice explains that the "withholding will end when the Minnesota Medicaid agency fully and satisfactorily implements a corrective action plan (CAP)."[38] Therefore, if CMS accepts Minnesota's revised CAP, the withholding process will presumably not go forward. It is less clear whether a CAP would also resolve the deferral, as CMS could still pursue disallowances even if Minnesota has an acceptable CAP in place.

One crucial question is when exactly Minnesota will be deprived of FFP. The withholding process cannot go forward until CMS has provided Minnesota with a hearing and issued a final decision, and thus the $515 million quarterly withholding should not occur for several months.

However, the deferral process results in an immediate delay of FFP to Minnesota. If CMS determines not to go forward with the disallowance process, Minnesota will eventually receive FFP for the quarter ending September 30, 2025, although it is difficult to estimate exactly when that would occur. However, if CMS decides to move forward with a disallowance and the federal court does not grant Minnesota's request for an injunction in its affirmative litigation to stop the process, Minnesota will not receive the FFP for the quarter ending September 30, 2025, unless the state is successful in the reconsideration, DAB, or federal court appeal processes. In that circumstance, it could be months, or potentially years, before Minnesota receives FFP for those service claims if it is ultimately successful on appeal.

IV. Conclusion

The actions that the administration has taken against Minnesota's Medicaid program are unprecedented in scope and have the potential to severely disrupt the provision of Medicaid services to Minnesotans. Significantly, Minnesota is not the only state being targeted by the administration, which has indicated that it plans to take similar actions against other states. Indeed, several states have already been targeted, with California, Maine, and New York having received letters from CMS raising concerns with FWA in the operation of their Medicaid programs. As in Minnesota, the same or similar home and community-based, behavioral health, and transportation services are targeted. Consequently, advocates should continue to pay attention to CMS's actions toward Minnesota, as they could have ripple effects for Medicaid programs across the country.

[38] *See Withholding Notice.*

NAMI News

Statement of Leading Mental Health and Substance Use Disorder Organizations on Medicaid

NAMI | March 17, 2026

House Energy and Commerce Committee, O&I Subcommittee "Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud"

The undersigned national organizations represent people with mental health and substance use disorders, family members, mental health and addiction providers, advocates, and other stakeholders who recognize the importance of efforts to maintain program integrity for Medicaid and all programs funded at taxpayer expense. Claims of fraud, waste, abuse, or improper payments should always be investigated, but broadly undermining the Medicaid program does not address these and only harms Americans, particularly those with mental health and substance use disorders. We urge Congress not to make further cuts to Medicaid, which will harm individuals who depend on lifesaving care.

Our nation is already bracing for the impact of the nearly $1 trillion of Medicaid cuts resulting from passage of Pub. Law 119-21 (H.R. 1 or OBBBA), which the Congressional Budget Office (CBO) projects will result in **10 million people** becoming uninsured, including 7.5 million losing Medicaid coverage. Additional cuts to Medicaid will exacerbate this damage, especially for the **nearly 40%** of Medicaid enrollees with mental health (MH) conditions and/or substance use disorder (SUD). In the midst of our ongoing **MH crisis** and **opioid overdose public health emergency**, we need to stop cutting off access to the services and supports people need.

More Medicaid cuts will reduce access to lifesaving services. Congress and the Centers for Medicare and Medicaid Services (CMS) have made laudable progress in helping the most vulnerable people in our country access health care by expanding eligibility, MH/SUD parity protections, and coverage of medications for opioid use disorder in Medicaid. But now, Congress and CMS are targeting numerous states' Medicaid funding under the guise of investigating fraud. This unprecedent approach will not address program integrity: instead it prevents states from delivering the lifesaving care that Medicaid recipients need. This broad and untargeted strategy will harm the very people that Medicaid is intended to help, particularly the community our organizations represent and serve. Further, this strategy is unlikely to save costs, as cutting critical services will result in expensive and avoidable hospitalizations, emergency room stays, nursing facility admissions, and other costly interventions

Rather than protecting people with MH conditions and SUD, these cuts directly target them. When passing Pub. Law 119-21, members of Congress kept repeating

they were not going to cut care for people with MH conditions, SUD, and/or disabilities. However, the very services Congress and CMS are targeting are those that people with these conditions rely on to stay healthy and remain in their homes and communities. Our organizations can point to thousands of stories of people with **MH conditions** and **SUD** whose lives were saved because they had Medicaid, not the least of which because Medicaid has the highest rates of treatment access of quality care for **MH conditions** and **opioid use disorder** compared to other types of insurance. Congress and CMS cannot purport to be protecting individuals with these conditions while their current actions attack the services they need.

Although deaths of despair in this country have declined somewhat recently, we are still losing more than 200 people a day to drug overdose and nearly 135 people a day to suicide. Access to MH and SUD care couldn't be more important. We urge Congress not to make further cuts to Medicaid under the pretext of combatting fraud and abuse. Instead, we believe CMS should partner with states and stakeholders to continue to improve access to lifesaving MH and SUD care.

If you would like to discuss our comments, please contact Deb Steinberg at **dsteinberg@lac.org** and Jennifer Snow at **jsnow@nami.org**.

American Association on Health and Disability
Bazelon Center for Mental Health Law
Lakeshore Foundation
Legal Action Center (LAC)
National Alliance on Mental Illness (NAMI)
National Association for Rural Mental Health (NARMH)
National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD)
NHMH – No Health without Mental Health
SMART Recovery
The Jed Foundation
Treatment Communities of America

The state of our nation's children is dire: homelessness is rising rapidly among infants and toddlers, child poverty has nearly tripled in recent years, more than half of Americans live in a child care desert, children's uninsurance is on the rise reversing decades of progress, and the federal government recently passed the largest cut in history to Medicaid and food assistance, which millions of children depend on for health care and nutrition. Countless children across the country already do not receive the services they are eligible for and entitled to. And what are the nation's leaders doing about this? Weaponizing the specter of fraud in federal programs by looking under rocks for scandal and harming children in the process.

The true scandal, however, is the federal government's failure to address child well-being and ensure all children and their families have access to the services they need, deserve, and for which they are eligible under federal and state law. In Fiscal Year 2025, the share of spending on children fell to a mere 8.57%, meaning that for every $100 spent by the federal government, just $8.57 went toward meeting the needs of children. And the Trump Administration is inflicting real harm on millions of children by withholding and threatening to eliminate federal funds they depend on for health care, child care, and their well-being.

Children lose at every level when funding freezes or threats of them disrupt the support they rely on, and when officials spend their time debating minimal levels of fraud instead of addressing real needs. The Administration's efforts have unfairly taken food from children, limited their access to education, and made it more difficult to receive health care.

Long-standing policies and procedures throughout all federal programs already address fraud risks, including government-wide reviews for improper payments and requirements to take corrective actions to address their findings. Fraud requires intentional deception, while improper payments are payments that should not have been made, were made in the wrong amount (too little or even too much), or that lacked sufficient supporting documentation. The purposeful conflation of fraud and improper payments creates a disproportionate response to minimal levels of wrongdoing in our government programs and results in children not getting the benefits they need.

CHILD CARE

Federal funding for child care flows to states through the Child Care and Development Fund (CCDF), which includes the discretionary Child Care and Development Block Grant (CCDBG) and the mandatory Child Care Entitlement to States. The federal government and states have regular review processes in place and are continually sharing lessons learned and system improvements to tracking spending in child care under these programs, which has resulted in over **96% of federal child care payments being made correctly under CCDF**.

