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**United States House of Representatives
Committee on Ways and Means
Full Committee Hearing with Health System CEOs**

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Chairman Smith, Ranking Member Neal, Members of the Committee, thank you for the opportunity to submit testimony for the record.

United States of Care (USofCare) is a nonpartisan, nonprofit organization working to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. Importantly, we are committed to improving the health of everyday people and are eager to engage in solutions that do just that. We advocate for new solutions to tackle our shared health care challenges – solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our [work in states](#) and [listening to people's experiences](#) with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the [federal level](#).

The concept of “affordability” may have [recently entered](#) the political consciousness in a more prominent way, but for a long time, **cost has been the driving concern** people across demographic, geographic, and ideological spectrums have about health care – and that’s irrespective of their coverage type or status.

Through USofCare’s extensive work since we launched the organization in 2018 to listen to people about the health care system and their experiences with it, [cost is consistently the first – and most prominent – issue people raise](#). It is not solely about their inability to pay, but also the anxiety and the worry they won’t be able to afford the care they or a family member need in the future. For people, affordability impacts every facet of their experience – it’s the through-line of every single entry point into the health care system and impacts every decision they make. Cost also [impacts people’s decisions not to seek care](#).

As Congress and this Committee put health care affordability into sharper focus, one resounding truth is clear: people are struggling to pay for the care they need.

Year after year, people are straining to access care as costs and prices continue to skyrocket. Hospital spending continues to make up the [largest share](#) of total health care expenditures – outpacing spending on retail prescription drugs and physician services combined.

Since [2000](#), more than 1,300 mergers have occurred among roughly 5,000 hospitals nationwide – and market consolidation is one of the primary drivers of hospital price increases. This [decades-long hospital consolidation has resulted in](#) large hospital systems amassing substantial market power, crowding out competition, and hiking prices and fees for patients who are

ultimately left making an impossible decision to assume financial hardship to afford care, or forego care altogether.

If Congress is going to meaningfully address the affordability challenges that people are facing, it must prioritize excessive hospital prices. USofCare offers the following solutions to tackle this affordability crisis, which have broad, bipartisan public support, as demonstrated by [recent polling](#) we conducted.

Solutions are available to Congress that address health care costs for people without impacting hospital solvency. USofCare partnered with the Brown University Center for Advancing Health Policy through Research (CAHPR) to [evaluate](#) the impact of three different policies – facility fee limitations, site neutral payments, and commercial payment caps – on consumer premiums and out-of-pocket costs in three states (Indiana, Massachusetts, and North Carolina), as well as on hospital operating margins. **This analysis demonstrated savings for consumers while also having virtually no impact on hospital operating margins.**

Facility Fee Limitations

A growing body of research shows that provider consolidation is **raising out of pocket health care costs for consumers**. As more sites of care fall under hospital ownership, consumers have more exposure to facility fees for even routine services. In some cases, patients are being charged facility fees for telehealth visits with their doctors, without ever stepping foot in a facility. In one instance, a [Colorado family](#) was billed for an \$847.35 facility fee for one speech therapy session that was conducted via telehealth.

In addition, as hospital prices rise, consumers face increased out-of-pocket costs through deductibles and coinsurance, which are tied to the underlying cost of the service. One [study](#) found that between 2011 and 2017, outpatient surgeries saw a 53% increase in facility fee charges and consumer out-of-pocket expenses grew by 50 percent. These additional charges and higher prices are expected to only [increase](#) as provider consolidation intensifies. And finally, as overall hospital prices go up, commercial payers are [more likely](#) to pass those costs onto consumers in the form of higher premiums.

Hospitals have argued they need to charge facility fees to account for key features that are unique to hospital care like 24/7 hour operations and staffing for high-acuity services like emergency and trauma care. But physician offices owned by hospitals that have none of these key features are charging facility fees – something that these very same offices didn't do before they were bought by the hospital. Policies that put reasonable limits on facility fees for services like routine doctors' office visits and telehealth appointments have been successfully implemented in [states](#) such as Indiana, Connecticut, and Colorado. Despite hospital arguments that these policies will devastate hospitals financially, a [recent study](#) found that Connecticut's 2017 facility fee law had no overall impact on hospital profits in the state, while it also protected consumers from facing additional exorbitant fees.

We strongly urge Congress to take steps to prohibit facility fees for routine, preventive, and telehealth services.

Improved Price Transparency

Despite good-faith reform efforts, the health care system **remains complex and difficult to understand for patients**. Federal efforts to promote hospital price transparency have represented an important step forward, but patients remain as baffled as ever by a health care system that is designed to confuse. More than five years after federal rules from CMS [first required](#) hospitals to post the prices of hundreds of everyday services on their websites, [compliance](#) with the rules is still a problem, leaving patients in the dark about the true cost of hospital care.

As health care costs continue to rise and exacerbate the health care affordability crisis people are facing, medical debt is a growing financial burden that many people face when they need care. A recent [poll](#) from USofCare found that 49% reported experiencing at least one financial pressure related to a medical bill (i.e. put a medical bill on a credit card, contacted by a credit agency, took out a loan, etc.) in the past two years. 21% of people reported that they've carried medical debt in the last two years. Nearly [30%](#) of adults who owe medical debt owe it entirely for hospital bills.

