

October 2, 2026

Sen. Ron Wyden (D-OR), Ranking
Member, Committee on Finance
Sen. Jon Ossoff (D-GA)
Sen. Lisa Blunt Rochester (D-DE)
Sen. Sheldon Whitehouse (D-RI)

Sen. Elissa Slotkin (D-MI)

Sen. Tina Smith (D-MN)

Sen. Mark Warner (D-VA)

Sen. Raphael Warnock (D-GA)

Sen. Tammy Baldwin (D-WI)

Sen. Jeff Merkley (D-OR)

Sen. Elizabeth Warren (D-MA)

Sen. Peter Welch (D-VT)

Dear Senators Wyden, Ossoff, Blunt Rochester, Whitehouse, Slotkin, Smith, Warner, Warnock, Baldwin, Merkley, Warren, and Welch:

Thank you for the opportunity to comment on your [request for information](#) outlining proposals to improve health care affordability and lower costs for all Americans. The **Alliance to Fight for Health Care** shares your goal of making coverage and care more affordable, which is key to making care more accessible for all patients and commend your work to ensure all Americans have access to affordable coverage. We appreciate the opportunity to engage with the working group.

We believe that any future coverage reforms must focus on improving the current coverage system. Employer-sponsored coverage (ESI) is the backbone of U.S. health care. More than 180 million Americans¹ rely on employer plans for their health and financial security. Employers do more than purchase insurance: they invest in prevention, care coordination, and benefit innovations that keep workers healthy and productive. Any durable solution to rising health costs must preserve and strengthen employer coverage, including protecting the current tax treatment of this health care, while addressing the underlying market drivers that increase premiums and out-of-pocket costs for American workers and their families.

Employers, unions, and health trusts are invested in the health of their employees and their family members. Employers want to offer the most robust comprehensive coverage that is affordable to employees, but they too must balance expenses and work to control health care costs and demand quality. Unfortunately, broken markets and structural drivers like high hospital prices, opaque billing practices, hospital and provider consolidation, and payment distortions that divorce cost from quality and encourage care in higher-priced settings and reward care that doesn't drive improved health outcomes.

¹ Census. (2026, September). Health Insurance Coverage in the United States: 2026
<https://www2.census.gov/library/publications/2026/demo/p60-291.pdf>

These forces affect not just ESI costs but also Medicare and Medicaid spending, federal tax expenditures, and household budgets.

Employers provide comprehensive and affordable coverage to more Americans than any other source of coverage in the United States. If employer coverage is weakened the consequences would be immediate and measurable for millions and millions of workers and their families. Working people could face higher out-of-pocket costs and narrower networks. Benefits would be designed not for individuals and their families but based on what the government deems affordable or valuable. People could lose access to ancillary supports that employers provide, like supplemental wraparound mental health care, women's health support, nursing lines, advanced primary care services, financial counselling, benefit navigation services, cancer support, and many more.

In some cases, employees could lose coverage entirely, such as when the government limits who is eligible for coverage. Employers would face greater turnover and productivity losses, and taxpayers could see higher governmental and uncompensated care spending. Supporting high-quality, cost-effective employer-sponsored coverage is not just a health issue: it is an economic priority.

In addition, any efforts to weaken employer coverage would also negate the innovation that employers have designed and championed in recent years to help control costs. This includes innovative payment models and value-based care arrangements that strive to address the underlying market drivers increasing costs by fundamentally changing the way we pay for care.

Health care needs vary drastically by geographic location and patient population, and the current system enables employers and their partners to tailor benefit designs to specific employee populations. This means an employer operating in a rural area can tailor benefits to ensure those workers have access to a broad network of coverage that includes telehealth options and on- or near-site clinics and community partnerships with reduced or no cost-sharing for preventive care. Meanwhile, an employer in an urban area — where there are more care options — can ensure workers have access to high-value providers with more streamlined and high-performance networks that enable them to control costs.

Research has demonstrated that employer-provided coverage provides significant economic, social, and public health [benefits](#). According to a National Bureau of Economic Research [working paper](#), employer-provided coverage delivers significant value – at least \$1.5 trillion in social value annually beyond the cost of insurance borne by businesses, workers, and government tax exemptions, accruing nearly \$10,000 per person.