The true emergency in child care are the millions of children and their families who are not receiving services they are eligible for, and the poverty-level wages that professionals are paid to care for our children. Child care provides families with the opportunity to work or study; supports an early learning workforce; and supplies crucial infrastructure for the U.S. economy. However, of the nearly 6.3 million children ages 5 and under whose families qualify for CCDBG, fewer than 840,000 receive it (or approximately 13%). Only one-third of eligible Head Start and 11% of eligible Early Head Start children receive services. Child care continues to be an enormous expense that many families cannot afford. In 2024, the cost to a family of child care for two children in a center was more than annual mortgage payments in 45 states and the District of Columbia, and the cost of child care for an infant at a center was more than in-state tuition at a public university in 41 states and D.C.

Consulting with providers and families to find out what their experiences are offers the best way to determine whether federal programs such as CCDF are operating as they should. Child care providers in Michigan are doing just that — conducting their own audit to find out what their providers and teachers do to keep the child care system running. So far this audit has revealed that underpaid early educators are footing the federal government's unpaid bills: the government owes providers hundreds of thousands of dollars in payments that are late or caught in red tape and

current federal subsidy payment rates are inadequate, forcing providers to personally finance the purchase of equipment, food, and other necessary supplies.

The Administration also has fired significant numbers of federal child care staff this year, and unspecified new requirements for all states to justify their child care spending have already resulted in missed payments to providers. A proposed rule by the Department of Health and Human Services would roll back important policies that make running a child care business viable and care affordable for families. These efforts cumulatively hurt children, their families, and child care providers and professionals without delivering efficiencies that the Administration professes to be searching for.

MEDICAID

In 2025, more than 9-out-of-every-10 Medicaid payments were made correctly, according to federal audits of the 56 state and territorial programs. This data is available because the federal government and a multitude of state partners have long-standing and wide-ranging efforts to identify and reduce improper payments in federal programs, and Medicaid is no exception. For decades, the Centers for Medicare & Medicaid Services (CMS) and state Medicaid programs have carried out federal requirements to regularly improve the integrity of their programs under the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs. Under PERM and MEQC, CMS and states continuously run three-year-long cycles of Medicaid audits, make reports to Congress, and agree on corrective action plans to prevent and reduce improper payments. Overwhelmingly and consistently, this process has revealed that the vast majority of Medicaid payments are made properly — 93% in FY 2025 — and the vast majority of identified Medicaid improper payments are due to insufficient documentation — 77% in FY 2025 — which, according to CMS, is not indicative of fraud or abuse.

By refusing to pay more than $250 million in federal funds it owes Minnesota's Medicaid program this month, the Administration made clear it does not actually understand how Medicaid works. Medicaid is a jointly financed federal-state partnership in which the state estimates costs, pays claims, and reports its costs to the federal government. The federal government provides its share of the costs — generally 50-83% of the state's expenditures — to the state on a rolling basis, making it possible for the state to continue paying claims. As a result, CMS' deferral of payments to Minnesota's Medicaid program simply makes it more difficult for the state to pay for care being provided for its 1.3 million Medicaid enrollees, including nearly 600,000 children, whose need for care continues. The Administration's approach also makes it more difficult for the state to fund its ongoing program integrity efforts — the same efforts that ensure the overwhelming majority of Medicaid payments are made properly. What Minnesota and other states really need from their federal partners are increased coordination and support for their continuous and rigorous program integrity activities. Abruptly stopping payments to the state does nothing more than jeopardize the

integrity of a critical safety net program, the trust and partnership between the federal government and states, and the health of more than half a million children in the state of Minnesota.

When implemented carefully, joint federal and state program integrity efforts strengthen Medicaid by ensuring that eligibility determinations are made correctly, enrolled providers meet federal and state requirements, and payments are made in the correct amount and for appropriate services. However, when baseless allegations are used as a weapon to freeze essential Medicaid funds, it can cause great harm to children and other populations that rely on Medicaid and impede the multitude of ongoing federal and state efforts to improve program integrity.

THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Though the public narrative used to justify deep cuts to SNAP in H.R. 1 focused on "reducing fraud," the law's statutory trigger penalizes states for exceeding a payment error rate — a measure that captures administrative inaccuracies, not intentional wrongdoing.

Even if a family receives less than they're entitled to, this still accrues to the error rate. Underpayments in SNAP can occur when income is miscalculated, deductions (such as child care or shelter costs) aren't properly applied, a caseworker makes a data entry error, or documentation isn't processed in time for the correct benefit level to be issued. Because many SNAP households have fluctuating earnings, even small timing discrepancies can affect the benefit formula.

Though SNAP overall has high payment accuracy, nationally, about 1.7% of total SNAP benefits were underpaid — meaning eligible families were shortchanged compared to what federal rules say they should have received. In most states, underpayments make up a much smaller share of the total error rate than overpayments, but they are present everywhere. In human terms: when policymakers cite the "error rate," they are talking about a number that includes cases where families were denied part of their food assistance. The same metric used to justify crackdowns also captures mistakes that hurt children and families.

Prior to the passage of H.R. 1, 12% of eligible people already did not receive the SNAP benefits to which they were entitled. With states soon to be financially penalized for higher error rates under H.R. 1, they are expected to tighten verification, increase documentation requirements, slow approvals, reduce benefits, or drop out of SNAP entirely. Those steps may reduce measurable errors, but they will also make it harder for otherwise eligible children and their families to put food on the table. Continued Congressional attacks on SNAP could make it even harder for states to deliver SNAP benefits to eligible children and families.

Meanwhile, Congress and the Trump Administration have failed to permanently address skimming — *actual* fraud being perpetrated *against* SNAP beneficiaries. Skimming is a type of theft in which criminals target the Electronic Benefit Transfer (EBT) cards that SNAP participants use to steal their benefits. In this scheme, the thieves install illegal devices on point-of-sale terminals (or similarly capture card data from an ATM or swipe machine) so that when a SNAP recipient swipes their card, the skimmer captures the card number, PIN, and other data. The criminals then use that information to duplicate the card and drain the victim's SNAP account, leaving families without the food assistance they depend on. Unlike most improper payment errors, which generally are accidental administrative mistakes, skimming is *actual fraud*, which Congress and the Trump Administration have both failed to take permanent steps to prevent. Because EBT cards generally lack the security protections of typical debit or credit cards, beneficiaries often have no built-in legal recourse to recover stolen benefits — which Congress should provide.

CONCLUSION

If lawmakers are looking for a scandal, they should focus on the benefits their constituents are eligible for but not receiving — an access gap that will only widen under H.R. 1 and the exaggerated claim that millions of Americans are stealing from their own benefit systems.

The Administration and Congress could be spending their time and resources improving critical safety net programs for the children and families who need them — improving health coverage rates for children, supporting child nutrition programs, and partnering with states to conduct program integrity efforts. But that's not what's happening, to the detriment of millions of families across the country. The Administration's distracting actions that deprive children and families in need are the true scandal.

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Unfounded Fraud Allegations Threaten Vital Medicaid Home And Community-Based Services

Jane Tavares, Alison Barkoff, Sara Rosenbaum, Marc A. Cohen

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Editor's Note

This article is the latest in the Health Affairs Forefront *featured topic, "Health Policy at a Crossroads," produced with the support of the Commonwealth Fund. Articles in this topic offer timely analysis of regulatory, legislative, and judicial developments in health policy under the Trump-Vance Administration and the 119th Congress.*

The Centers for Medicare & Medicaid Services (CMS) has just announced <https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud> a major crackdown on Medicaid fraud, including the deferral <https://bipartisanpolicy.org/explainer/medicaid-payment-deferrals-what-they-are-and-how-they-work/> of more than $250 million in federal Medicaid funds owed to Minnesota as well as an intent to withhold future funds exceeding $500 million per quarter. CMS has opened investigations into several other states' Medicaid programs, citing potential fraud in Home and Community-Based Services <https://www.kff.org/medicaid/understanding-medicaid-home-care-amid-cms-focus-on-potential-fraud-and-abuse> (HCBS), the services that help people with disabilities and older adults live in their own homes and communities instead of in nursing homes or other institutions. Just days before the CMS announcement, a policy commentary

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vulnerable to fraud and the case for stronger CMS enforcement/> coauthored by the former White House health policy lead in the first Trump Administration characterized HCBS as particularly vulnerable to fraud, citing rapid spending growth and arguing that services delivered in individuals' homes present heightened oversight challenges compared to services delivered in institutional settings.

