Documents for the Record

Subcommittee on Health Hearing
Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability
Thursday, January 22, 2026 – 9:45AM

Majority:

1. January 22, 2026, statement from Purchaser Business Group on Health.
2. January 22, 2026, statement from the National Federation of Independent Business.
3. January 22, 2026, written comments from the National Consumers League.
4. January 22, 2026, statement from the Federation of American Hospitals.
5. January 22, 2026, statement from the American Society of Anesthesiologists.
6. January 22, 2026, statement from the American Medical Informatics Association.
7. January 22, 2026, statement from the American College of Cardiology.
8. January 22, 2026, statement from the American Benefits Council.
9. January 22, 2026, statement from the American Academy of Family Physicians.
10. January 22, 2026, statement from the American Hospital Association.
11. January 22, 2026, comments from the American Dental Association.
12. January 22, 2026, letter to Chairman Griffith and Ranking Member DeGette from the National Association of Manufacturers.
13. January 22, 2026, statement from The Campaign for Sustainable Rx Pricing.
14. January 22, 2026, statement from the Partnership for Employer-Sponsored Coverage.
15. January 22, 2026, statement from the Blue Cross Blue Shield Association.
16. November 3, 2025, article titled "UnitedHealth pays its own physician groups 17% more than outside ones, study shows" submitted by Rep. Joyce.

Minority:

1. January 22, 2026, statement from AHIP.
2. January 22, 2026, statement from the Association of American Medical Colleges.
3. January 7, 2026, letter to Speaker Johnson and Leader Jeffries from AARP.
4. September 30, 2025, article by KFF entitled "ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire."
5. January 22, 2026, statement from Margaret A. Murray, CEO, Association for Community Affiliated Plans.
6. December 10, 2025, statement from the American Cancer Society.
7. January 22, 2026, statement from the American Hospital Association.
8. January 8, 2026, article by the American Lung Association entitled "American Lung Association Applauds House Passage of Bill to Extend Healthcare Tax Credits; Urges Senate to Act Immediately on Bipartisan Solution."

9. January 27, 2025, article by KFF entitled "Claims Denials and Appeals in ACA Marketplace Plans in 2023" submitted by Rep. Barragan.
10. September 11, 2025, article by Medicare Rights entitled "Congress Must Preserve Access to Affordable Marketplace Coverage."
11. October 15, 2025, article by Medicare Policy Initiative entitled "Damage From Inaction on ACA Tax Credits Has Begun and Will Grow With Further Delays.
12. October 2025, article by Urban Institute entitled "Eligibility Cliff on ACA Tax Credits Would Make Health Care Unaffordable for Middle-Class Families."
13. July 2025, Fact Sheet from the American Hospital Association entitled "Fact Sheet: Enhanced Premium Tax Credits."
14. January 8, 2026, statement from Families USA.
15. November 3, 2025, article by the Center on Budget and Policy Priorities entitled "Health Insurance Premium Spikes Imminent as Tax Credit Enhancements Set to Expire."
16. January 7, 2026, letter from AFSCME.
17. December 4, 2025, article by the Center on Budget and Policy Priorities entitled "How to Evaluate Proposals to Address Expiring Premium Tax Credit Enhancements."
18. September 19, 2025, article by AARP entitled "Older Adults Face Spike in Health Insurance Costs as ACA Tax Credits Expire."
19. September 15, 2025, letter from coalition of physician organizations.
20. January 20, 2026, statement from Keep Americans Covered.
21. February 18, 2025, article by the Los Angeles Times entitled "A proposed law could force California health insurers to explain claim denials."
22. July 29, 2025, article by the Center on Budget and Policy Priorities entitled "Marketplace Enrollees Tell Congress: Extend the Enhanced Premium Tax Credits."
23. November 18. 2025, letter from the National Association of Insurance Commissioners.
24. January 22, 2026, letter from the National Alliance of Healthcare Purchaser Coalitions.
25. January 22, 2026, statement from the National Multiple Sclerosis Society.
26. October 30, 2025, article by the Medicare Rights Center entitled "Older Adults at Risk if ACA Subsidies Expire."
27. January 22, 2026, statement from Patients for Affordable Drugs NOW.
28. December 4, 2025, article by KFF entitled "Poll: 1 in 3 ACA Marketplace Enrollees Say They Would "Very Likely" Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They "Very Likely" Would Go Without Insurance."
29. August 21, 2024, letter from 40 Partnership to Protect Coverage member organizations.
30. January 8, 2026, statement from American College of Emergency Physicians.
31. November 5, 2025, statement from Families USA.
32. January 6, 2026, article by Hunterbook entitled "'Bullshit' – The New Way Health Giants Hide Billions," submitted by Rep. Auchincloss.
33. January 22, 2026, statement from The Campaign for Sustainable Rx Pricing.
34. January 22, 2026, statement from Blue Cross Blue Shield Association.
35. January 22, 2026, statement from Cystic Fibrosis Foundation.

Purchaser Business Group on Health

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January 22, 2026

Re: House Energy and Commerce Health Subcommittee Hearing Entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

Chair Guthrie, Chair Griffith, Ranking Member Pallone, and Members of the Committee:

The Purchaser Business Group on Health ("PBGH") applauds the Committee for holding this timely hearing on *the* most pressing issue in health care: Affordability. Our members agree. Cost control and affordability emerged as the top issue for large employers and public purchasers* in PBGH's 2025 Annual Survey [1] against a backdrop of escalating costs [2] and growing fiduciary risk.[3]

PBGH and our members especially support the Committee's focus on what health insurers – in their role as third party administrators ("TPAs") to self-insured purchasers – are (or are *not*) doing to improve health care affordability for American businesses, employees, and families.

TPAs perform vital tasks, like providing administrative services and helping to ensure purchasers are in compliance with, among other laws and regulations, the transparency provisions in the Consolidated Appropriations Act of 2021 ("CAA") and the Transparency in Coverage ("TiC") Final Rule. For employer-sponsored insurance ("ESI") to continue delivering value to the 164.7 million Americans covered by it,[4] there should be complete alignment between the interests and business models of purchasers and their TPA partners.

Troublingly, many recent developments in legal disputes between purchasers and their TPAs,[5] policy analysis,[6] and academic research [7] as well as the firsthand experiences of PBGH members [8] have exposed that too often the business models of TPAs are out of alignment and in conflict with the interests of self-insured purchasers. At a foundational level, health insurers (and TPAs) have shown they do not share the urgent incentive to reduce the cost of health care, and their business incentives and practices contribute to our affordability crisis in the commercial market.

Furthermore, two current PBGH-led initiatives have shed light on the business practices of TPAs:

1. A Health Care Data Demonstration Project testing the usability of health care price transparency data by self-insured purchasers – when analyzed alongside purchasers' claims data and independent measures of quality – to inform health care purchasing strategies.[9] Key learnings from the first phase of this project are available here and takeaways include:

    - **Price and Quality Are Not Correlated in Health Care Markets**. PBGH's analysis revealed providers with higher insurer-negotiated rates frequently performed

* Throughout this Statement, "purchasers" will be used to refer collectively to public and private employers as well as non-employer purchasers of health care (e.g., Taft-Hartly benefit funds, state health plans, state exchanges).

worse on standardized quality and safety measures, while providers with lower insurer-negotiated rates often demonstrated superior safety and clinical outcomes.

- **Insurer/TPA Market Share Does Not Always Predict Competitive Pricing**. Some insurers and TPAs with limited market penetration achieved superior negotiated rates with providers compared to dominant insurers/TPAs. This finding raises serious questions what the empirical data on negotiated rates implies for whether insurer/TPA business interests are aligned (or not) with the interests of purchasers and patients. This is an area of future exploration for PBGH.

