



**Statement**  
**of the**  
**California Hospital Association**  
**for the**  
**United States House of Representatives**  
**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**

The California Hospital Association (CHA), on behalf of nearly 400 hospitals and health systems, appreciates the opportunity to share the hospital field’s perspective on affordability challenges and access to care.

Access to high-quality and affordable health care is out of reach for too many Americans, and California is no exception. The causes are many (workforce shortages, rising inflation, and an increasingly sicker population), the solutions are complex, and the challenge can only be overcome with meaningful collaboration. Your examination of health care costs comes at a particularly critical time, as hospitals are wrestling with the anticipated impacts of last year’s funding cuts. Hospitals applaud your efforts to hold insurance company executives responsible earlier this year and encourage you to continue pressing insurance companies to do their part to ensure Americans receive the care they need. As you continue your examination of our nation’s rising health care costs, it is critical that your work consider a few key facts:

- **California hospitals are more cost-efficient than the larger health care system.** For decades, California hospitals have worked to make care more affordable and more accessible. Because of these efforts, per-capita hospital spending in California ranks 18th lowest nationally, outpacing most of the nation in delivering cost-effective care to patients, particularly when accounting for the state’s high cost of living. By comparison, overall health care spending in California ranks at 29<sup>th</sup> highest nationally, a full 11 places worse. Already, hospitals are more efficient than the state’s health care system at large.
- **Hospitals cannot solve this problem alone.** Nearly two-thirds of health care spending occurs outside of hospitals — even though hospitals are the highest, and therefore most expensive, level of care. Efforts to cut costs must consider the system as a whole and address the underlying drivers of health care spending.

- **Government programs must pay their fair share.** With Medicaid and Medicare paying just 83 cents for every dollar of care that hospitals provide, many hospitals are struggling to stay afloat. Every day, 44% of California’s hospitals lose money providing care to patients. With every unreimbursed dollar, hospitals inch closer toward cutting services, laying off staff, or closing their doors entirely.
- **Insurers must be held accountable for meeting their commitment to patients.** Instead of allowing commercial insurance companies to continue padding their own bottom lines (in California, insurer profits grew by more than 20% from 2022 to 2023<sup>1</sup>), Congress must build stronger protections to ensure that health care dollars actually go toward patient care.

### Hospitals’ Efforts to Improve Access and Reduce Costs

For years, hospitals have endeavored to make care more affordable for patients and improve access. These efforts keep patients’ needs at the forefront, recognizing the fact that simplifying access to care ultimately improves patients’ health. For example:

- Hospitals have adopted new care delivery models, like the Acute Hospital Care at Home model, that provide patients with hospital-quality care in their own homes. Similarly, [home care programs](#) in which patients with certain diagnoses receive daily virtual care visits and equipment for at-home self-monitoring and reporting have been proven effective to both improve outcomes and reduce costs. Growing support for telehealth services, particularly for behavioral health, have also increased patients’ access to the services and care they need while reducing costs.
- Clinically integrated care programs provide a full continuum of care that both improves patients’ health and prevents unnecessary hospital stays. For instance, the Medication Assisted Treatment (MAT) program provides patients with inpatient services and medication for buprenorphine for opioid use disorder. Patients are linked to outpatient MAT maintenance and treatment when discharged, preventing costly — and avoidable — readmissions.
- Hospitals leverage new technologies that improve patient care, such as whole genome sequencing under Project Baby Bear (which helps diagnose and treat newborns with serious health conditions). Some hospitals have also begun offering chimeric antigen receptor (CAR)-T cell therapy in the outpatient setting — as opposed to inpatient only, where it has historically been offered — increasing patients’ access to this innovative, lifesaving cancer treatment while reducing the cost of care. Hospitals across California are also embracing artificial intelligence-empowered ambient listening technologies that ensure accurate medical note taking, allowing clinicians to more meaningfully engage with their patients.
- Hospital presumptive eligibility programs are critical to facilitating patients’ health care enrollment. Hospitals also help patients determine their eligibility for discounted care and integrate community health workers into care processes to support patients in navigating health and social services. And, hospitals’ efforts to support their communities often include providing high-cost medications at low or no cost, community health and mental health services, medication management services, and mobile health care clinics to vulnerable populations in their communities.