As a coalition representing employers, workers, patient advocates, unions, and other stakeholders, our focus is on strengthening and improving ESI by protecting the tax treatment of this health care and advancing policies that lower underlying system costs and improve patient care. We believe reforms should avoid merely shifting costs among patients, employers, and taxpayers and instead focus on the root drivers of spending growth, particularly in areas where evidence shows prices are rising and competition is limited. Below, we:

- outline the importance of protecting the tax treatment of health care.
- warn against new policies that would further decrease affordability, and
- list several key contributors to increased health care unaffordability, along with bipartisan, concrete policy solutions to address them.

We appreciate your consideration and look forward to working together to lower costs and improve care.

Protecting the Stable Employer Coverage Upon Which 180 Million Americans Rely by Protecting the Tax Treatment of Health Care

As noted in the RFI, the health benefits unions and employers provide workers are not treated as taxable income or wages to the employee. The cost of health coverage is “excluded” from an employee’s taxable income. Some have argued the tax treatment of health care leads to greater health care inflation and various policymakers have proposed eliminating, capping, or converting the current tax exclusion.

Unfortunately, one such proposal was signed into law, imposing a 40% “Cadillac Tax” on coverage above certain thresholds. Unions, employers, and patients quickly realized the tax would lead to higher deductibles and out-of-pocket costs for workers and it would most affect employers that employ higher numbers of older workers, women, or those with larger families or family members with chronic or acute illnesses – the populations that most need robust health coverage. The 40% “Cadillac Tax” also would have inadvertently targeted workers in specific industries, such as manufacturing or law enforcement, which tend to have higher health care costs for riskier jobs. For these reasons, our organization (under the name the Alliance to Fight the 40), worked closely with bipartisan members of Congress to achieve full repeal of the 40% “Cadillac Tax” in 2019. Any renewed efforts to eliminate, cap, or convert the tax exclusion would constitute a new tax on employees and threaten the primary source of health care coverage in the United States.

Instead, we urge policymakers to **protect** the tax treatment of health care, thereby protecting employers' investment in the health of their workforces. The tax-free nature of employer-sponsored coverage drives employers to innovate (through creative benefit strategies and designs) and invest: for every dollar the government foregoes because of the exclusion, employers pay \$5.37 in health care benefits for workers.² Increasing costs and health care prices are the true drivers of health care inflation – not the tax treatment of health care. One of the best ways to protect the employer-sponsored coverage upon which 180 million Americans rely is to advance policies that lower costs for employers and make it easier for employers to offer workers robust benefits packages – utilizing designs that reward high-quality and allow maximum flexibility for employers.

In addition, we urge the committee to consider the unintentional policy impacts – such as additional fees on employer-sponsored insurance – can have patients' out-of-pocket costs and premiums. For example, the Affordable Care Act included several fees that employers ultimately shouldered that did not result in improved outcomes or lower costs for workers, but ultimately contributed to the rise in costs workers face. The latest polling data show how important the current affordability debate is to voters. For example, Kaiser Family Foundation polling show health care costs are a top concern for voters, with 62% saying they are “very worried” or “somewhat worried” about health care costs.³ Similarly a poll from Families USA found 94% of voters believe it is important for the President and Congress to take action to lower health care costs, with 74% calling it very important.⁴

Below the Alliance outlines seven specific policies we urge Congress to advance, and we stand ready to work with you to protect and strengthen this critical source of coverage for so many American workers and their families.

The Rising Cost of Care

A key concern of many American voters is the cost of 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 \$5.7 trillion in

² American Benefits Council, (2026, September) Benefits Bargain 2025.

<https://www.americanbenefitscouncil.org/pub/17316EFE-CABB-D1BD-3D05-E9E96C375F6C>

³ Kearney et al, (2026, July) Kaiser Family Foundation.

<https://www.kff.org/public-opinion/kff-health-tracking-poll-public-views-on-fraud-in-government-health-programs/>

⁴ Families USA, Press Release, (2026, August). <https://www.familiesusa.org/press-releases/high-health-care-costs-unreasonable-hospital-prices-top-voter-concerns-in-new-national-poll-as-midterm-elections-inch-closer/>

2025, growing 7.3% year over year and increasing health spending share of GDP to 18.4%.⁵ The increase in health care costs and spending are being driven by several structural factors:

- high hospital prices,
- opaque billing structures,
- provider consolidation, and
- payment distortions that encourage care in higher-priced settings.