- **Price Variation in Insurer-Negotiated Rates Defies Economic Logic**. Pricing varied within and between the ten regional markets PBGH examined, and among and across different insurers/TPAs within the same facilities. For example, median negotiated rates for a cesarean section without complication ranged from $11,547 (Chicago) to $27,199 (Northern California). In another instance, at one hospital the negotiated rate for the same medication varied by 49% between two health plans.

- **TiC Files Require Substantial Analytical Infrastructure to Use**. The conversion of the TiC machine-readable files ("MRFs") into reliable and actionable information requires advanced analytic capacity and significant resource investment that most purchasers currently lack. The files are frequently voluminous, inconsistent, and error-ridden, rendering them impractical for purchasers to use on their own – even if the MRFs are *technically* compliant with the public disclosure requirements under the current iteration of the TiC Rule.[*]

- **Purchaser Claims Data Access Barriers Persist**. Despite clear legal rights for purchasers to access their data under CAA § 201,[10] insurers and TPAs frequently challenged purchasers' access to their own claims data, citing proprietary concerns or contractual restrictions in provider network agreements.

- **Purchasers Are Denied Transparency into Provider Network Agreements**. Purchasers are bound by the terms of provider network agreements negotiated by their insurer/TPA, yet purchasers are not parties to these contracts and – under current law – cannot review them.[†] This opacity prevents purchasers from understanding how claims that they pay are adjudicated and why payer-reported prices in the TiC files may diverge from hospital-reported prices in the hospital price transparency ("HPT") files. Contract language within provider network agreements may explain some of these discrepancies, and so purchaser access to these agreements is critical for true transparency and fiduciary oversight.

[*] PBGH is aware of, and thankful for, the Administration's dedication to strengthening and improving the price transparency rules, including TiC. In July 2025, PBGH provided detailed responses to both the Administration's hospital price transparency RFI and its TiC prescription drug MRF RFI. We are also in-process of responding to the Administration's December 2025 TiC Proposed Rule.

[†] CAA § 201 contains a significant limitation, in that it only allows a purchaser to access a narrow sliver of the provider network agreements that a carrier, TPA, or PBM has in-place with providers. Namely, CAA § 201 only entitles purchasers access to "claim-related financial obligations included in the provider contract" (**p. 2891**).

Perhaps most significantly, PBGH had to lead this effort on behalf of self-insured purchasers because TPAs were not providing this information even to their largest purchaser-clients. Standard reporting by TPAs to purchasers does not include the information needed for fiduciary oversight.

2. A Purchaser-Driven Contracting Request for Information ("RFI") for a TPA contract, which PBGH sent on behalf of five self-insured purchasers to 47 health insurers and TPAs nationwide. The contract conveyed clear expectations and sought reasonable provisions that safeguard purchasers' ability to oversee their health plans as prudent fiduciaries.

   Only 10 of the 47 insurers/TPAs responded (or signaled intent to respond) to the RFI despite it being issued by some of the largest purchasers in the country. In declining, some reasoned that they were concerned about setting precedents for new contract terms and standards that reinforced purchasers' rights to data or prohibited anti-competitive practices. Key learnings from the initial phase of the project include:

   - **Contractual Barriers to Purchaser Data Access Persist**. National TPAs were more likely to deny purchasers' right to unrestricted access to their own claims data by erroneously citing privacy concerns, requiring certain permissions to access claims data, or placing limitations on the number of claims disclosed. Independent TPAs were more likely to affirm purchasers' rights to their data.

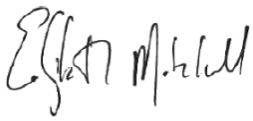
   - **Insurers/TPAs Refuse to Provide Full Disclosure of their Compensation and Conflicts of Interest**. Despite repeated Congressional clarification[11] that the intent of CAA § 202 was, and continues to be, for compensation disclosure requirements under ERISA § 408(b)(2) to apply not just to health insurance brokers and consultants but to all covered service providers (including TPAs), many responding insurers/TPAs resisted disclosing fully disclosing their direct and indirect compensation and their potential conflicts of interest.

   - **Most Insurers/TPAs Refused to Agree to a Unit Price Guarantee**. This type of provision would hold insurers/TPAs accountable for health care affordability and transparency – but is a provision that has historically not been a consideration in contract negotiations and thus does not appear in TPA contracts today.

   Self-insured purchasers have traditionally been reliant on TPAs to administer their health care benefits. As the health care affordability crisis worsens and fiduciary pressure grows, many self-insured purchasers are seeking alternatives – including directly administering health benefits [12] or transitioning to newly emerging "transparent" TPAs. This initiative demonstrates a clear divide between traditional insurers/TPAs and new TPA market entrants willing to be transparent and flexible to support purchasers' affordability goals.

PBGH sincerely appreciates this Committee's attention and dedication to scrutinizing the role TPA intermediaries play in helping (or hindering, as the case may warrant) purchasers to improve health care affordability for America's workers and families. As PBGH's members have demonstrated, through these two projects and many other initiatives, purchasers are leading and innovating creatively, by leveraging price transparency data and holding their TPA partners accountable. It is our sincere hope that health insurers and TPAs would enable these goals. This Committee can improve affordability in the commercial market by advancing policies that support a functional market, prohibit anti-competitive practices, and further enable purchasers' courageous work on behalf of American businesses and their workforce.

Sincerely,



Elizabeth Mitchell, President and CEO
Purchaser Business Group on Health

About Purchaser Business Group on Health

PBGH is a nonprofit health care purchaser coalition comprised of members that include the largest purchasers of health care in the United States. Collectively, these organizations – spanning an array of private employers and public sector entities – spend roughly $350 billion annually buying health care for over 21 million workers and families. PBGH's mission is to advance a health care system that delivers quality health outcomes and is affordable and responsive to the needs of purchasers and patients. For over 35 years, PBGH has supported our innovative purchaser members to implement solutions that advance health care quality, affordability, and transparency. For more information, visit www.pbgh.org.

Endnotes

[1] PBGH (May 13, 2025) "PBGH Announces Jumbo Employers' Top 5 Health Care Priorities" *Announcement* [Link]

[2] Mitchell (Jul. 2, 2025) "Want to Lower the Price of Eggs? Start with Health Care Costs" *US News & World Report* [Link]

[3] PBGH (Mar. 31, 2025) "Purchaser Innovation and Policy Engagement Against a Backdrop of Unaffordability and Fiduciary Risk" *Issue Brief* [Link]

[4] Claxton et al. (Oct. 8, 2025) "Employer-Sponsored Health Insurance 101" KFF [Link]

[5] See, e.g., the pattern of allegations alleged by purchasers against their TPAs in cases like *Bricklayers and Allied Craftworkers et al. v. Elevance, Massachusetts Laborers' Health and Welfare Fund v. Blue Cross Blue Shield of Massachusetts, Kraft Heinz v. Aetna, Owens & Minor v. Anthem, Tiara Yachts v. Blue Cross Blue Shield of Michigan,* and *Su v. Blue Cross Blue Shield of Minnesota.*

[6] See, e.g., Monahan (Mar. 24, 2023) "Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators" *Georgetown CHIR* [Link] and Handorf et al. (May 28, 2025) "Third-Party Administrators – The Middlemen of Self-Funded Health Insurance" *Georgetown CHIR* [Link];

