The Alliance to Fight for Health Care
Advancing employer-provided coverage

April 28, 2026

The Honorable Jason Smith
Chairman
U.S. House of Representatives
Ways and Means Committee

The Honorable Richard Neal
Ranking Member
U.S. House of Representatives
Ways and Means Committee

Dear Chairman Smith, Ranking Member Neal, and members of the committee:

The **Alliance to Fight for Health Care** applauds the House Ways and Means Committee for continuing to examine the key drivers of the nation's health care affordability crisis, particularly the role of hospitals and health systems in driving higher health care costs, at its April 28 hearing with health system CEOs.

The **Alliance to Fight for Health Care** is a diverse coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage. We are deeply concerned about the rising cost of health care in the United States and are focused on strengthening and improving the employer-sponsored coverage that more than 181 million Americans rely on today[1] while advancing policies that lower underlying system costs.

Rising Health Care Costs

The cost of providing health care coverage continues to rise at an unsustainable pace – and premium increases largely reflect the underlying cost of health care services across the system. National health spending reached $5.28 trillion in 2024, growing 7.2% year over year and increasing health spending's share of GDP to 18.0%.[2] Several structural factors are driving this growth, including hospital prices and facility fees and anti-competitive practices.

Hospital prices and facility fees continue to grow faster than wages and inflation, driven in part by consolidation and acquisition of physician practices, which enables hospital-owned facilities to charge higher rates for the same services. Several reports have found that such mergers can lead to up to 65% in price hikes and despite claims to the contrary, deliver no meaningful improvements in quality, but result in higher costs to patients and employers:

- ***2025 HHS Consolidation Report***: Found that hospital-to-hospital mergers in already concentrated markets are associated with hospital price increases ranging from 6% to 65%.[3]

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[1] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2024* (2025, September). https://www2.census.gov/library/publications/2025/demo/p60-288.pdf

[2] Centers for Medicare & Medicaid Services (CMS), *National Health Expenditure Fact Sheet*, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

[3] U.S. Department of Health and Human Services. (2025, January 15). *Consolidation in health care markets: Request for information response report*. https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf

- ***2025 GAO Report***: Concluded that hospital acquisition of physician practices typically raises prices, with physician service prices increasing ~14% on average after acquisition.[4]
- ***2017 MedPAC Report***: Showed that physician-hospital consolidation increases prices for both commercial and Medicare physician services, with no commensurate quality gains identified.[5]

Anti-competitive practices blunt the ability for employers and other payers to meaningfully steer patients to high-value sites of care and negotiate with providers in good faith to enter into network contracts. For example, the U.S. Department of Justice antitrust lawsuits against OhioHealth and New York-Presbyterian Hospital allege that hospitals used anti-steering, anti-tiering, and "all-or-nothing" contract provisions that prevent insurers and employers from steering patients to lower-cost, higher-value providers and sites of care, restricting the ability of payers to design budget-conscious plans, including narrow networks and tiered benefits, thereby blunting competition and keeping prices high.[6]

A report from the O'Neill Institute for National and Global Health Law found that anti-steering and all-or-nothing hospital contracting raise costs by preventing insurers from directing patients to affordable providers, even when insurers use tiered copays or value-based network designs, by forcing insurers to keep higher-priced systems in preferred tiers, reducing price competition across hospitals and outpatient settings.[7]

Policy Solutions to Lower Costs

Policies that reduce price distortions, improve competition, and curb non-value-added billing practices can generate savings for Medicare and taxpayers while easing pressure on employer and household premiums. We believe Congress can play a critical role in targeting specific practices that increase costs for patients and employers without improving outcomes:

1) Expand Site-Neutral Payment Reform

Patients are frequently charged more simply because care is delivered in a hospital-owned setting rather than a physician office or ambulatory setting, even when the service is clinically identical. Expanding site-neutral payment policies and limiting inappropriate facility fees would reduce incentives for consolidation and lower out-of-pocket costs. Currently, Medicare pays hospital

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[4] U.S. Government Accountability Office. (2025, September 22). *Health care consolidation: Published estimates of the extent and effects of physician consolidation* (GAO-25-107450). https://files.gao.gov/reports/GAO-25-107450/index.html#_Toc208982287

[5] Medicare Payment Advisory Commission. (2017, June). *Provider consolidation: The role of Medicare policy* (Chapter 10). In *Report to the Congress: Medicare and the health care delivery system*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch10.pdf

[6] Gonen, D. J., & Martin, L. K. (2026, April 14). *DOJ sends clear signal with latest antitrust challenge to hospital contracting practices*. *National Law Review*. https://natlawreview.com/article/doj-sends-clear-signal-latest-antitrust-challenge-hospital-contracting-practices