As a result of these efforts, California hospitals’ per-capita spending is far more efficient than the state’s health care spending as a whole — underscoring the fact that meaningful, thoughtful investment is a strong path toward making our communities healthier **and** reducing costs.

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<sup>1</sup> [www.calhospital.org/wp-content/uploads/2025/07/CHA-Comment-Letter-July-2025-OHCA-Board-Meeting\\_Final.pdf](http://www.calhospital.org/wp-content/uploads/2025/07/CHA-Comment-Letter-July-2025-OHCA-Board-Meeting_Final.pdf)

### To Bend the Cost Curve, Address the Underlying Drivers of Health Care Spending

Despite these gains, more work is needed to improve affordability while improving health care access, quality, and equity. This requires clearly understanding and addressing the drivers of high and inequitable health care costs. Far too often, advocates identify a seemingly simple problem: hospital prices. However, this short-sighted scapegoating fails to consider the costs that lie behind the price tag:

- Recruiting/retaining a highly skilled workforce comes at a high cost — typically 55-60% of California hospitals' operating costs.
- Upgrading equipment and improving facilities to ensure patients receive the best care possible is heavily influenced by factors outside hospitals' control, like inflation.
- Providing the latest pharmaceutical therapies saves lives, but can cost millions.
- Implementing well-intentioned but expensive mandates from state and federal policymakers can add significant cost — California's seismic requirements, for example, are estimated to cost hospitals more than \$150 billion.

Hospitals must contend with costs that are often out of their control. According to Kaufman Hall<sup>2</sup>, western states' year-over-year hospital costs per day are currently increasing at 6% for labor, 13% for supplies like personal protective equipment, and 13% for drugs — far outpacing economy wide-inflation of 2.4% (as of January 2026). In addition, global trade uncertainty and tariffs have increased costs for the supplies hospitals need to deliver high-quality patient care.

To address the drivers of health care spending, Congress should:

- **Ensure federal policies allow for the flexible deployment of labor.** Expanding medical schools, lifting the cap on Medicare-funded residency positions, and creating a health care sector exemption for the new H-1B visa fee requirement would help strengthen and diversify the health care workforce amid ongoing shortages. Congress should further ensure that new labor-saving technologies and clinical practice modalities may be deployed when they sustain and improve patients' experience and their quality of care.
- **Promote macroeconomic stability, including in supply chains.** This would allow hospitals to plan and keep up with the cost of care; help reduce supply chain disruptions that can impede access to critical medication and supplies for patients; and support hospitals' financial stability, allowing them to sustain services in their communities and invest in their physical infrastructure.
- **Protect the 340B Drug Pricing Program to ensure patients have access to lifesaving, life-changing treatments.** Drug manufacturers have repeatedly tried to scale back upfront drug discounts in the 340B program, ignoring the critical fact that hospitals use these funds to not only provide patients with access to expensive drugs at low or no cost, but also to support, improve, make care more affordable, and expand vital health care services and programs for their communities. Comprehensive program oversight and rigorous auditing already ensure that manufacturers are not subject to duplicate discounts. There is virtually no benefit to scaling back upfront discounts, and any potential savings are far outweighed by the serious harm jeopardizing these programs would cause in communities across the United States.