[7] Eisenberg et al. (Jul. 2021) "Large Self-Insured Employers Lack Power to Effectively Negotiate Hospital Prices" *The American Journal of Managed Care*, Vol. 27, No. 7 [Link]; Meiselbach et al. (Aug. 2023) "Hospital Prices for Commercial Plans Are Twice Those for Medicare Advantage Plans When Negotiated By the Same Insurer" *Health Affairs*, Vol. 42, No. 8 [Link]; and Sen et al. (Sep. 2023) "Health Care Service Price Comparison Suggests that Employers Lack Leverage to Negotiate Lower Prices" *Health Affairs*, Vol. 42, No. 9 [Link] *(Finding that "prices were higher in self-insured plans for most studied services" compared to fully insured plans)*

[8] For a written summary of the issues PBGH members have encountered, see PBGH (Oct. 31, 2023) "Letter to the Tri-Agencies Re: Attestation Requirement under Section 201 of the 2021 CAA" *Comment Letter* [Link], especially **Pages 2 and 3** and accompanying **Footnotes 4,5, and 6** and also PBGH (Mar. 15, 2024) "Response to House Committee on Education and the Workforce Request for Information" *Comment Letter* [Link], especially the answer to the first question on **Page 8**

For a discussion, in part, of the alignment issues between self-insured purchasers and their TPAs, see also Mitchell and Richter (May 2024) "EP 436: Let's Talk About TPA and Health Plan Inertia Instead of Jumbo Employer Inertia, With Elizabeth Mitchell" *Relentless Health Value Podcast* [Link]

[9] A concise summary of the PBGH data demonstration project alongside relevant policy recommendations can be viewed here.

[10] CAA § 201, modifying PHSA § 2799A-9 and ERISA § 724

[11] Committee on Education and Labor (Dec. 2022) "Letter to Lisa M. Gomez re: CAA Disclosures" [Link]; 118th Congress S. 1339 "PBM Reform Act" **Section 5** [Link] at **Pages 208** and **209**; 118th Congress H.R. 5378 "Lower Costs, More Transparency Act." **Title IV, Section 402** [Link] at **Pages 209-224**; and 119th Congress S. 3549 and H.R. 6837 "PBM Fiduciary Accountability, Integrity, and Reform Act" [Link] at **Pages 3 and 4**

The Administration has also expressed its intent for intermediaries to disclose compensation to employers.

[12] For example, 32BJ Health Fund will be responsible for administering its direct contract with Northwell Direct – and also brought the independent dispute resolution ("IDR") process under the No Surprises Act ("NSA") in-house after their TPA, Anthem, "struggled to respond to arbitration cases in time." Other PBGH members have brought certain traditional PBM functions in-house, like formulary design and aspects of utilization management.

TESTIMONY BEFORE THE UNITED STATES CONGRESS
ON BEHALF OF THE

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Statement for the Record of Tyler Dever
Principal, Federal Government Relations
National Federation of Independent Business

United States House of Representatives
Committee on Energy and Commerce

"Health Subcommittee Hearing with Health Insurance CEOs"

January 22, 2026

National Federation of Independent Business
555 12th Street NW, Suite 1001
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Chairman Griffith, Ranking Member DeGette, and Distinguished Members of the Committee:

Thank you for the opportunity to submit a statement for the record on behalf of the National Federation of Independent Business (NFIB), the nation's leading voice for small businesses.

Small businesses are the backbone of the American economy. They account for 99.9% of all U.S. businesses and generate more than 43.5% of the nation's gross domestic product.[1] Small employers are also anchors of their community, as they collectively create jobs for millions of Americans. As a way to attract and retain their workforce, small business owners will also go to great lengths to ensure they are able to offer health benefits to their employees. Yet, for many businesses, the guarantee of employer-sponsored coverage is becoming increasingly difficult to keep.

For more than four decades, the number one challenge facing small business owners has been the cost of providing health insurance.[2] Since the turn of the century, premiums have risen more than 120%, while the number of insurers willing to offer small group coverage has sharply declined.[3] This is not the result of a competitive marketplace failing, but rather the predictable outcome of a highly-regulated system that rewards consolidation and enforces rigid mandates.

Today's health care system is dominated by consolidation at every level, especially with insurers, hospital systems, and pharmacy benefit managers (PBMs). As consolidation has increased, competition has decreased. This has left small businesses with fewer choices, higher prices, and hardly any negotiating power. Nine out of every ten health care dollars now flow through a third-party payer.[4] This has distanced employers and their employees from control over their own health care decisions.

Federal mandates enacted under the Affordable Care Act (ACA) have accelerated consolidation while increasing costs for small employers. Requirements such as essential health benefits, the medical loss ratio, community rating restrictions, and

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[1] Small Business Administration, Office of Advocacy, Frequently Asked Questions About Small Business, 2024. https://advocacy.sba.gov/2024/07/23/frequently-asked-questions-about-small-business-2024/.
[2] Holly Wade & Madeleine Oldstone, Small Business Problems and Priorities, 2024 NFIB Research Center, 2024 https://strgnfibcom.blob.core.windows.net/nfibcom/2024-Small-Business-Problems-Priorities.pdf.
[3] NFIB, Addressing the Health Insurance Affordability Crisis for Small Businesses, 2025. https://www.nfib.com/wp-content/uploads/2025/02/Health-Care-Coverage-Policy-Paper-07.pdf
[4] Centers for Medicare and Medicaid Services, National Health Expenditure Fact Sheet, 2023. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202023:,12%20percent%20of%20total%20NHE

extensive reporting obligations have failed to account for the realities small businesses face when trying to provide health coverage to their employees. Instead of encouraging affordability, these mandates have favored large insurers and systems with the scale to absorb the regulatory costs, leading smaller insurers and local carriers to be pushed out of the market.

The essential health benefits (EHB) mandate forces all plans to cover a uniform package of ten benefits regardless of workforce demographics or actual utilization. This one-size-fits-all approach strips employers of the ability to tailor coverage and requires small businesses to pay for benefits their employees may never use. The result is higher premiums without improvements in outcomes.

The medical loss ratio (MLR) further distorts the market by tying insurer revenue to claims spending rather than cost control. Because higher claims permit higher administrative spending in absolute terms, the MLR weakens incentives to negotiate lower prices and has placed disproportionate pressure on smaller insurers. This has driven consolidation and reduced competition, leaving small businesses with fewer options and higher costs.

Community rating restrictions, particularly the 3:1 age band, prevent premiums from reflecting actual risk. This has led to inflated costs for younger workers, discouraging participation in group health plans and driving healthier individuals out of the risk pool. These distortions compound over time, fueling premium increases and market instability.

In addition to insurer and provider consolidation, the rise of pharmacy benefit managers (PBM) has become one of the least transparent and most costly elements of the health care system. The rise of PBM's is largely driven by ACA mandates like the MLR. Today, a handful of vertically integrated PBMs now control most of the prescription drug market, wielding significant influence over formularies, pharmacy reimbursement, and drug pricing. Small businesses oftentimes are the ones that bear the cost of these unclear arrangements without any meaningful ability to audit or challenge them.

One of the most harmful PBM practices is spread pricing, in which PBMs charge health plans more for a prescription than they reimburse the dispensing pharmacy, retaining the difference as profit. This practice drives up premiums, undermines local pharmacies, and provides no value to employers or patients. Banning spread pricing is a critical step toward restoring fairness and reducing prescription drug costs.

Equally important is requiring meaningful transparency from PBMs. Employers should have full visibility into rebates, fees, and pricing arrangements that directly affect the

cost of their health plans. Without transparency, PBMs operate with little accountability, allowing costs to rise unchecked while small businesses are told higher premiums are unavoidable.