Everyone would agree that, just as is true for all public and private health insurance programs, fraud prevention is essential in Medicaid, which finances care for more than 80 million Americans and accounts for nearly one-third of total state expenditures <https://www.nasbo.org/reports-data/state-expenditure-report> . Safeguarding public funds is an important shared federal-state obligation. But the tools to fight fraud must be effective and precise, especially when applied to HCBS, which is critical to the safety and independence of disabled people and older adults—the very populations CMS claims to be focused on protecting. CMS's framing of HCBS as inherently suspect suggests that in-home care lacks effective guardrails. This completely overlooks the fact that furnishing care in home and community settings has been a Medicaid program feature for decades <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities> .

Indeed, withdrawing support for HCBS and pursuing sweeping structural changes without clear evidence of systemic fraud jeopardizes services that have become foundational to our country's modern long-term care system. It would undo more than 40 years of bipartisan federal policy designed to rebalance that system away from institutional care toward less restrictive care provided in the homes and communities where disabled people and older adults want—and have a civil right—to live.

Fraud is a serious issue, and it cuts across all health care programs and all types of services. The real issue is whether current federal actions represent a reasonable response to the problem. A look back at the history of HCBS demonstrates that its growth is not, in fact, evidence of massive undetected fraud, but rather is based on decades of

priorities and implemented with strict fiscal guardrails.

HCBS Growth Reflects Bipartisan Federal Policy And Demographic Changes

The 1981 introduction of HCBS into Medicaid has long been hailed as an historic advance in health policy. Furthermore, since the Supreme Court's landmark 1999 decision in *Olmstead v. L.C. <https://supreme.justia.com/cases/federal/us/527/581/>* , which held that unnecessary institutionalization of people with disabilities constitutes discrimination under the Americans with Disabilities Act (ADA), federal <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD011400C.pdf> and state policymakers alike have sought to use HCBS to meet the ADA's integration mandate by directing care away from institutions and into home and community settings.

Both Republican and Democratic Administrations have reinforced that direction. The Deficit Reduction Act of 2005 <https://www.congress.gov/109/plaws/publ171/PLAW-109publ171.pdf> created a state plan HCBS option (Section 1915(i) <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i>) and the Money Follows the Person Program <https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person> to help people transition from institutions to the community. The Affordable Care Act established the Community First Choice <https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf> option (Section 1915(k)) and the Balancing Incentive Program <https://www.medicaid.gov/medicaid/long-term-services-supports/balancing-long-term-services-supports/balancing-incentive-program> , and the Obama administration emphasized community integration through Medicaid policy <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/AID/SMD10008.pdf> and enforcement of disability rights law <https://archive.ada.gov/olmstead/q&a_olmstead.htm> . The Trump administration released the 2020 Rebalancing Toolkit <https://www.cms.gov/newsroom/fact-sheets/long-term-services-and-supports-ltss-rebalancing-toolkit-fact-sheet> encouraging states to accelerate HCBS expansion. Under the Biden administration, the American Rescue Plan Act of 2021 <https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf> temporarily increased the federal Medicaid matching rate for HCBS to support COVID-19 pandemic recovery. Even the recently passed H.R. 1, which makes major cuts to Medicaid spending, included a new HCBS authority <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11182025.pdf> .

spending on long-term services and supports <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html> (LTSS) was directed to HCBS, compared to just 27 percent in 1995. This shift reflects deliberate policy decisions, not regulatory drift. The growth in HCBS also reflects demographic inevitability. The US Census Bureau <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf> estimates that 10,000 Americans turn age 65 each day, with the 85-and-older population projected to more than double by 2040; the majority <https://aspe.hhs.gov/sites/default/files/documents/08b8b7825f7bc12d2c79261fd7641c88/ltss-risks-financing-2022.pdf> of these older adults will need LTSS. The population of disabled people <https://www.cdc.gov/media/releases/2024/s0716-Adult-disability.html> is also growing, in part because individuals with intellectual and developmental disabilities are now living decades longer <https://www.prb.org/articles/u-s-adults-with-intellectual-and-developmental-disabilities-are-living-longer-but-covid-threatens-to-erase-recent-gains/> than in previous generations.

Access Is A Major Challenge Facing HCBS

At the same time these demographic trends are playing out, unmet need remains substantial. As of 2025, more than 600,000 individuals nationwide <https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2025/#:~:text=Forty%2Done%20states%20maintain%20waiting,12%20states%20reporting%20a%20decrease.> were on waiting lists for HCBS programs. Many states have reported substantial yearly increases <https://www.kff.org/medicaid/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2025> in the number of people on their waiting lists.

Workforce shortages <https://www.ancor.org/article/shortage-of-direct-support-workers-persists/> compound access challenges. Unpaid family caregivers, estimated at 63 million Americans <https://www.aarp.org/press/releases/2025-07-24-new-report-reveals-crisis-point-for-americas-63-million-family-caregivers.html> , provide the majority of long-term support—a 50 percent increase over the last decade due to these demographic shifts and longer waiting lists. States' HCBS programs often provide limited paid assistance to enable families to sustain caregiving and delay institutional placement. Thus, a primary challenge facing HCBS is insufficient access rather than unchecked growth in service delivery.

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Requirements And Civil Rights Law

As we seek ways to address the access challenges facing HCBS, it is important to understand that this is not an informal or weakly regulated benefit category—it is authorized under specific statutory authorities, most prominently Section 1915(c) HCBS waivers <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c> . Section 1915(c) of the Social Security Act, enacted in 1981, allows states to provide HCBS as an alternative to institutional <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-technical-assistance-states> care for individuals who would otherwise require a nursing facility, an intermediate care facility for individuals with intellectual disabilities, or a hospital level of care (LOC). These HCBS waiver participants must therefore meet an institutional LOC standard.

Equally important, Section 1915(c) waivers must demonstrate cost neutrality <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-technical-assistance-states> : On average, the cost of serving individuals in the community cannot exceed what Medicaid would have spent on institutional care for the same population. States must submit actuarial projections and obtain federal approval demonstrating that waiver services will be cost-neutral relative to institutional alternatives.

Building off the 1915(i) State Plan HCBS <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i> authority Congress passed over 20 years ago, Congress recently expanded the Section 1915(c) framework. Beginning July 1, 2028, H.R. 1 creates an additional Section 1915(c) waiver option <https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-07/NAMD-Memo-OBBBA-Medicaid-Policies.pdf> , allowing states to provide HCBS to individuals who do not meet the traditional institutional LOC threshold. This will permit states to offer earlier, preventive supports to individuals who need assistance to remain safely at home but who may not yet qualify for institutional care, while still tightly managing access. The policy logic is preventive in nature: Providing support before deterioration occurs may avert institutionalization. Importantly, this expansion remains subject to federal approval and program integrity requirements.

Clearly, HCBS is not an open-ended entitlement. It is, by design, an institutional substitute and now a structured preventive support option embedded within Medicaid's

The civil rights framework for HCBS reinforces this statutory design. Medicaid HCBS is the principal financing mechanism through which states comply with their obligations under the ADA and *Olmstead* <https://archive.ada.gov/olmstead/q&a_olmstead.htm> to provide services in "the most integrated setting appropriate to an individuals' needs"—people's own homes and communities instead of institutions.