Hospital prices and facility fees continue to grow faster than wages and inflation, accelerated by consolidation and acquisition of independent physician practices. Data show the proportion of hospitals affiliated with health systems has risen from 56% in 2010 to 69% in 2024 –this growth has occurred in both rural and urban areas. The data show 80% of hospital markets in metropolitan areas saw an increase in market concentration or single health system control from 2015 to 2024.⁶

This increased level of consolidation enables hospital-owned facilities to charge higher rates for the same services, at the same location, often by the same providers. Reports consistently find that such mergers can lead to price hikes of up to 65%, and despite claims to the contrary, deliver no meaningful improvements in quality, but result in higher costs to patients and employers. Patients are left paying higher premiums, higher copays, and indefensible hospital facility fees for care provided nowhere near the hospital facility. A decade of data offers insight into the effects of hospital consolidation on patient costs:

- **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%.⁷

⁵ Health Affairs. (2026, June 24). *National Health Expenditure Projections, 2025-34: Strong Utilization Growth Initially, Legislative Impacts Later*. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2026.00642>

⁶ Kaiser Family Foundation, One or Two Health Systems Controlled the Entire Market for Inpatient Hospital Care in Nearly Half of Metropolitan Areas in 2024, (2026, March 27). <https://www.kff.org/health-costs/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas/>

⁷ 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.⁸
- **2017 MedPAC Report:** Showed that physician-hospital consolidation increases prices for both commercial and Medicare physician services, with no commensurate quality gains.⁹

Anti-competitive practices blunt the ability of employers and other payers to meaningfully negotiate for better, reasonably priced care for patients without risking patient health. Hospitals have used anti-steering, anti-tiering, and “all-or-nothing” contract provisions that prevent insurers and employers from incentivizing patients to use lower-cost, higher-value providers and sites of care. These restrictions limit plan design tools—such as tiered benefits and high-performance networks—that employers use to control costs and reward higher-value providers. Hospitals coerce employer-sponsored health plans to sign anti-competitive contract terms that often protect low-quality or high-priced facilities in exchange for basic patient access to rural health care, emergency or maternal health care. For example, the U.S. Department of Justice (DOJ) antitrust lawsuits against OhioHealth and New York-Presbyterian Hospital allege that hospitals used anti-steering, anti-tiering, and “all-or-nothing” contract provisions that prevented insurers and employers from incentivizing patients to use lower-cost, higher-value providers and sites of care, restricting the ability of payers to design budget-conscious plans, including quality networks and tiered benefits, thereby blunting competition that could incentivize providers to improve care or reduce outlier high-prices.¹⁰

Internal documents included in DOJ litigation show that hospital systems view tiering and steering as threats to their profits, reinforcing claims that such provisions are used strategically to suppress competition rather than to improve quality or support patient interests.

⁸ 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

⁹ 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

¹⁰ 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>

A report from the O'Neill Institute for National and Global Health Law found anti-steering and all-or-nothing hospital contracting raises costs by preventing insurers from connecting 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.¹¹

Ultimately, these practices can leave patients paying more for care without receiving better outcomes and can impact their ability to make informed decisions about their care.

Health care workforce shortages, particularly in primary care and mental health, result in patients seeking care in higher priced and clinically inappropriate settings. Several reports highlight the burden these workforce shortages place on our health system and the patients it is meant to serve:

- **2024 Milbank Memorial Fund Primary Care Scorecard:** Found that shortages and underinvestment in primary care are associated with increased reliance on higher-cost settings such as emergency departments and hospitals, as patients face limited access and longer wait times for primary care.¹²
- **2025 HRSA / 2026 CDC Behavioral Health Data:** Showed that widespread mental health workforce shortages (affecting ~40% of the U.S. population) are linked to high and increasing levels of mental health-related emergency department visits, indicating care shifting to costly and clinically inappropriate settings.¹³

The Role of Employers and Labor Unions in Driving Down Costs

Employers and labor unions are uniquely positioned to help control health care costs as they play a central role in delivering health coverage for working families and retirees, not as passive intermediaries, but as active purchasers and innovators committed to improving affordability, quality, and health outcomes. Collectively, they have strong incentives to invest in workplace wellness, care management, and value-based payment pilot programs,

¹¹ 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/>

¹² Milbank Memorial Fund. (2024, February 28). *The health of U.S. primary care: 2024 scorecard report—No one can see you now*. <https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/>

¹³ U.S. Department of Health and Human Services, Health Resources and Services Administration. (2025, December). *State of the behavioral health workforce, 2025*. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>

and to reduce unnecessary spending because healthier, happier, more productive employees reduce total labor and benefits costs¹⁴.