Real reform means restoring competition, eliminating policies that reward consolidation, banning abusive PBM practices such as spread pricing, and requiring transparency throughout the health care supply chain. In addition to eliminating mandates, Congress should also increase flexibility and options for small businesses through health savings accounts, CHOICE plans, short-term, limited-duration plans and association health plans. Until these structural issues are addressed, small employers will continue to face rising costs, shrinking options, and an increasingly unsustainable health insurance market.

NFIB urges Congress to pursue reforms that dismantle consolidation incentives, promote competition, and restore balance to a health care system that is no longer working for small employers or their employees.

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January 22, 2026

Re: Written Comments for the Hearings with Insurance Company CEOs

Dear Chairman Guthrie, Chairman Smith, and members of the Committees:

The National Consumers League (NCL), America's oldest consumer advocacy organization, appreciates the opportunity to submit comments in advance of the Committees' hearings with health insurance company CEOs. Given rising healthcare costs, including premiums for coverage purchased through employers and the ACA marketplace, NCL remains deeply concerned that healthcare access is increasingly being put out of reach for American families. As part of these hearings, we urge the Committees to closely examine how vertical integration and certain insurance practices undermine affordability for consumers.

Vertical Integration Weakens Competition and Consumer Choice

Major healthcare conglomerates control a significant portion of the prescription drug marketplace, creating a system in which a single corporation often owns a health insurer, a pharmacy benefit manager (PBM), and retail and specialty pharmacies.

Parent/Owner	CVS Health Corporation	The Cigna Group	UnitedHealth Group Inc.	Humana Inc.	MedImpact Holdings Inc.	19 BlueCross BlueShield plans
Drug Private Labeler	Cordavis Limited	Qualient Pharmaceuticals	NUVAILA			
Health Care Provider	MinuteClinic, Signify Health	Evernorth Care Group	Optum Health	CenterWell		
Pharmacy Benefit Manager	CVS caremark 34%	Express Scripts 23%	Optum Rx 22%	Humana Pharmacy Solutions. 7%	MedImpact 5%	Prime Therapeutics 3%
"PBM GPO"/ Rebate Aggregator	Zinc Health Services	Ascent Health Services	Emisar Pharma Services	Ascent (via contract)	Prescient Holdings Group LLC	Ascent (minority owner)
Pharmacy - Retail	CVS Pharmacy					
Pharmacy - Mail Order	CVS Caremark Mail Service Pharmacy	Express Scripts Pharmacy	Optum Rx Mail Service Pharmacy	CenterWell Pharmacy	Birdi, Inc.	Express Scripts Pharmacy (via contract)
Pharmacy - Specialty	CVS Specialty Pharmacy	Accredo	Optum Specialty Pharmacy	CenterWell Specialty Pharmacy	Specialty by Birdi	Accredo (via contract)
Health Insurer	Aetna	Cigna Healthcare	UnitedHealthcare	Humana		19 BlueCross BlueShield plans

Source: Federal Trade Commission, *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Interim Staff Report* (July 2024)

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This structure gives the company control over nearly every step of a patient's prescription care: the insurer decides coverage and cost-sharing, the PBM negotiates drug prices and manages formularies, and affiliated pharmacies dispense the medications. They can steer patients toward their own network, favor certain drugs, and set pricing in ways that prioritize corporate profit over patient health.

PBMs provide a striking example of how vertical integration and consolidation in the healthcare market can give a single company outsized influence over patient care and costs. According to the Federal Trade Commission, as a result of consolidation, the six largest PBMs manage nearly 95 percent of all prescriptions filled in the United States.[1] As their influence has grown, so have their opaque business practices, complex rebate arrangements, and lack of transparency in compensation models. For example, the Senate Finance Committee's bipartisan investigation found that PBMs leveraged their market power and used tools like formulary exclusion to secure large rebates and fees tied to list insulin prices, creating incentives that kept prices high and left patients paying more out of pocket.[2] In practice, PBM tactics drive up costs and create barriers to accessing needed medications, ultimately undermining the goals of insurance coverage.

Insurance Practices Undermine Affordability and Access for Patients

Misaligned incentives also shape insurer and PBM use of restrictive practices such as step therapy and prior authorization, which frequently delay care and can create unnecessary barriers to medically appropriate treatment. While these tools are often justified as cost-containment measures, they can place patients' health at risk. One study found that 40 percent of patients discontinued medications they were required to step through because the drugs did not work.[3] Nonadherence results in worse health outcomes, including as much as 50 percent of treatment failures, approximately 125,000 deaths, and up to 25 percent of hospitalizations annually in the United States.[4]

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[1] FTC Releases Interim Staff Report on Prescription Drug Middlemen | Federal Trade Commission
[2] [2021-01-14] Grassley, Wyden Release Insulin Investigation, Uncovering Business Practices Between Drug Companies and PBMs That Keep Prices High | The United States Senate Committee on Finance
[3] How Prior Authorization, Step Therapy Result in Medication Discontinuation and Worse Outcomes | AJMC
[4] Medication Adherence: The Elephant in the Room

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Financial barriers can compound these clinical hurdles. Copay assistance programs are intended to help patients afford high-cost medications, yet many insurers and PBMs exclude this assistance from counting toward patient cost-sharing obligations, allowing plans to retain the benefit rather than patients. In 2024, an estimated 43 percent of commercial insurers used copay accumulator programs.[5]

As Congress continues its work to address rising healthcare costs, NCL urges the Committees to:

- Enact comprehensive PBM reform to promote transparency, fair competition, and affordability for patients and employers.
- Ensure insurance benefit designs do not delay or obstruct access to medically necessary care, particularly when utilization management tools are not clinically appropriate, such as by passing the bipartisan Safe Step Act (H.R. 5509).
- Protect patients from bearing higher out-of-pocket costs when assistance is available to help them afford essential medications by enacting the bipartisan Help Lower Patient Copays Act (H.R. 6423).

NCL looks forward to working closely with the Committees to advance these common sense, bipartisan solutions. Swift action is essential to empower patients and build a healthcare system that is affordable, transparent, and puts the needs of patients first.

Sincerely,

Lisa Bercu
Senior Director of Health Policy

Samantha Sears
Senior Manager of Health Policy

[5] Two years after Court victory, patients still saddled with unaffordable drug costs | HIV+Hepatitis Policy Institute

Federation of American Hospitals

Charlene MacDonald
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the U.S. House Energy and Commerce Health Subcommittee hearing:
"Lowering Health Care Costs for All Americans:
An Examination of Health Insurance Affordability."
January 22, 2026

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Energy and Commerce Health Subcommittee hearing entitled, "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability." The FAH appreciates the opportunity to submit this statement for the record as Congress examines health care affordability, the influence of insurer practices on patient access to care, and the impacts they have shifting costs to patients and increasing costs throughout the health care system.

As the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the United States – accounting for approximately 20 percent of community hospitals nationally – the FAH appreciates the subcommittee's leadership in addressing patients' rising out-of-pocket health costs and the topic of health insurer accountability.

FAH hospitals provide lifesaving care around the clock to all patients, regardless of their ability to pay, and provide more uncompensated care than the national average. Yet their ability to deliver care is increasingly constrained by insurance industry practices that raise costs for patients, delay access to necessary services, and burden clinical teams with unnecessary administrative requirements.