Portraying HCBS as inherently high-risk for fraud overlooks the fact that HCBS operates at the intersection of fiscal guardrails and civil rights obligations. It has generally been limited to individuals who meet institutional LOC criteria, is subject to federal cost-neutrality requirements, and has evolved through defined statutory authority, while also serving as a central mechanism for states' compliance with federal disability law.

HCBS Is More Cost-Effective Than Institutional Care

The assumption that HCBS is prone to wasteful spending is contrary to the evidence that consistently has demonstrated its cost effectiveness. CMS data show that institutional LTSS users broadly have substantially higher average expenditures <https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html> than HCBS users. In fact, a Mathematica analysis <https://www.mathematica.org/publications/medicaid-long-term-services-and-supports-users-and-expenditures-by-service-category-2022> estimated that average 2022 Medicaid spending per person was $47,000 for institutional LTSS users compared to $16,600 for people receiving HCBS.

Plentiful peer-reviewed research <https://pubmed.ncbi.nlm.nih.gov/22106902/> supports <https://doi.org/10.1377/hlthaff.28.1.262> the fiscal logic <https://pubmed.ncbi.nlm.nih.gov/37326313/> of rebalancing <https://www.medicaid.gov/medicaid/long-term-services-supports/balancing-long-term-services-supports> . The Money Follows the Person (MFP) <https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html> demonstration has shown that transitioning individuals from institutions to community settings reduces Medicaid expenditures over time while improving quality-of-life outcomes. State-level comparisons further reinforce this pattern, showing that positive impacts of rebalancing are consistent nationwide <https://pmc.ncbi.nlm.nih.gov/articles/PMC10915491> . If HCBS is retrenched under the banner of fraud prevention, the likely fiscal outcome is increased institutional spending <https://www.ltsscenter.org/wp-content/uploads/2025/04/Impact-of-HCBS-

cost far more than any purported savings from new efforts to reduce fraud.

Strong Safeguards Against HCBS Fraud And Targeted Enforcement Already Exist

Before considering new options for addressing HCBS fraud, it is important to understand the strong safeguards already in place to prevent such fraud through targeted enforcement. Electronic Visit Verification <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-guidance-additional-resources/electronic-visit-verification> (EVV), mandated under the 21st Century Cures Act <https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf> , requires verification of time and location before payment for personal care and home health services. Provider enrollment screening includes background checks and periodic revalidation of credentials <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/revalidations> , and managed care contracts require compliance <https://medicaiddirectors.org/resource/state-and-territory-medicaid-programs-share-the-federal-governments-interest-and-urgency-around-medicaid-program-integrity-2/> programs and referrals to state authorities. In fact, states' Medicaid Fraud Control Units reported <https://oig.hhs.gov/documents/evaluation/10227/OEI-09-25-00090.pdf> over 1,100 convictions and $1.4 billion in recoveries in fiscal year 2024. States also use <https://medicaiddirectors.org/resource/state-and-territory-medicaid-programs-share-the-federal-governments-interest-and-urgency-around-medicaid-program-integrity-2/> predictive analytics, recovery audit contractors, utilization management standards, and corrective action plans.

These mechanisms allow states and the federal government to identify and address specific vulnerabilities without disrupting lawful—and critical—services. By contrast, broad funding deferrals or categorical moratoria substitute financial shock and service disruptions for targeted oversight, placing legitimate providers and vulnerable beneficiaries at risk before any finding of wrongdoing.

Improper Payments Are Different From Fraud

CMS's fraud initiative is based on an assumption that all types of payment errors are fraud, which incorrectly conflates intentional wrongdoing with administrative and paperwork errors. CMS's Payment Error Rate Measurement (PERM) program makes clear that improper payments are not measures of fraud <https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/payment-

<https://www.kff.org/medicaid/a-look-at-the-medicaid-payment-error-rate-measurement-perm-program-and-upcoming-changes-and-impacts/> further explains that PERM estimates are measures of compliance error, not indicators of intentional wrongdoing, and outlines methodological complexities that make a direct fraud inference inappropriate.

Improper payments often reflect documentation deficiencies, eligibility-processing issues, or other administrative compliance problems, not intentional deception. Collapsing improper payments, abuse, and fraud into a single category inflates perceptions of criminal misconduct and risks misdirected policy action. Administrative compliance issues certainly warrant administrative remedies, but not larger structural retrenchment.

Blunt Financial Tools Risk Collateral Damage

Even if withholding federal Medicaid funds may be legally authorized, it is a blunt instrument that is likely to be ineffective over the long term. Such actions do not directly pinpoint fraudulent actors. Instead, they introduce fiscal instability into programs serving populations who rely on Medicaid for their safety and independence.

Recent reporting from Minnesota <https://minnesotareformer.com/2026/01/15/dhs-abruptly-delayed-all-payments-to-providers-of-14-medicaid-services-in-fraud-prevention-effort/> illustrates risks from abrupt enforcement actions <https://accesspress.org/unintended-consequences-eyed-with-states-medicaid-crackdown/>, including delayed payments to legitimate providers and service disruptions for disabled and aging beneficiaries. When payroll stalls or providers close, the consequences fall on individuals with significant disabilities of all ages and their families. Again, empirical analysis <https://www.ltsscenter.org/wp-content/uploads/2025/04/Impact-of-HCBS-Cutbacks-on-Nursing-Home-Care-Utilization-April-2025.pdf> indicates that cutbacks in HCBS just shift care into more costly institutional settings, harming the very beneficiaries federal policy aims to protect.

History shows <https://www.ltsscenter.org/wp-content/uploads/2025/04/Impact-of-HCBS-Cutbacks-on-Nursing-Home-Care-Utilization-April-2025.pdf> that when Medicaid funding is reduced, states often cut HCBS for older adults and people with disabilities first. This is particularly problematic when demographic pressures driving demand for HCBS will not reverse. When enforcement tools destabilize essential services rather than isolate wrongdoing, they cease to be instruments of integrity and instead become catalysts for harm.

Maintaining program integrity in Medicaid is essential. Fraudulent actors must be identified and prosecuted. Enforcement must be proportionate to the fraud, evidence-based, and structured to avoid collateral damage.

HCBS is the principal means by which older adults and people with disabilities avoid unnecessary and more expensive institutional care; it is the legal framework for state compliance with federal civil rights law. Growth in HCBS spending does not reflect evidence of systemic corruption but rather bipartisan federal policy choices, demographic change, and structured statutory evolution.

Federal law embeds strong fiscal guardrails in HCBS: institutional LOC standards, cost-neutrality requirements, waiver approval processes, electronic verification systems, and layered program integrity mechanisms. Where vulnerabilities exist, they should be addressed through targeted analytics and corrective action plans, not broad funding leverage or rhetoric that casts suspicion on an entire program. Oversight strengthens public programs when it is precise and collaborative. When it is blunt, it risks destabilizing programs such as HCBS—the very system that bipartisan federal policy has spent decades building—and harming disabled and aging people whose lives depend on HCBS. The goal should not be to characterize the entirety of HCBS as prone to fraud, but to ensure that HCBS continues to function as Congress designed it: fiscally disciplined, legally grounded, and centered on enabling people to live safely in their homes and communities.

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In Talking to Parents About Vaccines, Pediatricians Navigate a Sea of Misinformation

Practitioners nationwide are striving to do what's best for children's health, while staying supportive in the face of mistrust and confusion.

Listen · 11:03 min


By Apoorva Mandavilli **Photographs by Maddie McGarvey**
Reporting from Ashland, Ky.