Employers and unions increasingly demand measurable value from the health care system, including improved outcomes, better care coordination, and increased accountability for cost and quality. Over the past decade, many have led successful efforts to move away from fee-for-service arrangements toward value-based purchasing strategies — such as alternative payment models, high-performance networks, data-driven benefit design, and enhanced care management for high-cost and chronic conditions.

This commitment to innovation is well documented. For example, the American Benefits Council, in partnership with Mercer, have twice highlighted examples of employer-led innovations that align payment with value, incentivize quality, personalize care, and embrace new delivery models – demonstrating that employers and unions are often ahead of the market in testing approaches that lower costs while improving outcomes for employees and their families.¹⁵

However, the ability of employers and labor unions to continue innovating is increasingly constrained by federal policies that penalize innovative benefit designs rather than addressing the underlying drivers of health care costs. Past proposals like the (thankfully) never-implemented “Cadillac Tax” on employer-provided coverage highlight the risks of blunt benefit-based penalties that do not distinguish between high-cost care and high-value coverage, particularly for collectively bargained plans and employers in high-cost regions or with higher-cost workforces.

It is essential that any reforms to the coverage system preserve the flexibility for these types of innovative care models while ensuring a level playing field and protecting competition. Further, Congress should seek to better understand the full impacts of broad mandates on benefit designs — including, but not limited to, reforms related to coinsurance, deductibles, and out-of-pocket costs — as those changes would have both direct and indirect impacts on premiums, enrollment, federal spending, and consumer

¹⁴ Gallup. *Employee Wellbeing Is Key for Workplace Productivity*.
<https://www.gallup.com/workplace/215924/well-being.aspx>

¹⁵ American Benefits Council and Mercer, *Leading the Way: Employer Innovations in Health Coverage* (2018 March) and *Leading the Way, Volume II: Employer Innovations in Healthcare Affordability and Value* (2026 July) <https://www.americanbenefitscouncil.org/pub/16E9BBE3-9B27-D7AA-EC7C-E9F86419C786>
https://www.mercer.com/assets/us/en_us/shared-assets/local/attachments/pdf-american-benefits-council-innovation-report.pdf

choice. It is imperative Congress fully understand those full impacts, including how they will increase costs for patients, before creating new mandates.

Employers and labor unions are seeking partnerships with working groups and policymakers to advance solutions that focus on the true sources of health care spending growth and that partner with employers to support the changes needed to innovate on behalf of workers.

Policies to Address Health Cost Drivers and Distortions

One of the most important ways policymakers can protect and strengthen coverage for all Americans – including the ESI upon which 180 million Americans rely – is to advance 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 premiums and household budgets. We believe Congress can play a critical role by targeting specific practices that increase costs for patients, employers, and unions without improving outcomes.

1) Site-Neutral Payment Reform

The Alliance strongly supports ensuring all Americans have access to life-saving medical care when they need it. Alliance members are grateful to the millions of health care workers, including nurses and all levels of providers who work hard to ensure their patients have the care they need. Unfortunately, some actors within the health care system are taking advantage of the \$5.7 trillion our country spends every year at the expense of employers and workers. Patients are frequently charged inflated prices simply because care is delivered in a hospital-owned setting rather than a stand-alone physician office or ambulatory setting, even when the service is clinically identical. Currently, Medicare pays hospital outpatient departments (HOPDs) higher rates than stand-alone physician offices for the same services, which encourages the hospital acquisition of physician practices and conversion to higher-paid billing status. Expanding site-neutral payment policies and limiting inappropriate facility fees would reduce incentives for consolidation and lower out-of-pocket costs.