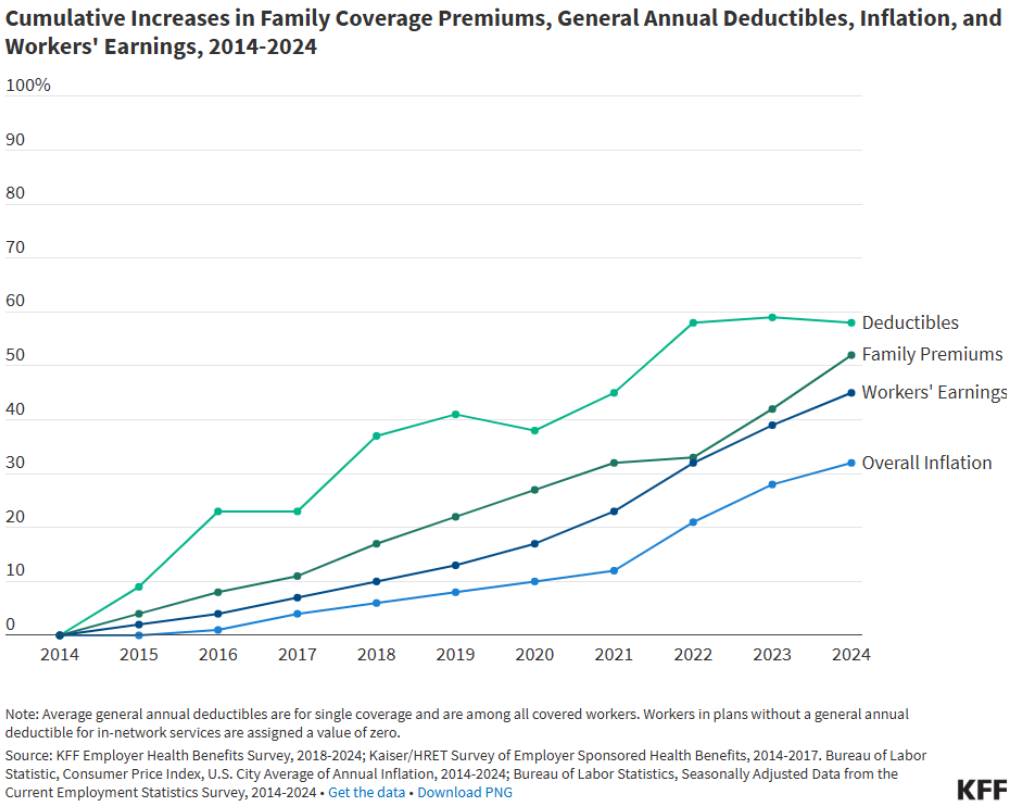
Growth in Health Insurance Premiums and Out-of-Pocket Costs

One of the most significant drivers of financial pressure on American families is the rapid growth in health insurance premiums. Annual premiums for employer-sponsored family health coverage reached $26,993 in 2025, a six percent increase over 2024, and the average deductible for individual coverage has climbed to nearly $1,900.[1] This is what working families have to pay out of pocket before their insurance will even start to help.

[1] Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks | KFF

750 9th Street NW, Suite 600, Washington, D.C. 20001 | (202) 624-1500 | Fax: (202) 737-6462 | www.fah.org

Consumers are shouldering a growing share of these rising costs not only through premiums but also through deductibles and other forms of cost sharing. According to the Kaiser Family Foundation's Employer-Sponsored Health Insurance analysis, the average worker contribution toward employer-based insurance has climbed to roughly $1,440 annually for single coverage and $6,850 for family coverage, and a larger share of workers are enrolled in plans with higher deductibles than in prior years.[2] This trend shows both the rising share of premiums paid by employees and the upward trajectory of deductibles that families must meet before insurance coverage begins. These costs cannot be dismissed as one-off increases. As deductibles grow, workers face higher out-of-pocket exposure at the very moment they are required to pay more just to maintain coverage, reducing disposable income and creating real affordability challenges for middle-class households. In fact, family premiums grew roughly 32% from 2019 through 2025, reflecting persistent upward pressure on household budgets in recent years.[3]



For individuals and families purchasing coverage on the Affordable Care Act marketplace, the financial strain can be even more acute. Analysts estimate the marketplace will lose 7.3 million enrollees due to premium spikes and the expiration of enhanced subsidies.[4] We must strengthen the individual market and lower costs for families – and that requires an extension of the enhanced premium tax credits and appropriate oversight to ensure coverage works for patients.

[2] Annual Family Premiums for Employer Coverage Rise 6% in 2025, Nearing $27,000, with Workers Paying $6,850 Toward Premiums Out of Their Paychecks | KFF
[3] Employer-Sponsored Health Insurance 101 | KFF
[4] Putting the Extraordinary Increase in ACA Premiums in 2026 in Perspective | The Commonwealth Fund

As policymakers focus on lowering health care costs, it is critically important to understand the impact of rising insurance premiums and growing patient out-of-pocket costs, which have far outpaced inflation.[5] Voters consistently report that insurers and pharmaceutical companies—not hospitals—are primarily responsible for rising health care costs.[6] This perception reflects the real-world experience of patients and providers who face higher premiums and deductibles each year while insurers impose new administrative hurdles that get between patients and their clinicians.

Health Insurer Administrative Burdens Raise Costs - Medicare Advantage and Prior Authorization Abuses

The insurer-driven administrative burden placed on both patients and providers has skyrocketed in recent years. Nearly 50 million prior authorization requests were submitted in Medicare Advantage (MA) in 2023, a sharp increase from previous years, and denial rates continue to rise. Many of these denials involve services that fully meet Medicare coverage criteria, contributing to care delays and creating a significant administrative burden for hospitals.[7] Private payers routinely deny claims at high rates as well; nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized.[8] More than half of these denials are eventually overturned, but only after multiple rounds of costly appeals, frustrating patients and providers alike because they divert time and resources away from direct patient care.

Medicare Advantage plans, in particular, have adopted practices that delay and deny seniors' care, impose burdensome prior authorization requirements, and limit access to essential health care services. Despite federal requirements that MA coverage must match the standards of Traditional Medicare so that all seniors receive the care they've earned after a lifetime of hard work, MA plans routinely fall short. Many plans rely on non-transparent proprietary decision tools and algorithms that conflict with Medicare coverage policies and often lead to inappropriate denials or premature discharge determinations without necessary clinical oversight. Studies consistently show that MA plans underperform compared to Traditional Medicare across multiple quality measures, including patient experience, mortality rates, racial and ethnic disparities, and readmission rates. Furthermore, MA plans frequently reclassify medically necessary inpatient stays as "observation" care, undermining seniors' access to benefits they would receive under Traditional Medicare. At the same time, the federal government continues to overpay MA plans by tens of billions of dollars each year—funds that often do not translate into improved care for seniors.

Congress can address these issues by simplifying administrative barriers and ensuring MA patients receive the same benefits as those in Traditional Medicare. The FAH supports bipartisan legislation, including the *Improving Seniors' Timely Access to Care Act* (S. 1816 / H.R. 3514), which would reform prior authorization and strengthen reporting requirements, reducing unnecessary burden and complexity. Additionally, there is a lack of consistent standards defining a "clean claim" or timelines for MA reimbursement to in-network providers. MA plans frequently update claim submission requirements, impose excessive documentation

[5] How much do people with employer plans spend out-of-pocket on cost-sharing? | Peterson-KFF
[6] Understanding voter attitudes towards hospitals and health care | FAH
[7] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023 | KFF
[8] Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims | Premier, Inc.