March 11, 2026

As she examined 11-day-old Asher, her eighth patient of the day, Alissa Parker talked to his parents about his sleep habits, the nub of his umbilical cord that had yet to fall off and a harmless rash on his bottom.

Nine minutes into the appointment, she gently probed: Had they given any more thought to a shot that would protect Asher from respiratory syncytial virus, or R.S.V.? No, they demurred, not yet.

Dr. Parker, a pediatric nurse practitioner at Primary Plus, a community clinic in Ashland, Ky., did not push. Asher's parents, Autumn and James Skaggs, had already declined the hepatitis B vaccine when he was born, and planned to refuse all the other routine childhood vaccinations.

"If there's any way I can answer your questions and make you feel more comfortable about it, I'm happy to," she said. Then she left the room.

Across the country, clinicians like Dr. Parker, who also holds a doctorate in nursing practice, are contending with a sharp rise in vaccine hesitancy. They are trying to do what is best for children's health while staying sensitive and supportive, even as they bear the brunt of parents' mistrust and confusion.

Skepticism about vaccines was once a fringe view, held by a small group of Americans. But the Covid-19 pandemic, with its mandates and rapid rollout of vaccines, breathed new vigor into the anti-vaccine movement and bred hostility toward the medical establishment.

Pediatric vaccine doses at the Primary Plus clinic; Dr. Parker in January.

Now vaccine skepticism emanates from the highest echelons of the U.S. government. Over the last year, Health Secretary Robert F. Kennedy Jr. and his associates have questioned the safety of childhood vaccines, made false statements about their effectiveness and rescinded recommendations for routine vaccination against a half-dozen diseases.

And despite the fact that pediatrics is the lowest paid medical specialty — as pediatricians are quick to point out — Mr. Kennedy and others have portrayed its practitioners as greedily promoting vaccines in order to earn fat profits.

In a survey by the health research group KFF and The Washington Post, released in September, 16 percent of parents said they had skipped or delayed at least one childhood vaccine other than for flu or Covid-19. And doubts about vaccines are increasingly spilling into refusal of other mainstays of pediatric medicine, including antibiotics, medications like Tylenol and diagnostic procedures like spinal taps.

At a hospital in Boise, Idaho, for example, three infants died last year after their parents declined a shot of vitamin K, administered to newborns to prevent bleeding, said Dr. Amanda Lee, a pediatrician there.

Parents have always had questions about vaccines, but Dr. Lee and other pediatricians say they are now finding their expertise to be sometimes powerless against the flood of misinformation.

“Families are not actually interested in information or facts or rates of side effects,” Dr. Lee said.

“Logic is no longer part of the discussion,” she added. “It’s just kind of based on a feeling.”

Most parents still say they consider pediatricians the most trusted source of information. But the messaging about vaccines is straining even the strongest relationships.

“It’s getting harder and harder to maintain that connection that we have with families,” Dr. Kenneth Strzelecki, a primary care pediatrician at Children’s Wisconsin in Milwaukee, said. “We’re up against a lot of noise.”

For some practitioners, it has proved to be too much: They are contemplating leaving the profession.

“It’s just a really a sad and stressful time for pediatricians,” said Dr. Megan Schultz, a pediatric emergency physician at Children’s Wisconsin in Milwaukee. “I really worry about us as a field, honestly.”

Ashland sits at the junction of Ohio, West Virginia and Kentucky, each of which has its own mix of laws. Kentucky offers an easy out for religious grounds, which “was a really rude awakening,” Dr. Parker said.

Trust is the key

Bethany Browning knows exactly what turned her away from the medical system — and what brought her back.

When her daughter, now 14, was hospitalized with a fever as an infant, she said, a series of health care workers made her feel stupid and threatened to report her to child protective services for asking questions about the treatments.She found acceptance in a “natural living” community that recommended skipping vaccines.

Four years later, after her son was born, she met Dr. Parker at a group for breastfeeding mothers. “We saw differently about the vaccine thing, but she never made me feel like she thought that I was a bad parent” Ms. Browning said.

After being hospitalized twice with the flu, she realized that the infection could quickly turn dangerous and that she would never forgive herself if her children were harmed by it.

When the Covid-19 pandemic began, she said, the influencers she had trusted “started to sound absolutely insane,” rejecting masks and precautions like staying home when sick. “It definitely made me take a big step back and be like, ‘Wait, what else have you been saying that’s horrendous?’”

She turned to Dr. Parker, whom she had come to trust, and began catching her children up on their shots.

Dr. Parker with her partner, Dr. Kelli Brown. They both formerly practiced in West Virginia, which offered only medical exemptions. (The state is in the midst of a contentious battle over religious exemptions.)

Conferences of pediatricians now routinely hold workshops on earning parents' trust. They are training clinicians to be less authoritarian, less judgmental and more patient, said Dr. Brandan Kennedy, a pediatric hospitalist in Kansas.

Some doctors become angry and defensive when patients question their hard-won expertise and experience, he said. The training is intended to help clinicians manage the conversations "without making ourselves crazy and angry and resentful," Dr. Kennedy said.

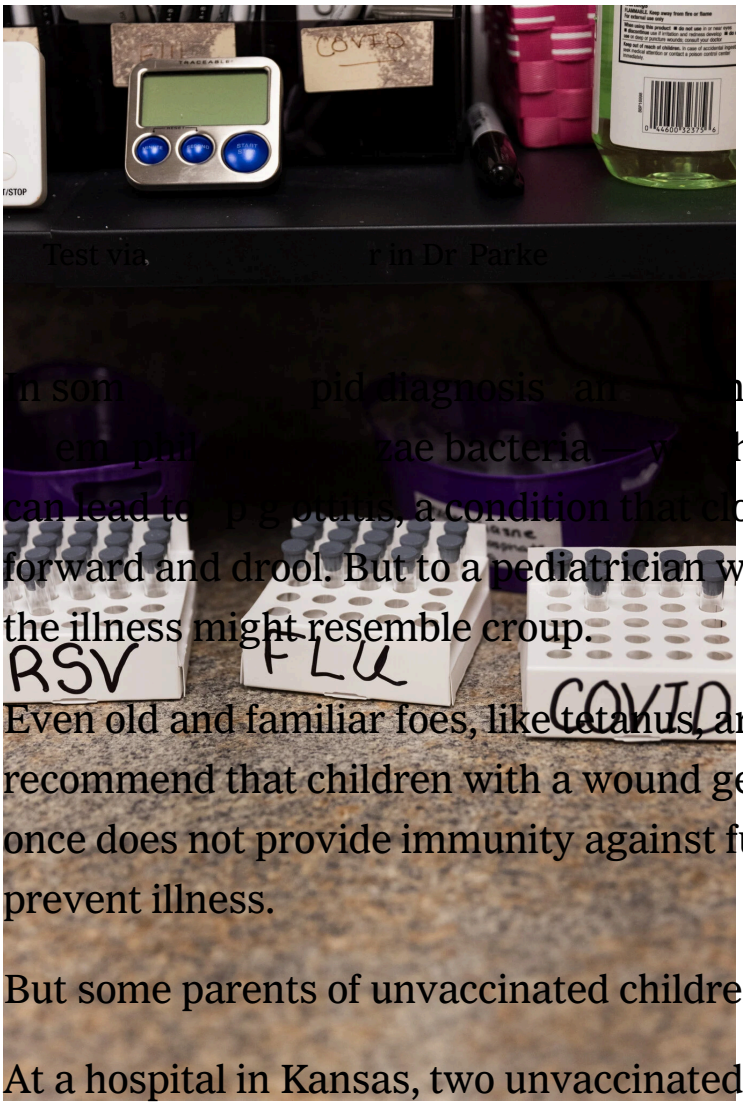
The conversations tend to be smoother when a family already trusts the clinician. "Definitely, I'm more successful when I have built a relationship with the family," said Dr. Meera Nagarajan, who practices in Salt Lake City.