The Alliance supports expanding site-neutral payments and urges Congress to codify CMS's recent rule¹⁶ to apply site-neutral payments to outpatient drug administration services and

¹⁶ 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>

imaging without contrast. Savings are estimated to be \$220 million for the Medicare program – \$70 million in lower cost-sharing for beneficiaries in 2026 alone.¹⁷ Starting this year, CMS will apply site-neutral payment rates to these services in excepted off-campus provider-based departments, excluding rural sole community hospitals.¹⁸

We also support more expansive proposals such as removing the grandfathering provision in the Bipartisan Budget Act of 2015 and 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. These policies and other site-neutral policies were assessed in a 2025 *Health Affairs* article that highlights annual Medicare payment reductions ranging from \$212 million to \$7.36 billion (See Table 1). These policies would not only generate savings for Medicare beneficiaries and the program but would critically mitigate unintended financial incentives that spur consolidation in the physician market and result in higher prices for all payers and patients.

Table 1: Service volume (claims) and payments by outpatient setting, and estimated savings, under three Medicare site-neutral payment policy options, 2021

	Lower Costs, More Transparency Act (H.R. 5378, 118th Congress)* Off-campus (4 APCs)	Actuarial Research Corporation (ARC) Off-campus (12 APCs)	MedPAC On- and off-campus (66 APCs)
Hospital outpatient department			
Claims (thousands)	3,541	6,733	89,082
Payments (millions)	\$428	\$980	\$15,371

¹⁷ CMS. (2026, July) Medicare Physician Fee Schedule Proposed Rule. <https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other>

¹⁸ Lou, K. K., Linehan, K. E., da Fonte, L. N., Lai, P., & Buntin, M. B. (2025). *Medicare site-neutral payment policies: Effects of proposals on hospitals and beneficiary groups*. *Health Affairs*, 44(6). <https://doi.org/10.1377/hlthaff.2024.01501>

Ambulatory surgical center			
Claims (thousands)	12	36	4,663
Payments (millions)	\$1	\$2	\$3,150
Physician offices			
Claims (thousands)	19,693	55,921	181,217
Share performed in physician office	46.8%	56.4%	65.9%
Payments (millions)	\$1,166	\$4,585	\$15,887
Total			
Claims (thousands)	23,246	62,689	274,962
Payments (millions)	\$1,596	\$5,567	\$34,408
Annual estimated savings (millions of 2021 dollars)	\$212	\$516	\$7,358
Annual estimated savings (millions of 2021 dollars)	\$42	\$103	\$1,472

*Site neutrality for four Ambulatory Payment Classification (APC) codes for drug administration provided in hospital outpatient departments is included in this legislation.

To address these disparities, we urge lawmakers to advance policies that:

- **Expand Medicare site-neutral payments** for appropriate outpatient services, such as those outlined in the above table, with appropriate protections for rural hospitals.

- **Increase transparency around, and impose limits on, so-called “facility fees,”** including clearer billing disclosure of site-of-service and stronger guardrails against add-on “junk fees”– for example, hospitals should be prohibited from charging facility fees for telehealth services.

Enacting site-neutral payments will lower the cost of coverage across markets by reducing Medicare spending, restraining price-driven consolidation, slowing premium growth for employer plans, and reducing surprising out-of-pocket charges for employees.

2) Hospital Price and Billing Transparency

We strongly support efforts to advance hospital price and hospital 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, 2026.¹⁹ That provision will require off-campus hospital outpatient departments (HOPDs) of Medicare providers to obtain and use a unique National Provider Identifier (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 hospital billing practices, the Senate Finance Committee could:

- Require standardized, machine-readable hospital transparency files that include site-of-service identifiers, facility NPIs, and a clear delineation of professional versus facility charges for each billed service.
- Strengthen civil monetary penalties for hospital noncompliance and authorize federal funding for periodic HHS audits to validate hospital transparency data.
- Require hospitals to provide patient-friendly pre-procedure cost estimates for scheduled services that separate professional and facility charges and provide an expected out-of-pocket estimate.

Clearer and enforceable hospital transparency reduces administrative disputes and plan trend increases, helping to stabilize premiums and out-of-pocket exposure.

3) Eliminate Anti-Competitive Contracting and Protect Network Design Flexibility

¹⁹ The Alliance to Fight for Healthcare. (2026, February 4). *Alliance Applauds Passage of Honest Billing Provision*.
https://www.fightforhealthcare.com/_files/ugd/7fe67d_2d571e3d217e4cd1929271b5642a20aa.pdf

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 patient care incentives. The U.S. Department of Justice's litigation against New York-Presbyterian highlights restrictions that "preclude insurers and employers from offering ... budget-conscious health insurance plans," including restrictions that limit tiering and the development of quality networks.