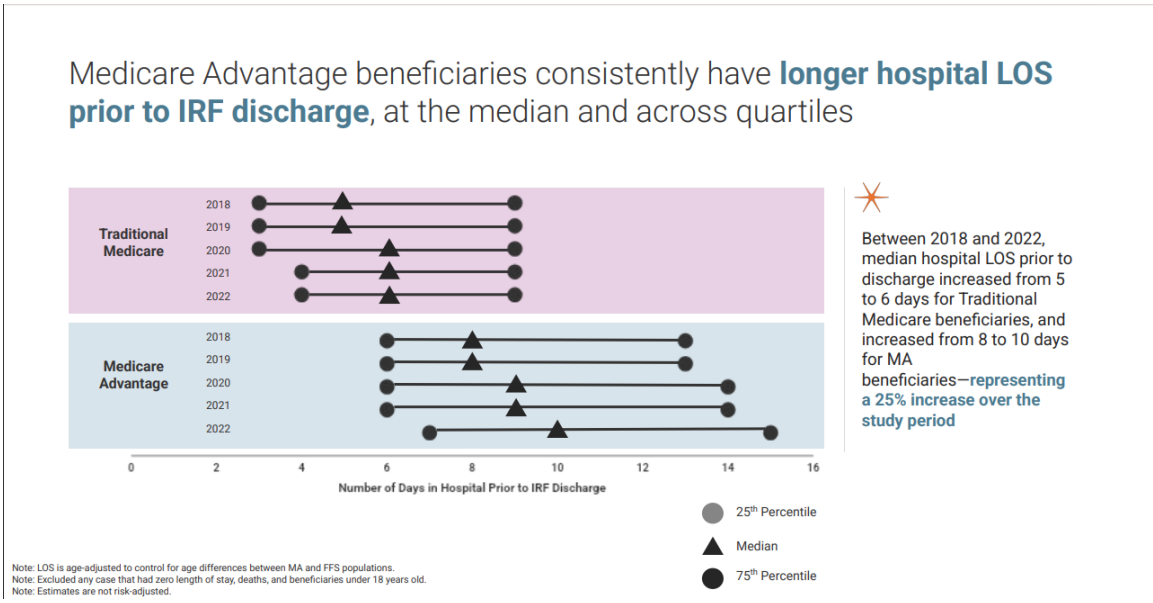
requests, and initially deny technically clean claims, creating administrative burdens, delayed payments, and unnecessary costs. Passing the *Medicare Advantage (MA) Prompt Pay Act* (H.R. 5454 / S. 2879) would help maintain MA participation, particularly in rural areas, protect seniors' access to care, and ensure providers are fairly compensated.

These insurer practices contribute substantially to rising system costs. Repeated denials, appeals, diversion of clinical staff time, prolonged inpatient stays, and delayed transitions to post-acute care increase overall spending, raise costs for hospitals and the Medicare program, and undermine the patient experience.

Seniors' Access to Post-Acute Care

Access to post-acute care represents another major concern. Seniors recovering from serious illness or injury depend on timely access to skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals to ensure safe recovery and prevent rehospitalization. Unfortunately, MA plans increasingly deny or delay authorization for these services, often at rates significantly higher than their overall authorization denial rates.[9] These delays force patients to remain in hospital beds longer than medically necessary, slowing recovery, reducing capacity for incoming patients, and increasing costs across the health care system.

In fact, between 2018 and 2022, median hospital length of stay prior to discharge increased from 5 to 6 days for Traditional Medicare beneficiaries, and increased from 8 to 10 days for MA beneficiaries—representing a 25% increase over the study period for inpatient rehab facility discharge.[10]



Some insurers have implemented automated review systems to reduce spending on post-acute care, tying financial incentives to higher denial rates and placing algorithms between clinicians and patients. These practices place seniors at risk and undermine appropriate clinical decision-making. To protect access to

[9] Analysis of hospital discharges to PAC settings among Medicare beneficiaries | NORC
[10] Analysis of hospital discharges to PAC settings among Medicare beneficiaries | NORC

the full range of post-acute services, FAH urges Congress to direct CMS to establish meaningful network adequacy standards for inpatient rehabilitation facilities and ensure MA plans comply with the Two Midnight- Rule and other Medicare coverage requirements.

Health Insurance Industry Consolidation

Consolidation within the insurance industry—both horizontal consolidation among insurers and vertical integration with physician practices and other components of the delivery system—has profoundly affected patient choice, competition, and access to care. In many states, the three largest insurers control more than 80 percent of the insurance market,[11] and some insurance companies employ or control as many as 10 percent of all physicians nationwide.[12] This concentration of power enables insurers to dictate which providers patients may see, what services those providers may deliver, how much they are paid, and the administrative hurdles they must overcome. Further, insurers that have vertically integrated with provider entities can inflate reported medical spending by directing care to their own high-priced affiliates, effectively weakening Medical Loss Ratio (MLR) requirements and contributing to higher health care costs without delivering additional patient benefit.[13]

Patients enrolled in Medicare Advantage (MA) often have access to only a fraction of the physicians available to Traditional Medicare beneficiaries, and approximately one-third of MA enrollees are in narrow-network plans that significantly restrict provider choice. At the same time, insurer provider directories are frequently inaccurate or outdated—so-called “ghost networks”—leaving patients unable to identify in-network physicians or secure timely appointments. Together, these practices severely limit patient choice and undermine meaningful network adequacy.

Insurer acquisitions and consolidation have created markets in which only a few dominant insurers wield disproportionate leverage over hospitals while imposing substantial administrative requirements that drive up costs and divert resources away from patient care. These trends have had significant negative implications for patient access, affordability, and the sustainability of community-based providers.

Hospital Transparency Versus the Insurer Black Box

Our members have made substantial investments in transparency to comply with federal price transparency requirements, but hospitals are only part of the equation. Complex cost-sharing structures, opaque benefit designs, inaccurate or incomplete network directories, and burdensome prior authorization requirements make it extremely difficult for hospitals to provide accurate cost estimates. As a result, patients frequently encounter unexpected financial exposure, not because of hospital pricing, but because of insurance design. Patients often cannot determine what their insurance covers, which providers are truly in-network, or how much they will owe until after receiving care, making meaningful comparison shopping impossible.

[11] Private Health Insurance: Market Concentration Generally Increased from 2011 through 2022 | GAO
[12] HEALTH CARE CONSOLIDATION: Published Estimates of the Extent and Effects of Physician Consolidation | GAO
[13] How Insurers That Own Providers Can Game The Medical Loss Ratio Rules | Health Affairs

Additional transparency mandates on hospitals alone will not solve this problem; real transparency requires insurers to provide accurate, complete, and timely information about coverage, networks, and cost-sharing. Without insurer accountability, patients will continue to face uncertainty and may delay or avoid needed care due to concerns about affordability.

Conclusion

The FAH urges Congress to hold insurers accountable for practices that inflate costs and restrict access to care for patients. Policymakers should address these excessive and inappropriate behaviors by insurers that lead to growing costs to the health care system and to the individual consumer. FAH member hospitals remain committed to providing patients with the high-quality care they deserve, but meaningful reform requires insurers to meet the same standards of accountability, transparency, and patient-centeredness that hospitals meet every day.

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FAH appreciates the Committees' leadership and attention to these critical health insurance coverage issues and welcomes the opportunity to continue working together to improve health care access, affordability, and quality for all patients.

American Society of Anesthesiologists®

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Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

Statement for the Record of
Patrick Giam, MD, FASA, President
American Society of Anesthesiologists

United States House of Representatives Energy and Commerce Committee,
Subcommittee on Health

January 22, 2026

On behalf of the 60,000 members of the American Society of Anesthesiologists (ASA), I commend Chairman Guthrie and your committee for this critically important and timely hearing exploring the role of health insurance companies in health care affordability. Patients, physicians, and hospitals all feel the impact of insurer decisions, and any serious discussion of affordability must consider whether those decisions support timely, appropriate care.