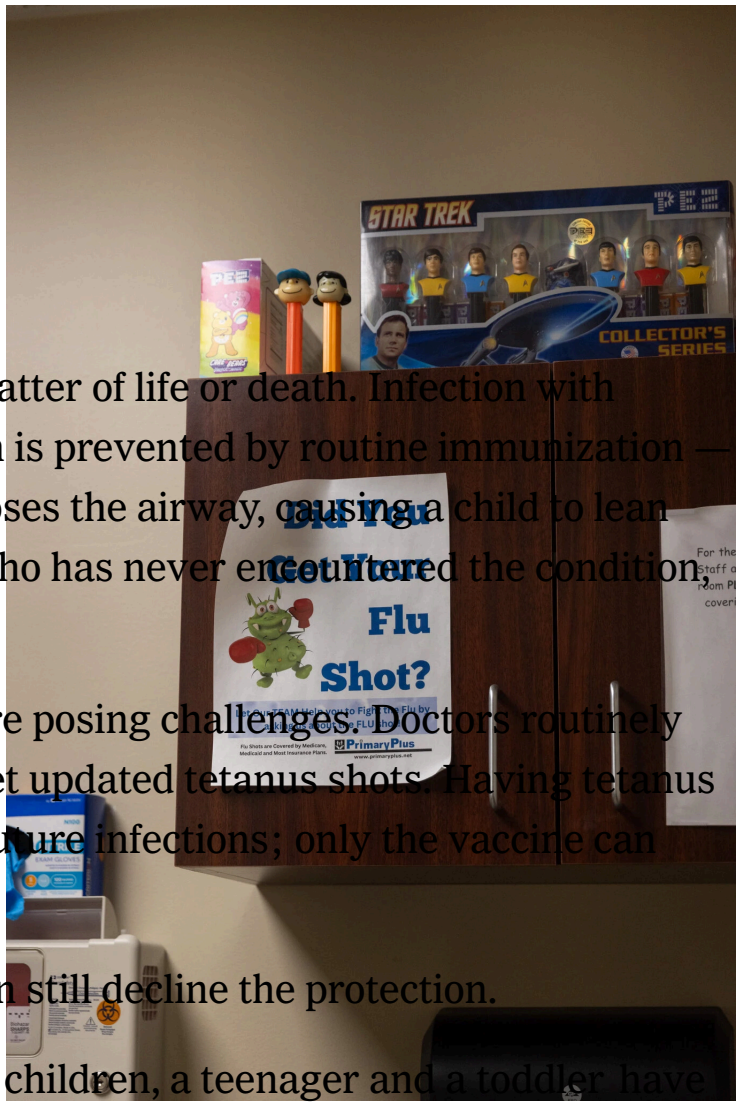
While many families decline vaccines for Covid and flu, the measles outbreak in Utah prompted some parents to seek out earlier doses of the measles vaccine to protect their infants, she said.

Trust is more difficult in hospitals and emergency rooms, where a doctor may be seeing a patient for the first and only time. Compounding the difficulty, those places are also where pediatricians are increasingly likely to encounter the consequences of a lack of vaccination: illnesses they were perhaps never trained to treat.

Many young pediatricians have never seen a case of measles, for example. But as the country faces multiple outbreaks of the disease, they have to prepare for the possibility that an unvaccinated child might bring the virus to their waiting rooms, exposing other patients and staff.

In Wisconsin, emergency room physicians have had to devise new guidelines for treating the increasing number of unvaccinated children who come in with fevers of unknown cause, Dr. Schultz said.





Test via r in Dr. Parke

In som pid diagnosis an matter of life or death. Infection with em phil zae bacteria y h is prevented by routine immunization — can lead to p g ottitis, a condition that closes the airway, causing a child to lean forward and drool. But to a pediatrician who has never encountered the condition, the illness might resemble croup.

Even old and familiar foes, like tetanus, are posing challenges. Doctors routinely recommend that children with a wound get updated tetanus shots. Having tetanus once does not provide immunity against future infections; only the vaccine can prevent illness.

But some parents of unvaccinated children still decline the protection.

At a hospital in Kansas, two unvaccinated children, a teenager and a toddler, have been hospitalized with tetanus, said Dr. Kennedy, who treated the children. The teenager's parents opted for catch-up vaccinations; the mother of the toddler did not.

The toddler was in the hospital for three months and almost died twice. The child's mother "seemed to listen" when Dr. Kennedy explained that the child could easily get tetanus again.

"I tried very hard to approach in a very nonthreatening manner, but at the end of the day, she refused to give a reason," he said. "I don't think we still fully understand how some families get to where they got."

A fear of unknown harms

Every state requires certain vaccines to attend school, but all allow medical exemptions — if a child has cancer for example — and nearly all honor religious reasons for refusing vaccines. Exemptions on personal or philosophical grounds are rarer, allowable in only 16 states, but the numbers are rising.

Ashland sits at the junction of Ohio, West Virginia and Kentucky, each of which has its own mix of laws.

Dr. Parker and her partner, Dr. Kelli Brown, practiced in West Virginia, which allowed only medical exemptions. (The state is in the midst of a contentious battle over religious exemptions.) Moving to Kentucky, one of the majority of states with religious exemptions, “was a really rude awakening,” Dr. Parker said.

The Skaggses, the couple in Dr. Parker’s practice, did not offer a religious reason when they announced their intention to refuse all vaccines for their son.

They have two older children, aged 15 and 12, both of whom are fully vaccinated. But they were trying “the more natural route this time around,” Mr. Skaggs said.

Autumn Skaggs, left, and her husband James have decided to skip all vaccines for their infant son, Asher.

The older children have developed fevers from the shots but never been ill beyond that, he said. He added that he and his wife wonder now if the vaccines had any benefit or if they might have harmful ingredients that cause autism or other problems. Under Mr. Kennedy's direction, the Centers for Disease Control and Prevention changed its website to say that "studies have not ruled out the possibility that infant vaccines cause autism." The website previously said rigorous studies had not found a link between vaccines and autism.

The revised language, Mr. Skaggs said, was "one of the main things" that made him change his mind about vaccines.

Some shots, like those against measles, have long been a target of anti-vaccine groups, which have falsely linked them to autism. But hesitancy has now spread even to stalwarts of medical practice, like the vaccine against polio. As a result,

pediatricians may find themselves spending an entire visit explaining the rationale for a single shot, shunting aside many other important topics.

Some pediatricians, like Dr. Peter Sinton in Ponca City, Okla., refuse to take on unvaccinated children as patients, worrying that having unvaccinated children in the practice could endanger other patients who may be immunocompromised or too young for a shot.

More commonly, pediatricians opt to have parents sign a “refusal to vaccinate” form, with the understanding that they will revisit the topic periodically.

Their hope is that over time, they may slowly regain parents’ trust — as Dr. Parker did with Ms. Browning.

Looking back now, Ms. Browning said, she can see that a fear of unknown harms to her children had led her to trust the wrong people.

“I feel a little bit angry about it, because I think there is a market online where people profit from feeding off of those fears,” she said. “We were really fortunate that nothing bad happened with our kids.”

Ms. Browning with Cassidy. “We saw differently about the vaccine thing, but she never made me feel like she thought that I was a bad parent because of that,” Ms. Browning said of Dr. Parker.

Apoorva Mandavilli reports on science and global health for The Times, with a focus on infectious diseases and pandemics and the public health agencies that try to manage them.