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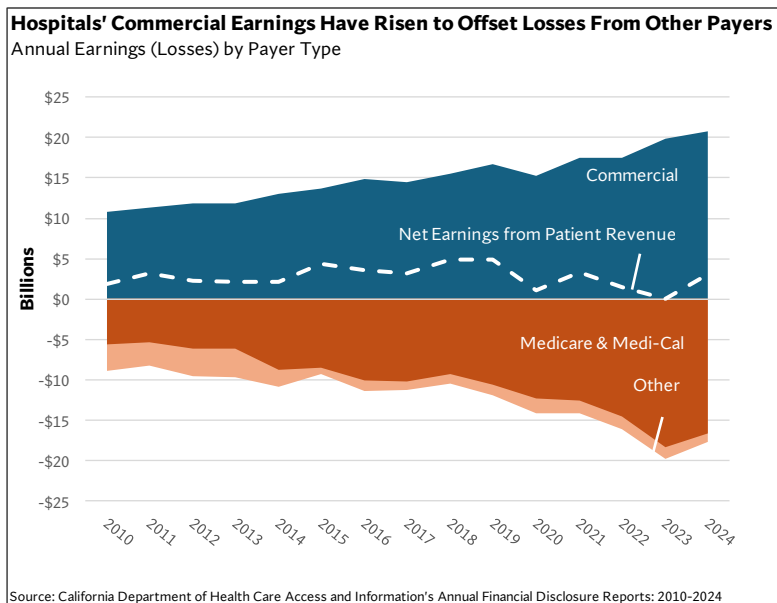
<sup>2</sup> [https://www.kaufmanhall.com/sites/default/files/2026-02/KH-NHFR\\_Report\\_December2025\\_Metrics.pdf](https://www.kaufmanhall.com/sites/default/files/2026-02/KH-NHFR_Report_December2025_Metrics.pdf)

### Government Underfunding Drives the Worsening Cost Shift

Not only are hospitals facing escalating operational costs and economic pressures, but they continue to be chronically underpaid by government payers — Medicaid (Medi-Cal in California) and Medicare — that typically reimburse only 83 cents for every dollar of care provided. Hospitals have only one way to make up for these payment shortfalls: seek higher commercial payments so that they can break even. The alternative is to operate at a loss (which is already the reality for the 44% of California hospitals that currently operate in the red), an unsustainable path that will lead to reduced services, workforce reductions, or outright closure.

As the figure at right shows, growth in hospitals' commercial reimbursement is negated by growing reimbursement shortfalls from Medicare, Medi-Cal, and other payers. This relationship persists over the course of more than a decade, with every increase in commercial reimbursement offset by growing losses elsewhere, keeping hospitals' earnings near zero.

Unfortunately, the problem is only worsening as payment increases from government programs continue to lag inflation and as California enters an unprecedented demographic era where 22% of Californians will be 65 or older by 2040.<sup>3</sup> To address this longstanding problem, federal policymakers should ensure proper funding for public health care programs, including reimbursement rates that cover the costs of hospital care so that costs are not shifted onto employers, employees, and patients.



### Greater Scrutiny of Insurers Needed to Support Affordable Coverage and Care

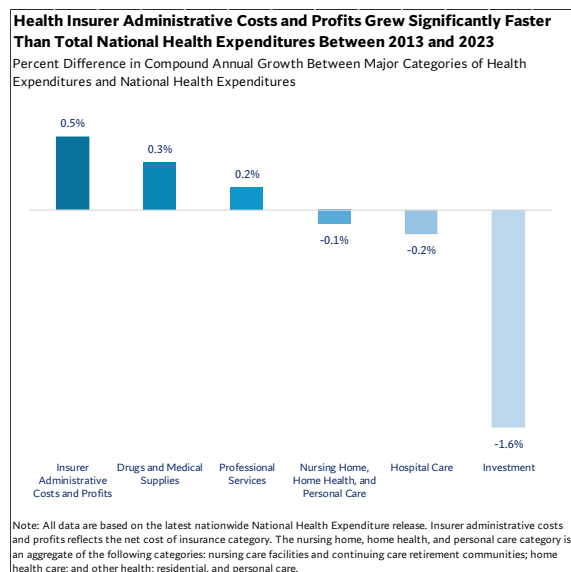
Health insurance companies primarily control what Californians pay for coverage and care. They set premiums, determine what benefits are covered, and say how much patients must pay in deductibles, co-insurance, and copays when they visit the doctor or hospital. Given this outsized role, health care affordability cannot be addressed without a closer look at insurance companies — whose profits are high and growing. In fact, a [recent state health care spending report](#) showed that **insurer profits grew by more than 20% between 2022 and 2023, more than 4 times the rate of their spending on actual medical care.** In other words, 21 cents of every dollar increase in health care in 2023 in California supported higher health insurance company profits, not patient care.