Policies that prohibit pro-patient contracting — i.e. allowing employers, unions and health plans to identify low-performing hospitals or doctors for patients, allowing benefit designs that lower patient cost-sharing at the best-performing hospitals and other policies that help patients access the highest value hospitals — prevent our whole health care system from advancing the lower-cost and high-quality options patients are demanding.

- We urge the committee to **support S. 4027, the Healthy Competition for Better Care Act**, which would address these anti-competitive practices holding back our health care system. The Congressional Budget Office estimated that a previous version of the bill introduced in the House during the 118th Congress, H.R. 3120 would reduce deficits by nearly \$5 billion over 2025–2034.²⁰

Enabling employers and plans to design high-value networks – (1) lowers premium and benefit cost trends, (2) gives workers access to higher-value, lower-cost providers, (3) can prevent medical complications for patients, and (4) encourages hospitals and providers to offer higher quality and where possible, lower cost care.

4) Freestanding Emergency Departments (FSEDs)

Hospitals are increasingly building or purchasing FSEDs where they can bill for emergency department-level care that may be safely delivered in lower-cost settings. Often these FSEDs are marketed to appear as independent in-network urgent care facilities, leaving patients surprised when they receive a higher emergency room bill. Employers have reported the construction of FSED's in neighborhoods designed to cherry-pick patients, followed by double patient admission charges when FSEDs are not able to adequately handle emergency-level care or inpatient admissions and those patients are transferred to hospitals better equipped to manage their care.

²⁰ Congressional Budget Office. (2024, November 12). *H.R. 3120, Healthy Competition for Better Care Act* (Cost estimate). <https://www.cbo.gov/publication/60976>

Insurers also report an increase in FSEDs refusing to negotiate for in-network status to secure exorbitant reimbursement through binding “surprise-billing” arbitration settlements.

One of our members reported a sharp increase in plan costs, after several FSEDs opened near their patient populations. 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 7.0% per-capita growth per year on average over that period.²¹

We urge the committee to:

- Investigate **FSEDs** to stem rising costs and inappropriate advertising practices, and
- Further explore **how Medicare payment policy and transparency/ownership rules can curb excess spending** while protecting emergency access.

Curbing inappropriate FSED growth and advertising prevents unexpected plan cost spikes that translate into higher premiums and reduced benefit generosity for enrollees.

5) Private Equity Ownership Transparency and Reporting Gaps

Affordability and competition concerns increasingly intersect with opaque private equity ownership structures, that can obscure accountability and market dynamics. The Federal Trade Commission (FTC) has highlighted major growth in private equity acquisition of physician practices. A 2025 Government Accountability Office (GAO) analysis found that private equity investment in physician practices can lead to increases in commercial insurance spending, particularly for specialty physician practices.

We support recent federal enforcement efforts that underscore heightened scrutiny of private equity-backed consolidation strategies in health care—particularly roll-up activity that may reduce provider competition and increase costs for patients. These actions reinforce the importance of targeted, fact-specific antitrust oversight while preserving access to high-quality clinical services.

- The Alliance supports **increasing ownership transparency for hospitals and private equity-backed health facilities**, and we encourage the committee to

²¹ 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/

pursue **reporting frameworks** that make such ownership, affiliations, and consolidation patterns transparent to patients, payers, and policymakers.

Increased transparency around private equity ownership, affiliations, and physician-hospital consolidation patterns should help regulators better monitor and potentially prevent acquisitions that would lead to more concentrated health systems and increased costs for employers and workers.

6) Surprise Billing: Protecting Patients from Surprise Bills and Surprise Premium Increases

We strongly support the consumer protections established by the No Surprises Act (NSA) and agree patients should not be caught in the middle of payment disputes. However, while the NSA has provided important consumer protections, new problems have emerged—particularly when certain providers exploit arbitration and ancillary billing pathways. Continued oversight and enforcement are essential to ensure patients are fully protected from unexpected charges. While patients are not paying the surprise bills directly, they are experiencing surprise premium increases, because the current surprise billing framework has contributed to higher costs. CMS recently reported health care providers secured nearly \$15 billion in additional payments in 2025 using the NSA arbitration process — a 264% increase from the \$4.04 billion awarded in 2024. These increased payments are being passed along to patients and workers in the form of higher premiums.²²