Many [states](#) have taken action to promote price transparency to provide patients with the information needed to make educated health care decisions for themselves and their families. By making this information available and transparent, **policymakers are also able to use this data to pursue additional cost-savings solutions that can ultimately lower the underlying cost** of care and deliver savings for people, employers, and state budgets.

Congress should build on CMS's efforts to improve hospital price transparency by codifying these requirements and enhancing civil monetary penalties for hospitals that fail to follow these requirements. Additionally, Congress should follow the lead of states – like [Colorado](#) – that have prohibited hospitals not in compliance with hospital price transparency rules from taking extraordinary collection actions on medical debt from patients. **This comes down to basic fairness – if a patient can't find out the cost of the care they need, they shouldn't face financial ruin through [lawsuits](#), [wage garnishments](#), [liens on their homes](#), and lower credit scores.**

Site Neutral Payments

A **major driver of high costs** in hospital care – and the health system as a whole – stems from **payment differentials between care settings**. Under their respective payment systems, Medicare pays outpatient health facilities, including hospital outpatient departments (HOPDs) higher rates than physician offices for delivery of the same service. This discrepancy incentivizes hospitals to move patients into higher-cost settings in order to receive a higher payment rate. The payment rate under the OPDS is often [200-300%](#) of the rate paid for the same services in physician offices – shifting additional costs onto beneficiaries and the Medicare program as a whole.

Hospital and health system acquisition of physician offices and outpatient facilities has highlighted the need to implement site neutral payments in [Medicare](#) and also in the [commercial market](#). In too many instances consumers are charged more for a service on the sole basis of where it's performed, **increasing costs to them personally as well as to the system overall**. What's more, there's **no improvement in the quality** of that service.

The Centers for Medicare & Medicaid Services (CMS) took action in the Calendar Year (CY) 2026 Hospital Outpatient Prospective Payment [final rule](#) to establish a site-neutral payment rate for drug administration services. This change alone is estimated to save Medicare beneficiaries \$70 million in reduced coinsurance costs and the Medicare program \$210 million for CY 2026 alone.

There is evidence indicating that billing for a number of different services has shifted from the PFS to the OPDS, resulting in increases in utilization of higher-cost settings. Similarly, the Medicare Payment Advisory Committee (MedPAC) has also signaled the misalignment in payment rates when it comes to charges for care across dozens of services delivered at off-site locations. **We strongly urge Congress to build on regulatory efforts from CMS and apply site neutral payment rates to additional services that can be safely performed in outpatient settings with a particular consideration of the [66 services](#) identified by MedPAC.**

Ensuring Reasonable Prices in Anticompetitive Markets

Rising health care costs **limit people's health care choices and put a strain on family and government budgets**. [A main driver](#) of those rising costs are the [prices charged by hospitals](#), which only continue to increase as a consequence of [consolidation](#). In some states, hospitals charge commercial carriers an average of [three times what they charge Medicare](#). These [higher prices](#) paid by health insurers result in health plans increasing premiums and out-of-pocket costs as they attempt to recoup revenue. This impacts patients, employers, and state and federal governments in significant ways – [costs](#) go up, health care [value](#) stagnates, and [quality](#) does not improve.

Recognizing the [impact](#) of these trends on state budgets and people alike, state policymakers are increasingly pursuing [solutions](#) to lower hospital prices. One emerging solution USofCare has advocated for in states is to directly limit the prices hospitals charge by implementing [reference-based pricing](#) within programs or markets states run or regulate, such as the commercial market or within state employee health plans (SEHPs). This policy directly targets what hospitals can charge by benchmarking prices to a "[reference price](#)" – most often a percent of Medicare reimbursement rates. This would bring the prices charged for hospital services more in line with the [actual cost](#) to provide services, rather than relying on negotiated rates set by hospitals as Medicare rates are [regularly](#) reviewed and updated to reflect local market conditions. Reference-based pricing programs can also be designed to improve access to [high-value care](#) by creating payment floors for specific services or types of providers, such as behavioral health services or for primary care providers.

A recent [report](#) found that capping hospital payments at 200% of Medicare rates would have saved SEHPs an average of \$150.2 million per state in 2022, totalling \$7.1 billion nationwide, all while minimally impacting hospital operating margin. When used in the commercial market, reference-based pricing benefits other purchasers by helping to [lower](#) premiums and out-of-pocket costs. For example, a recent USofCare [analysis](#) looked at the impact of capping hospital payments in the commercial market and found three states alone could save almost \$26 billion through lower premiums and out-of-pocket costs. This policy can also provide more predictability for people by establishing more uniformity and fairness with prices that don't rely on how well their plan is able to negotiate with an individual hospital or health system.

This policy provides the opportunity to constrain cost growth, lowering costs for the state and other purchasers, such as people and employers. **Congress should follow the lead of red, blue, and purple states that have worked to tackle hospital costs inflated by rampant consolidation and anticompetitive health care markets to place reasonable limits on hospital costs.**

Conclusion

Thank you for your attention to this important issue, and USofCare appreciates the opportunity to submit this testimony for the record. We stand ready to help support any efforts from the Committee to help address hospital and health system consolidation and the high costs that result for consumers.