A version of this article appears in print on , Section A, Page 10 of the New York edition with the headline: Pediatricians Navigate a Sea of Vaccine Misinformation

HEALTH • 8 MIN READ

Hospitals fighting measles confront a challenge: Few doctors have seen it before

FEB 25, 2026

By Andrew Jones, KFF Health News

A sign points the way to measles testing in West Texas in 2025. Officially, the U.S. has maintained ...

At around 2 a.m., 7-year-old twin brothers arrived at Mission Hospital in Asheville. Both had a fever, a cough, a rash, pink eye, and cold symptoms.

The boys sat in one waiting room and then another. Two hours and 20 minutes passed before the two were isolated, according to **Centers for Medicare & Medicaid Services records** obtained by KFF Health News. Then two more hours ticked by.

As the sun rose, an emergency room doctor called the state epidemiologist and described the symptoms. The public health official told him to keep the kids in the hospital and quarantine them. Shortly after that call, the patients were diagnosed.

It was measles.

Hospital staff gave the father instructions on how to quarantine the family and sent them home.

The virus exposed at least 26 other people in the hospital that January day, federal investigators determined. Health inspectors for CMS investigated the measles

have triggered an isolation procedure for which Mission Hospital staffers had trained seven months earlier. CMS designated Mission in "**Immediate Jeopardy**" for the exposures and other unrelated issues, one of the most severe sanctions a hospital can face, threatening to pull federal funding unless it remedied the problems.

A spokesperson for Mission said its staff was trained to manage airborne sickness and is following federal rules.

As U.S. hospitals face an increasing risk of encountering measles, and pressure to immediately spot it, health care workers face an unusual barrier: Many don't know what it looks like.

"There's a word, 'morbilliform' — it means measles-like, and there are lots of viruses that can cause a rash that looks like a measles rash in children," said Theresa Flynn, a pediatrician in Raleigh and the president of the North Carolina Pediatric Society. In 30 years in health care, she's never seen a measles case, she said.

North Carolina has reported more than 20 cases since mid-December, and more than 3,000 people nationwide have been infected since the beginning of 2025.

Children in areas with low immunization rates **have been especially susceptible** to outbreaks, triggering public health campaigns to promote the measles vaccine. CMS

Dr. Oz reacts to skyrocketing measles cases across U.S.: 'Take the vaccine, please'

8:19

With two doses of the measles, mumps, and rubella vaccine, a person has a 3% chance of getting the virus after exposure. If exposed, an unvaccinated person has a 90% chance of being infected, according to the CDC. It can take a week or two before someone infected with measles shows symptoms.

effectiveness. Health and Human Services Secretary Robert F. Kennedy Jr. was a longtime anti-vaccine activist before taking office, and under his leadership the Centers for Disease Control and Prevention has reduced the number of shots recommended to children.

After measles erupted in West Texas last year, Kennedy publicly **recommended unconventional and unproven treatments** for the virus, including steroids, antibiotics, and cod liver oil.

Infectious disease experts and doctors said federal policies have left health care workers to lean on their own experience or guidance from their state public health systems to fight a disease that many are preparing to see for the first time and that initially may behave like the common cold.

“As measles becomes more common, all of us are leveling up in our ability to recognize and immediately respond to suspected measles,” Flynn said.

Three C’s

Officially, the U.S. has maintained “measles elimination status” since 2000, meaning the U.S. has avoided significant spread of the virus. After outbreaks in Texas, Arizona, Utah, and now South Carolina, the nation is on track to lose that designation before the year is out. **Its own adopted regulations** tie elimination status to a lack of a continuous viral spread persisting for 12 months.

One county in South Carolina, an hour's drive from Asheville, has had **more than 900 cases** in the current outbreak — more than Texas reported in all of 2025.

Symptoms of measles, a virus that **attacks the lungs and airways**, can include fever, cough, a blotchy rash, and red, watery eyes. Researchers consider measles among the most contagious diseases, and the virus may remain active for up to two hours after an infected person leaves a room.

It can be lethal, with **1 to 3 deaths per 1,000 cases in children**.

In 2025, two children in Texas and one adult in New Mexico died of measles.

A paramedic administers a dose of the measles vaccine at a health center in Lubbock, Texas, in February 2025, amid a large measles outbreak that led to the deaths of two children. *(Ronaldo*

Along with tracking data, the CDC **provides detailed summaries** on its website for diagnosing measles. State public health agencies and some counties have developed dashboards tracing the disease as it surfaces in such places as hospitals, schools, grocery stores, and airports. Large hospital systems developed staff training protocols last year and shared them with area clinics.

Look for the three C's, **that guidance said**: cough, coryza (cold symptoms), and conjunctivitis (pink eye). According to CMS inspection records, HCA Healthcare, which owns Mission Hospital, trained Mission staff on the three C's early last year. On top of failing to isolate the twin patients right away, Mission staff didn't have a designated area for patients with respiratory symptoms, federal inspectors found.

The CDC advises health workers to immediately place patients with measles or suspicious symptoms in a special isolation room, where airflow is controlled inward. The Mission patients were separated from other patients only by plastic partitions, according to the CMS records.

Mission spokesperson Nancy Lindell said the hospital was equipped and staffed to manage airborne illnesses like measles.

preparedness, and we are following guidance provided by the CDC," Linden said.

Dogwood Health Trust, a private foundation established as part of HCA's purchase of Mission Health, helps fund KFF Health News coverage.)

Most U.S. clinics and hospitals have never experienced measles cases, said Patsy Stinchfield, a former president of the National Foundation for Infectious Diseases and a nurse practitioner. She called CMS' Immediate Jeopardy penalty for Mission "extreme," given the virus can be so difficult to identify.

"In the middle of winter right now, measles looks like every other viral respiratory infection that kids come in with," Stinchfield said.

The CDC has been less communicative in the past year with clinics about their response to outbreaks, said health workers and infectious disease experts. This disconnect began soon after Trump took office, according to a **KFF Health News investigation** finding that health officials in West Texas were unable to talk with CDC scientists as measles surged last February and March.

"We certainly do not feel the support or guidance from the CDC right now," said Brigette Fogleman, a pediatrician at Asheville Children's Medical Center, where staff

patients over the phone and in their cars before a visit.

In response to questions about how the CDC is supporting health care organizations during the measles resurgence, spokesperson Andrew Nixon said that “state and local health departments have the lead in investigating measles cases and outbreaks” and that the CDC provides support “as requested.” He pointed to numerous guides and simulation tools the agency has developed as the virus has spread.

Jennifer Nuzzo, an epidemiologist and director of the Pandemic Center at Brown University, acknowledged that diagnosing measles is a major challenge, emphasizing that coordination among public health agencies is critical in overcoming that challenge.

Stinchfield attributed the spread of measles to CDC leaders’ lack of communication to clinics and to the public — no ads on buses, no social media campaigns, no sense of urgency. “When you are at the highest level of measles cases in 30 years, we should be seeing lots more from our federal government,” Stinchfield said. “And I think it’s harming kids and causing an inordinate amount of work and expense that really doesn’t belong in health care right now.”

State prepares for more measles cases

officials had counted seven measles cases by mid-February and anticipated many more, according to state epidemiologist Zack Moore. It's unclear how many of those are connected to the Mission exposure.

"We are preparing for a future in which we follow a trajectory like South Carolina," Moore said, "where we see sort of a gradual accumulation of cases, and then all of a sudden it reaches kind of a tipping point, and we see a more explosive growth in the outbreak and spread across the state."

Fogleman, who is also a pediatrician, and Buncombe health department director Jennifer Mullendore spoke during a **recent Facebook livestream** hosted by the county, urging families to get their children vaccinated, debunking vaccine misinformation, and updating parents on local case numbers.