Anesthesiologists play a crucial but often overlooked role in keeping health care both safe and cost-effective. By preventing complications, reducing delays, and managing patients' medical needs before, during, and after procedures, anesthesiologists help avoid some of the most expensive problems in health care. These everyday contributions translate directly into savings for Medicare, Medicaid, employers, and commercial payers, demonstrating that physician-led, high-quality care is a foundation of true affordability.

Our commitment to value and patient safety stands in sharp contrast to insurer practices that add administrative burdens, create payment barriers, and shift costs onto our members. While later sections of this statement outline specific examples, it is important to underscore that anesthesiologists consistently act as responsible stewards of health care resources. Anesthesiologists are good actors in a system that far too often rewards obstruction rather than partnership. Each day, anesthesiologists demonstrate what is possible for patient outcomes and improving our health care system with their focus on providing patient-centered care in a cost-effective manner.

Anesthesiologists' Expertise Lowers Costs by Preventing Complications

Complications are among the costliest events in health care. Anesthesiologist delivered and led anesthesia care significantly reduces unnecessary tests, same-day surgery cancellations, and postoperative complications. When not addressed, these preventable events drive billions of dollars in avoidable spending each year. For example, an independent peer-reviewed study of anesthesia care calculated that patients face an 80% higher risk of unexpected hospital admissions after outpatient surgery when an anesthesiologist is not involved.[1] Anesthesiologists are the expert strategic partners hospitals turn to for managing high-risk patients safely, improving ICU and perioperative care, and ultimately strengthening the financial performance and efficiency of surgical services.

Anesthesiologist Perspectives on Insurer-Driven Barriers to Care

Despite an anesthesiologist's central role in maintaining high standards of care in a cost-effective manner, our members continue to face unnecessary and time-consuming disputes with large health insurers. Recent years have been marked by payer-driven behaviors that divert scarce healthcare dollars away from clinical services and undermine the very premium dollars intended to support patient access and quality. Payer policy changes have been increasingly reckless in the past few years, oftentimes announcing policy changes mid-year, without warning, and in a punitive way against physicians providing quality care to the payer's customers. Recent examples include:

Payer Proposes to Limit Anesthesia for Patients

An incident that garnered significant public outcry came as Anthem announced a policy to limit coverage for their enrollees' anesthesia care.[2] Under the policy, Anthem proposed to deny claims submitted when the reported anesthesia time exceeded the company's

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[1] Memtsoudis, S. G., Besculides, M. C., & Swamidoss, C. P. (2012). *Study of ambulatory surgery finds better outcomes when anesthesiologists provide care.* American Society of Anesthesiologists. (https://www.asahq.org/~/media/sites/asahq/files/public/resources/analytics-research-services/memtsoudis_onepager_final.pdf [asahq.org].)

[2] Worden, Z. (2024, December 5). *Anthem Blue Cross Blue Shield customers may soon pay out of pocket for anesthesia*. CNY Central.(https://cnycentral.com/news/local/new-yorkers-covered-by-blue-cross-blue-shield-may-soon-pay-out-of-pocket-for-anesthesia.)

arbitrarily established time limit for anesthesia. In effect, if a surgery lasted longer than the payer's designated time standards, Anthem would absolve themselves of responsibility to pay for the entire case. This irresponsible policy proposal failed to contemplate even the simplest of individual patient needs, let alone operating room workflows, patient comorbidities, complications and other situations that affect the duration of surgery and anesthesia time. The proposed policy reflected a significant disconnect between Anthem, its patients, and their needs. Fortunately, the policy was suspended following significant backlash from the ASA, patients, the public, Members of Congress, and health care professionals.[3]

Payers Halt Payments for Complex and High-Risk Patients

In yet another punitive policy change, several payers have proposed or implemented removing physician payments for treating complex patients as recognized by physical status (PS) modifiers.[4] Physical status modifiers classify the level of complexity of the anesthesia care. More complex patients are classified as III, IV, and V. A patient with a past or current disease or condition may require different or more intensive care than a healthier patient undergoing the same surgical procedure.

Because the standard anesthesia payment framework does not account for the added complexity involved in caring for higher-risk patients, many of the additional monitoring, safety measures, and care-coordination activities anesthesiologists provide go unrecognized in traditional billing. Historically, private payers have acknowledged these gaps by supplemental payments through the physical status modifier, which reflects the extra work and expertise required to safely manage patients with more complex medical needs.

When payers began to cease physical status modifier payments, their policies effectively limited an anesthesiologist's ability to receive appropriate payment for the care provided to more complex patients. Oddly, while some payers are removing payment considerations based on patient complexity, Medicare has begun to better recognize care for patient complexity. In 2024, the Centers for Medicare and Medicaid Services (CMS) finalized

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[3] U.S. News. *Insurer Anthem Rescinds Anesthesia Policy Change After Backlash*, (2024 December) (www.usnews.com/news/health-news/articles/2024-12-06/insurer-anthem-rescinds-anesthesia-policy-change-afterbacklash)

[4] Mathewes, F. (2025, July 9). *ASA slams recent UHC anesthesia policy change*. Becker's ASC Review. (https://www.beckersasc.com/anesthesia/asa-slams-recent-uhc-anesthesia-policy-change/.)

additional payment for complex patients using HCPCS code G2211, acknowledging that certain patients require additional effort and resources provided by physicians.[5]

The ASA physical status modifiers are used in a similar way. Unfortunately, insurers have not aligned with the prevailing notion that physician payments can be differentiated based upon the types of patients treated and the intensity of care provided. With older and more complex patients undergoing an increasing number of surgical procedures, in both inpatient and outpatient settings, the financial impact of these private insurance policy changes on anesthesia practice is substantial and will affect patient access to care.

Payer Excludes Hospital-Based Physicians from Network, Then Penalizes Hospital

Under a policy implemented in January of 2026, Anthem will impose a 10% administrative penalty on facility claims when payers have narrow networks that exclude important front-line clinicians — including anesthesiologists, radiologists, and others.[6] The policy further threatens facilities with potential termination from the payer's network for continued use of clinicians with whom the payer would not contract.

The policy is deeply flawed and operationally unworkable. It effectively shifts the payer's network adequacy obligations – the obligation to have sufficient physicians in their network - onto facilities, holding them financially liable for the decision of the payer to exclude certain physicians from the network. This is a function over which hospitals have no control or infrastructure to manage.[7] Hospitals will be forced to compel independent providers to join the payer's network potentially under unfavorable terms leading to a risk of worsening financial instability and loss of clinicians. Additionally, the need to reorganize or replace physician groups to accommodate payers will jeopardize hospitals' continuity of care and patient access to essential services.

Expecting facilities to monitor and enforce payer contracts across dozens of independent entities and multiple commercial plans is not only impractical but raises serious legal and

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[5] American Academy of Family Physicians (AAFP). (2024 March) *G2211: Simply Getting Paid for Complexity.* Family Practice Management (https://www.aafp.org/pubs/fpm/issues/2024/0300/coding-g2211.pdf)

[6] American Society of Anesthesiologists. (2025, November 24). *ASA expresses opposition to Elevance policy in meeting*. (https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2025/11/asa-expresses-opposition-to-elevance-policy.)

[7] American Hospital Association. (2025, December 18). *AHA urges Elevance Health to rescind Anthem's "Nonparticipating Provider Policy," citing harm to patient care access*. (https://www.aha.org/news/headline/2025-12-18-aha-urges-elevance-health-rescind-anthems-nonparticipating-provider-policy-citing-harm-patient-care)

ethical concerns. In effect, these strong-armed tactics from Anthem in the relationship between hospitals and medical professionals require that Congress act and strengthen its oversight to maintain fairness and transparency in our health care system.[8]

Payers Game the No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process

ASA welcomed the passage of the bipartisan No Surprises Act because of its patient protections and promise of a fair, transparent mechanism for resolving payment disputes between payers and physicians—while keeping patients out of the middle. To date, the law's patient protections have been proven effective. Millions of patients have been protected from surprise medical bills. Significant progress has been made to implement a user-friendly, functional Independent Dispute Resolution (IDR) process that recognizes appropriate payment offers and ushers the dispute to final resolution of a claim. However, payers continue their effort to disrupt and weaken the NSA and the IDR process.