<sup>3</sup> <https://www.ppic.org/publication/californias-aging-population/>

This is not a one-time phenomenon. Inflated growth in insurer administrative costs and profits have persisted for more than a decade, growing at a half percentage point faster than overall spending growth annually between 2013 and 2023, as shown in the figure at right.

Neither tighter financial regulations nor higher administrative costs explain this outsized growth, as health insurer reserves have grown by more than 100% in just the last six years — twice the rate that the primary state regulator requires<sup>4</sup>. And yet, despite these outsized earnings, insurers continue to raise premiums.

**From 2024 to 2026, while inflation grew only 2.9%, California insurers instead raised premiums by an average of 9.3% annually.**



Public oversight of insurance premiums and profits has not solved this problem. Mounting evidence shows that medical loss ratios (MLRs), designed to ensure most consumer premium dollars go directly to patient care and quality improvement, have loopholes. For example, insurers have used vertical integration — in which insurers are affiliated with the providers and vendors they pay — to hide profits by booking what are effectively self-payments as medical care costs<sup>5,6,7</sup>. Insurers have also gamed the MLR by manipulating year-end claim reserves — plans that do not meet their MLR overstate year-end outstanding claims, which allows them to avoid paying rebates to consumers, then release these excess reserves the following year as profit<sup>8</sup>.

Policymakers should explore policies to stop these practices, including:

- Setting new limits on patient cost sharing to address disparities in the cost of care based on health status, which often forces individuals experiencing a health emergency to choose between bankruptcy or going without lifesaving and preventative care
- Strengthening requirements on insurers to justify premium increases
- Closing loopholes in insurers' MLRs and ensuring health care dollars go to patient care

## Conclusion

California's hospitals are deeply committed to building a health care system that is both affordable and accessible, an undertaking that requires thoughtful, collaborative work with all players in the health care industry. We look forward to partnering with members of Congress on developing real solutions to today's affordability challenges, while protecting access to high-quality, patient-centered care. If you have any questions, please do not hesitate to contact Anne O'Rourke, senior vice president of federal relations, at [aorourke@calhospital.org](mailto:aorourke@calhospital.org).

<sup>4</sup> [www.calhospital.org/wp-content/uploads/2025/07/CHA-Comment-Letter-July-2025-OHCA-Board-Meeting\\_Final.pdf](http://www.calhospital.org/wp-content/uploads/2025/07/CHA-Comment-Letter-July-2025-OHCA-Board-Meeting_Final.pdf)

<sup>5</sup> [www.americanprogress.org/article/medical-loss-ratio-reform-can-help-curb-corporate-power-and-lower-health-care-costs/](http://www.americanprogress.org/article/medical-loss-ratio-reform-can-help-curb-corporate-power-and-lower-health-care-costs/)

<sup>6</sup> [www.healthcareuncovered.substack.com/p/gaming-the-system-medical-loss-ratios](http://www.healthcareuncovered.substack.com/p/gaming-the-system-medical-loss-ratios)

<sup>7</sup> [www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules](http://www.healthaffairs.org/content/forefront/insurers-own-providers-can-game-medical-loss-ratio-rules)

<sup>8</sup> [www.content.naic.org/sites/default/files/JIR-ZA-40-01-EL\\_0.pdf](http://www.content.naic.org/sites/default/files/JIR-ZA-40-01-EL_0.pdf)