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**STATEMENT**  
**of the**  
**Federation of American Hospitals**  
**to the**  
**U.S. House of Representatives**  
**Committee on Energy and Commerce**  
**Subcommittee on Health**

**Re: "Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers."**

**Wednesday, January 31, 2024**

The Federation of American Hospitals (FAH) submits the following Statement for the Record in advance of the House Energy and Commerce (E&C) Health Subcommittee's hearing entitled *Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers*.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the Subcommittee's leadership in exploring what factors are causing cost increases for patients, the health care sector, and for federal health programs such as Medicare and Medicaid. The FAH believes that to meaningfully address cost concerns in the health care system a holistic approach is necessary, encompassing a broad array of stakeholders including, among others, health care providers, payors, insurers, pharmaceutical manufacturers, medical device makers, and regulators.

Within the health care sector, hospitals are leaders in controlling costs. According to a recent report by CMS on National Health Expenditures,<sup>1</sup> U.S. health care spending grew by 4.1% to reach \$4.5 trillion in 2022. Despite this overall growth, Medicare spending growth on hospital services was at its lowest level in 17 years at 2.2%, well below other parts of the health care sector, including prescription drugs (8.4%) and nursing care facilities (5.6%). This is despite the fact that hospitals are an aggregator of costs across the system with many different inputs when it comes to patient care, including the high cost of prescription drugs, food, medical equipment, and other services. The data are clear that hospitals are doing our part to bend the cost-curve.

To help further the Committee's goal of lowering health care costs, the FAH offers the following recommendations:

### **1) Reduce Excess Payments in Medicare Advantage**

At MedPAC's January 2024 meeting, analysts presented data showing that Medicare Advantage practices regarding coding intensity and favorable patient selection will result in \$353 billion in excess payments this decade alone compared to what spending would have been in Traditional Medicare. These excess payments have been on a steady rise since 2021, from \$51 billion to an estimated \$88 billion in 2024. MedPAC has previously issued a number of recommendations to address the underlying causes of coding intensity. With respect to how plans engage in favorable enrollee selection, staff referenced various tools MA plans deploy such as limited networks and prior authorization that could disincentivize seniors in their decision whether to select an MA plan or remain in traditional Medicare. Curtailing both of these practices would greatly lower health care costs and generate significant savings extending Medicare Trust Fund solvency for many years.

### **2) Maintain the Current Ban on Self-Referral to Physician-Owned Hospitals (POH)**

To help keep health care spending under control, it is imperative that Congress continue to reject efforts to weaken the existing ban on self-referral to POHs. Such arrangements are mired in conflicts of interest, and years of independent data show such arrangements result in over-utilization of Medicare services at significant cost to patients and the Medicare program. It is for this reason, among others, that the FAH strongly opposes *The Patient Access to Higher Quality Health Care Act of 2023* (H.R. 977) and similar legislative proposals such as draft legislation recently circulated by Rep. Burgess.

There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to POHs. The empirical record is clear that the conflicts of interest inherent in these hospital ownership arrangements promote unfair competition and result in cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns. The standing policy includes more than a decade of work by Congress, involving numerous hearings, as well as analyses and findings by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), Government Accountability Office (GAO), and Medicare Payment Advisory Commission (MedPAC).

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<sup>1</sup> [National Health Expenditures 2022 Highlights \(cms.gov\)](https://www.cms.gov/nheppublications/2023/nheppublications-2023-01)

Recently released data from the health care consulting firm Dobson | DaVanzo reinforced those findings, showing that POHs:

- Cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- Treat fewer medically complex cases;
- Enjoy patient care margins 15 times those of community hospitals;
- Provide fewer emergency services—an essential community benefit; and,
- Despite POH claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.<sup>2</sup>

CMS itself recently reimposed “program integrity restrictions” on POH expansion criteria to guard against “a significant risk of program or patient abuse,” and to “protect the Medicare program and its beneficiaries from overutilization, patient steering, and cherry-picking.”<sup>3</sup>

### **3) Reduce Burnout and Eliminate Gaps in Health Care Workforce**

Hospitals are investing heavily in both training and patient care management innovation to improve the bandwidth of registered nurses and reduce nurse workload burden. By allowing nurses to reduce paperwork and non-clinical responsibilities through technology and process enhancements, nurses can spend time more efficiently caring for patients and reduce inefficient workload and therefore are less likely to experience burnout.

Medicare Advantage (MA) prior authorization processes, for example, cause increased workload and administrative burden for clinicians. Recent polling found that nearly nine in ten nurses reported insurer-required administrative burdens have negatively impacted patient clinical outcomes, and nearly three-fourths reported an increase in administrative tasks over the last five years.<sup>4</sup> Congress could put patients over paperwork by passing the *Improving Seniors Timely Access to Care Act* (H.R. 3173) to automate and streamline the prior authorization process.