Days before, a local private school had quarantined about 100 students after an exposure. **Only 41% of students there** were immunized, according to state data.

At Fogleman's clinic, parents are asked to wait in their vehicles with their children, and staffers come out to screen them there. Some parents resist vaccination and note recently weakened federal recommendations around measles vaccines **for children under 4**, she said.

Kennedy handpicked the committee members who made those recommendations, with several members having spread medical misinformation in the past.

One parent recently told a nurse, “It’s only measles. It doesn’t kill anybody,” Fogleman said.

That’s not true, her team must explain.

As the clinic holds families in the parking lot, trying to figure out whether symptoms point to the dangerous virus, it’s difficult to get the message across, Fogleman said, especially when the nation’s top disease agency hasn’t conducted a widespread information campaign about the risks from measles — or the vaccine’s ability to almost entirely prevent it.

“We can’t change the past,” Fogleman said. “All we can do is try to educate and move forward.”

Up next

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Judge halts RFK Jr.'s vaccine overhaul, citing flawed process

The judge said the government has undermined its history of recognizing the importance of involving independent experts in setting the national public health agenda.

Updated yesterday at 7:52 p.m. EDT

By Lena H. Sun and Rachel Roubein

A federal judge on Monday blocked the Trump administra
the nation's childhood immunization schedule, siding with
Health Secretary Robert F. Kennedy Jr. unlawfully altered
a federal vaccine advisory panel.

Under Kennedy, the federal government has cut the numb
children, including for flu, hepatitis A, rotavirus and menin
17 members of the vaccine advisory panel to the Centers fo
installing new members, several of whom have criticized vaccines, especially covid-19 mRNA shots.

Several groups sued, including the American Academy of Pediatrics, the American College of Physicians and the Infectious Diseases Society of America.

In his 45-page opinion, Judge Brian E. Murphy slammed t
government recommendations for how and when children
government has undermined its history of recognizing "the
independent experts in setting our national public health a
nature" to make such decisions.

"History is littered with once-universal truths that have sir
He added that even though science is not perfect, "neverth

The U.S. District Court judge from Massachusetts, who wa
Joe Biden, wrote that the government bypassed the CDC's
vaccine recommendations have been made for decades — t
called it a "technical, procedural failure" and a "strong indication of something more fundamentally problematic: an abandonment of the technical knowledge and expertise embodied by that committee."

The pause on the administration's actions are temporary, as the dispute is expected to wind through multiple rounds of appeals, raising the prospect of a drawn-out court battle over who ultimately calls the shots on the scientific standards shaping federal vaccine recommendations.

Andrew Nixon, a spokesman for the Department of Health and Human Services, said the department "looks forward to this judge's decision being overturned just like his other attempts to keep the Trump administration from governing."

Government attorneys have defended the secretary's authority to remove and appoint advisory committee members, arguing that federal law grants HHS broad discretion over such panels. They also contend that policy disagreements over vaccine recommendations do not amount to legal violations.

AAP President Andrew Racine hailed the ruling, saying it was important for such vital vaccine recommendations to be based on science.

“This decision effectively means that a science-based process for developing immunization recommendations is not to be trifled with and represents a critical step to restoring scientific decision-making to federal vaccine policy that has kept children healthy for years,” he said in a statement.

Racine said the ruling provided clarity for families so they know what vaccines are being recommended, and to talk to their pediatricians for the appropriate vaccine schedule for their children.

As health secretary, Kennedy — the founder of a prominent anti-vaccine group — has made clear that he wants to overhaul the nation’s immunization system and argued the prior panel of vaccine advisers was plagued with conflicts of interest.

In early December, President Donald Trump ordered federal health officials to review the childhood immunization schedule, including recommending fewer vaccines to align with other developed countries. The judge wrote that HHS cannot circumvent the long-standing practice of getting advice from the federal panel without offering an explanation “simply because they are following the President’s orders.”

He also wrote the government removed every member of the Advisory Committee on Immunization Practices and replaced them without undertaking the “rigorous screening” traditionally used to select members. The judge noted that “even under the most generous reading,” only six of the 15 members on the panel “have any meaningful experience in vaccines.”

The advisory panel was scheduled to meet Wednesday and Thursday, but that meeting has now been postponed, according to an HHS official. The judge temporarily suspended the appointment of 13 of the 15 panel members, finding they were not appointed properly. Therefore, he noted, that this week's meeting could not take place. "For how can a committee meet without nearly the entirety of its membership?"

The vaccine advisory panel was designed to be an independent panel of experts that reviews data on vaccine safety and effectiveness and recommends which shots Americans should receive and at what ages. Its guidance has long been widely followed by physicians, shapes school-entry requirements in many states and determines which vaccines insurers must cover with no out-of-pocket costs.

Under Kennedy, the meetings of the committee have provided a platform for those in the anti-vaccine movement to sow doubts in the safety and efficacy of vaccines. At its December meeting, committee members and presenters made at least 60 false, misleading or unsupported claims about vaccine safety, disease spread and rationale for childhood vaccination, according to the Evidence Collective, a coalition of science and medicine researchers.

In recent months, some members of the panel had publicly questioned the safety and manufacturing of covid-19 shots, such as raising a debunked theory that DNA contaminants in the vaccines were harmful — and some had been seeking to potentially stop recommending the mRNA shots. The plan had recently been abandoned as some Republicans have warned that additional overhauls to vaccine policy could be politically risky ahead of the November midterms, The Washington Post previously reported.

The judge paused all votes taken by the vaccine advisers. Some recent votes include moving from broadly recommending everyone 6 months and older get a coronavirus shot to instead advising Americans to first consult a clinician. The panel also voted to drop a recommendation that all newborns receive a vaccine for hepatitis B, an action that has drawn swift resistance from pediatricians, state health departments and major medical groups.

In court filings, the medical groups contend that Kennedy's reconstitution of the vaccine panel was improper and that subsequent votes on vaccine recommendations — including changes affecting covid-19 and other routine childhood immunizations — were, therefore, invalid. They argued that the administration bypassed established procedure and violated the Administrative Procedure Act, which governs how federal agencies make policy.

Government attorneys argued that the health secretary's authority is far-reaching. At one point during the hearings, the judge asked them: "If the secretary said instead of getting a vaccine … to prevent measles, I think you should get a shot that gives you measles; is that unreviewable?"

The government attorney replied: “Yes.”

On Substack, Robert Malone, the committee’s vice chair and a prominent critic of coronavirus vaccines, called the opinion a “judicial overreach.” He wrote that there is a compelling “case for bringing intellectual diversity and fresh expertise” to the panel and for aligning vaccine recommendations with the practices of other nations.

“In the meantime, the administration should continue its work,” he wrote.

In his opinion, Murphy wrote that he was not dictating what the health department can say related to vaccines, but rather the procedure by which federal officials can change policy.

Public health experts say the continuing legal dispute will create more confusion for parents.

The Trump administration's many changes to immunization policy have already fractured the response of states. Twenty-nine states and the District of Columbia have announced they are abandoning CDC guidance for some or all childhood vaccines mostly in favor of the American Academy of Pediatrics' schedule, according to a tally by the KFF, a health policy research organization. Most of states that are no longer following federal health guidance are led by Democratic governors, but several have Republican governors, including Alaska, Mississippi, New Hampshire and Nevada.

Lauren Weber and Aaron Schaffer contributed to this report.

What readers are saying

The comments express strong disapproval of RFK Jr.'s role in shaping vaccine policy, criticizing his lack of scientific expertise and the perceived danger his decisions pose to public health. Many commenters praise the judiciary for intervening to uphold scientific standards and... Show more

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