[7] Friedman, L. (2025, February 26). *Pushing back on anticompetitive hospital contracting*. O'Neill Institute for National and Global Health Law, Georgetown University. https://oneill.law.georgetown.edu/pushing-back-on-anticompetitive-hospital-contracting/

outpatient departments (HOPDs) higher rates for similar services, which encourages acquisition of physician practices and conversion to higher-paid billing status. We support expanding site-neutral payments and urge Congress to codify CMS's recent rule[8] to apply site-neutral payments to outpatient drug administration services. We also support more expansive proposals such as MedPAC's June 2023 recommendation to expand site-neutral payments to services "when safe and appropriate and when doing so does not pose a risk to access."[9]

To address these issues, we urge Congress to advance policies that:

- **Expand Medicare site-neutral payments** for appropriate outpatient services with appropriate protections for rural hospitals.
- **Increase transparency and limits around so-called "facility fees**," including clearer billing disclosure of site-of-service and stronger guardrails against add-on "junk fees" like facility fees.

2) Hospital Price and Billing Transparency

We strongly support efforts to advance hospital price and billing transparency, ensuring patients are billed accurately based on where and how they receive care. We applaud the advancement of the honest billing provision that was recently enacted as part of the Consolidated Appropriations Act, 2026. That provision will require off-campus hospital outpatient departments (HOPDs) of Medicare providers to obtain and use a unique NPI, ensuring that patients and payers have the data necessary to dispute erroneous fees, unfair add-on costs, hospital upcharges and other junk fees.

To build on this achievement and further protect patients from inappropriate billing practices, Congress should:

- **Strengthen and enforce hospital price transparency and billing requirements**.
- **Improve billing clarity by overseeing implementation of "honest billing" provisions in the Consolidated Appropriations Act, 2026 so patients can see the location of care and distinguish professional fees from facility fees**.

3) Anti-Competitive Contracting and Network Design Flexibility

One of the most onerous ways hospitals are preventing employers and payers from delivering real value is by imposing contract terms that constrain network design and block steering. The Justice Department's litigation against New York-Presbyterian highlights these plan restrictions that "preclude insurers and employers from offering…budget-conscious health insurance plans," including restrictions that limit tiering and steering.

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[8] CMS. (2025, November) Hospital Outpatient Prospective Payment Final Rule. https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

[9] MedPAC (2023, June): Report to Congress: Medicare and the Health Care Delivery System: https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/

Policies that prohibit anti-competitive contracting – such as “all-or-nothing,” anti-tiering, and anti-steering clauses – can empower employers to offer high-value networks and steer patients toward higher-quality, lower-cost providers, which retains patient choice while delivering cost savings.

- We urge Congress to **support H.R. 6248, the Healthy Competition for Better Care Act**, which would address these anti-competitive practices. The Congressional Budget Office estimated that a previous version of the bill, H.R. 3120, introduced in the 118th Congress, would reduce deficits by $4.9 billion over 2025–2034.[10]

4) Freestanding Emergency Departments

Hospitals are increasingly purchasing freestanding emergency departments (EDs) where they can bill for ED-level billing for care that may be safely delivered in lower-cost settings (when clinically appropriate). Further, oftentimes these freestanding EDs are marketed to appear as independent urgent care facilities, leaving patients surprised when they receive a high bill.

MedPAC’s work on stand-alone emergency facilities documented rapid growth in Medicare ED spending: outpatient and physician ED spending increased from $4.4 billion (2008) to $6.1 billion (2013), reflecting 7% per-capita growth per year on average over that period.[11]

- We urge the Committee to investigate **freestanding EDs** to stem rising costs and inappropriate advertising practices; and
- Additional exploration into **how Medicare payment policy and transparency/ownership rules can curb excess spending** while protecting emergency access.

We thank you for your leadership and your work to advance policies to lower health care costs for working families. We look forward to working together to advance public policy that makes health care more affordable, supports continued innovation, improves job-based coverage, and advances the health care system for all patients.

Respectfully,

The Alliance to Fight for Health Care

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[10] Congressional Budget Office. (2024, November 12). *H.R. 3120, Healthy Competition for Better Care Act* (Cost estimate). https://www.cbo.gov/publication/60976

[11] Medicare Payment Advisory Commission. (2015, September 11). *Emergency department services provided at stand-alone facilities* [Public meeting presentation]. https://www.medpac.gov/document/microsoft-powerpoint-free_ed_presentation_sept2015b-pptx/