Another avenue for cost containment is allowing new workers in the health care sector by opening pathways for legal immigration from foreign countries. The downstream impact of reduced net legal immigration in recent years due to both policy and pandemic factors has increased labor costs for struggling hospitals and created enormous gaps in “unskilled” employment areas. There are an estimated two million fewer working-age legal immigrants in the US than there would have been if pre-pandemic levels were maintained<sup>5</sup>. These factors push hospitals to turn to nurse staffing agencies who engage in concerning and potentially anticompetitive conduct including price gouging, as was widely reported throughout the

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<sup>2</sup> Dobson | DaVanzo Study. (2023). [https://www.fah.org/wp-content/uploads/2023/03/2023\\_FactSheetwAppendixandCharts\\_POH-vs.-NonPOH-Only.pdf](https://www.fah.org/wp-content/uploads/2023/03/2023_FactSheetwAppendixandCharts_POH-vs.-NonPOH-Only.pdf).

<sup>3</sup> Centers for Medicare and Medicaid Services. (2023). Proposed Inpatient Prospective Payment System and Policy Changes. Retrieved from <https://www.govinfo.gov/content/pkg/FR-2023-05-01/pdf/2023-07389.pdf>

<sup>4</sup> *Costs of Caring - The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise*. (2023, April). American Hospital Association. <https://www.aha.org/costsofcaring>

<sup>5</sup> Sasso, M. & Bloomberg News. (2023, February 24). Where are the Workers: Labor Market Millions Short Post-Pandemic. *Governing*. <https://www.governing.com/work/where-are-the-workers-labor-market-millions-short-post-pandemic>

COVID-19 pandemic.

Federal legislative action is essential to help hospitals maintain a strong workforce, including:

- *The Conrad State 30 and Physician Access Reauthorization Act* (H.R. 4942) to improve and extend the existing program that allows international physicians trained in America to remain in the country if they practice in underserved areas.
- *The Healthcare Workforce Resilience Act* to recapture 25,000 unused immigrant visas for nurses and 15,000 unused immigrant visas for physicians that Congress has previously authorized and allocate those visas to international physicians and nurses.

In addition to immigration reform solutions, other actions include eliminating State Department bureaucratic delays and inefficiencies in immigration to allow foreign-trained qualified physicians and nurses to come to the US to fill vacancies unfilled by US workers.

#### **4) Medical Liability Reform**

Medical liability reform should be a critical component of any effort to reduce costs in health care. Billions of dollars are spent annually on defensive medicine to mitigate the risk of liability. The high costs associated with the current medical liability system harm hospitals and physicians, as well as patients and their communities. In December 2016, the Congressional Budget Office (CBO) scored comprehensive medical liability reforms (e.g., capping awards for noneconomic damages at \$250,000 and punitive damages either at \$500,000 or at twice the value of awards for economic damages, whichever is greater) as reducing the federal deficit by \$62 billion.

These costs often force providers and physicians to move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. This adversely impacts patients' access to important health care services. To help make health care more affordable and efficient, the current medical liability system must be reformed.

#### **5) Encourage Responsible Use of Artificial Intelligence (AI) Tools to Improve Health Care**

The responsible use of AI technology can both improve health care outcomes and address long-standing systemic issues that lead to increased cost in health care delivery.

For example, the administrative burden on health care providers and clinicians has been a significant impediment to improving efficiency in health care delivery. Physicians and nurses often spend between 30-50 percent of their time on documentation, payer authorization processes, and other administrative processes. Generative AI, in particular, is capable of becoming a tool to assist in documentation, searching for and summarizing patient information, generating communication (e.g., with payers) and supporting communication with patients and families. These use cases are lower risk (i.e., they do not rely on the AI to directly answer clinical questions or support diagnosis or treatment) but high value in the form of returning time

to the care teams so they can focus on patients, critical decision making, and improving the quality of care delivered.

As Congress considers approaches for regulating AI, we urge you to recognize that the health care sector has an existing set of risk management frameworks. Any AI regulatory requirements that conflict with existing risk management processes will slow down progress in realizing the benefits of technology and could inadvertently result in less effective risk management of complex health care systems and organizations.

Congress should consider an AI framework that is risk-based and focuses on processes to ensure algorithms are transparent, auditable, ethical, fair, non-biased, and safe – as this would provide health care stakeholders with the necessary information for responsible use similar to the *Health Insurance Portability and Accountability Act* (HIPAA). Unleashing this technology would undoubtedly result in a more cost-efficient health care system.

Thank you for taking our comments into consideration as you consider solutions to reduce health care spending. If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Reinhart". The signature is fluid and cursive, with a long horizontal stroke at the end.