We recommend Congress and the administration advance policies that will stop rewarding the handful of bad actor provider organizations and middlemen that are exploiting the system by driving up costs and eroding networks. The NSA was estimated by the Congressional Budget Office to lower the deficit by reducing premiums and encouraging more network participation — unfortunately, the opposite has happened as even CBO has recognized in a [recent call for research](#). Specifically, the Alliance urges policymakers to restore congressional intent and restore the primacy of the median in-network payment for that service in that geographic area. We believe this will cut down on the runaway awards driving up costs and the overwhelming volume of claims sent to IDR – and it will lead providers back to networks — a key goal of the No Surprises Act. The Alliance believes providers should be paid fairly and timely — but awards that are multiples above in-

²² CMS. Independent Dispute Resolution Reports. <https://www.cms.gov/nosurprises/policies-and-resources/reports>

network amounts will begin to unravel our health care system as costs continue to balloon and networks erode.

Other actions must be taken to crack down on abusive IDR entity practices and decisions that favor providers nearly 90% of the time with outrageous payment determinations that are unsustainable for workers and families. According to a recent [*New York Times*](#) investigation, an arbitrator awarded \$333,000 — roughly 125 times the standard rate — for a diagnostic procedure to measure blood flow to the brain, with no cross-examination, no hearing, and no explanation. Sadly, these exorbitant examples are becoming more common as more cases are dumped into IDR. Congress and the administration must act quickly to put a stop to these abusive practices that are driving up costs for employers, workers, and patients.

Advancing policies that will encourage more providers to participate in networks will drastically lower costs and premiums for employers, unions, workers, and patients. While many of the other health care policies listed above will necessitate a longer lead time to result in lower costs, addressing arbitration abuse will likely result in lower costs for employers and unions.

7) Simplifying Access and Expanding Innovation

We also support a variety of other policies and efforts aimed at making health care easier to navigate and more accessible, including:

- **Expanding telehealth across state lines** and **eliminating unnecessary fees, like facility fees**, that increase costs for patients without improving care;
- Allowing **greater flexibility in HSA-qualified plans** so unions, employers, and health plans can offer high-value services before patients meet their deductible; and
- Investing in healthcare **workforce expansion**, particularly in primary care and behavioral health.

Addressing workforce shortages requires targeted, funded interventions. We recommend Congress pursue the following:

- Fund targeted loan-repayment and scholarship programs for primary care and behavioral health clinicians tied to practice in high-need and underserved areas.
- Expand and fund Medicare and Medicaid payment incentives for integrated primary care and behavioral health, including higher primary care visit payments and care management add-ons.

- Support evidence-based scope-of-practice reforms and state-federal collaborations that enable team-based care models (including nurse practitioners, physician assistants, community health workers, and clinical pharmacists) where safe and effective.
- Create grant programs to scale employer-provider apprenticeship and residency partnerships that expand primary care capacity and support upskilling of the workforce.

Strengthened primary care and behavioral health capacity reduces avoidable high-cost utilization, improves chronic disease management, and lowers total benefit cost pressure over time.

In conclusion, we welcome collaboration on reforms that protect and strengthen employer-sponsored health coverage by addressing rising health care prices and other factors driving health care cost increases, ultimately, reducing costs for patients and taxpayers without sacrificing access or quality. We believe the most durable path forward is to improve our current health coverage system by addressing structural cost drivers, including provider pricing and billing practices, site-of-care distortions and facility fees, anti-competitive contracting restrictions, hospital and provider consolidation and private equity opaque ownership, and implementation gaps that undermine surprise billing protections.

Employer-sponsored coverage remains the primary source of health security for a majority of Americans. Policies that lower prices, address hospital anti-competitive contracting practices, improve billing clarity, and protect plan design flexibility will directly reduce employer premiums, preserve benefits, and protect workers. The Alliance stands ready to partner with the committee to design pragmatic, evidence-based reforms that preserve the reach and value of employer coverage while lowering costs for patients, employers, and taxpayers.

Sincerely,

The Alliance to Fight for Health Care

CC: All members of the Senate Finance Committee

The **Alliance to Fight for Health Care** is a broad-based coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups and other stakeholders that support

employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an available and affordable option for working Americans and their families.