Payers have gamed various elements of the NSA system in order to delay or deny appropriate payments to physicians.[9] As an example, payers have leveraged loopholes in Qualifying Payment Amount (QPA) calculations and exploited enforcement of payer obligations. Payers have submitted zero dollar offers and other unreasonably low offers into the IDR process. These actions have eroded the statute's foundations to resolve disputes before the IDR process. Facing unreasonably low offers, practices are left with no other option than to utilize the NSA IDR process. As a result, the volume of claims submitted to the IDR process increases. Yet, the very payers who establish unreasonable terms and other barriers within the IDR process then publicly decry the volume of IDR disputes. Moreover, these payers often delay and even deny physicians the arbitrator-determined awards to which they are entitled.

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[8] American Society of Anesthesiologists. (2025, December 18). *ASA applauds bipartisan congressional action on Anthem 10% payment penalty policy*. (https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2025/12/asa-applauds-bipartisan-congressional-action-on-anthem-10-percent-payment-penalty-policy.)

[9] American Society of Anesthesiologists. (2025, July 24). *Anesthesiologist, emergency physician and radiologist groups strongly support new legislation that penalizes insurers for delayed payments*. (https://www.asahq.org/about-asa/newsroom/news-releases/2025/07/anesthesiologist-emergency-physician-and-radiologist-groups-strongly-support-new-legislation-that-penalizes-insurers-for-delayed-payments.)

Recommendations and Conclusion

ASA commends the House Energy and Commerce Health Subcommittee for its focus on healthcare affordability and urges Congress to aggressively increase its oversight of health insurer practices, especially in instances where the health insurance company policies undermine patient access to care, devalue physician expertise, and destabilize our health care delivery system. We also urge Congress to consider and pass the No Surprises Enforcement Act and continue to push for the finalization of the No Surprises Act Operations Rule.[10]

Anesthesiologists have long demonstrated that anesthesiologist delivered and led, patient-centered care not only improves outcomes but also controls costs by preventing complications, avoiding unnecessary utilization, and ensuring safe surgical care for patients of all ages and levels of complexity. These contributions stand in stark contrast to payer policies that prioritize cost-shifting and administrative hurdles over clinically sound, individualized care.

We respectfully urge lawmakers to safeguard fair coverage policies, ensure that insurer payment practices accurately reflect patient acuity, and reinforce the shared responsibility of all parties to maintain robust provider networks. Policies that cap anesthesia time, dismiss patient complexity, or penalize hospitals for payer contracting decisions threaten to erode quality, reduce access—particularly in rural and underserved areas—and weaken the very systems patients depend on during their most vulnerable moments.

[10] American Society of Anesthesiologists. (2025, October 20). *ASA urges swift release of final IDR operations rule to stabilize No Surprises Act implementation*. (https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2025/10/asa-urges-swift-release-of-final-idr-operations-rule-to-stabilize-no-surprises-act-implementation.)

Ways and Means Committee
U.S. House of Representatives
1129 Longworth House Office Building
Washington D.C. 20515

Health Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Re: Pass the *Improving Seniors' Timely Access to Care Act* (HR 3514) into Law

To the Honorable Members of the Ways and Means Committee and Energy and Commerce Health Subcommittee:

The American Medical Informatics Association (AMIA) appreciates the opportunity to submit statement in advance of the health insurance CEO hearings.

AMIA is the professional home for more than 6,000 informatics professionals, representing frontline clinicians, researchers, and public health experts who bring meaning to data, manage information, and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluation.

It is AMIA's position that prior authorization (PA) must be eliminated to improve patient access to necessary medical care, maintain the healthcare workforce, and reduce the required onerous documentation associated with PA. PA, the onerous process used by health insurance companies, including Medicare Advantage (MA) plans, requires clinicians to obtain approval before providing medically necessary care to patients for covered services and is a major source of burden for patients in need of care, clinicians, and health systems.

Until prior authorization can be eliminated effectively, **AMIA urges Congress to pass the *Improving Seniors' Timely Access to Care Act*[1].**

In short, the *Seniors' Act* would:

- Establish an electronic PA process for MA plans, including a standardization for transactions and clinical attachments.
- Increase transparency around MA PA requirements and their use.
- Provide a pathway for CMS to institute real-time decisions for routinely approved items and services in the future and clarify CMS' authority to establish timeframes for PA requests, including expedited determinations, real-time decisions for routinely approved items and services and any other PA request.

[1] *Improving Seniors' Timely Access to Care Act of 2025*. (H.R. 3514). 119th Congress. https://www.congress.gov/bill/119th-congress/house-bill/3514/text.

- Expand beneficiary protections to improve enrollee experiences and outcomes.
- Require the U.S. Department of Health and Human Services and other agencies to report to Congress on program integrity efforts and other ways to improve the PA process.

Passing the *Seniors' Act* will enhance and codify into law the Centers for Medicare & Medicaid Services (CMS) January 2024 Advancing Interoperability and Improving Prior Authorization Processes final rule (CMS-0057-F). This rule requires plans to implement electronic PA by 2027, implement HL7 FHIR APIs, provide specific reasons for request denials, and publicly report certain metrics annually.[2]

A physician survey conducted by the Regulatory Relief Coalition found that:[3]

- 82% of physician respondents state that PA always (37%) or often (45%) delays patient access to necessary care;
- Wait times can be lengthy: For most physicians (74%), it takes between 2 to 14 days to obtain PA, and for 15%, this process can take 15 to more than 31 days;
- 32% of respondents report that patients often abandon treatment and 50% report that patients sometimes abandon treatment;
- Overwhelmingly (87%), physicians report that PA has a significant (40%) or somewhat (47%) negative impact on patient clinical outcomes;
- The burden associated with PA for physicians and their staff is high or extremely high (92%); and
- Ultimately, most services are approved, with one-third of physicians getting approved 90% or more of the time.

The Medical Group Management Association found that:[4]

- 89% of medical practices find PA "very or extremely burdensome."
- 92% of medical practices "hired or redistributed staff to work on PA due to the increase in requests."
- 83% of practices said a top challenge is PA for routinely approved items and services.
- 97% of medical practices reported that patients "experienced delays or denials for medically necessary care due to prior authorization requirements."

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[2] Medicare and Medicaid Programs Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, 89 Fed. Reg. 8758 (Feb 8, 2024). https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

[3] Opposition to Implementation of the WISeR Model in Medicare Fee-for-Service. Regulatory Relief Coalition. August 12, 2025. https://www.mgma.com/getkaiasset/78d01508-2413-478c-9c8b-59b6f692675c/FinalRRC%20CommentsonWISeRDemonstration%2008122025.PDF

[4] Annual Regulatory Burden Report. Medical Group Management Association (MGMA). November 2023. https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf

These findings are a staggering illustration of burden, inefficiency, and barriers to care. Additionally, a report released in 2024 found that over 80% of PA appeals in 2022 resulted in overturning initial denials and that this was a trend that continued from 2019 and 2021,[5] yet again demonstrating that PA withholds medically necessary care.

Thank you for attention to these issues. For more information, please reach out to AMIA's Senior Vice President of Policy, Reva Singh, at rsingh@amia.org.

Sincerely,

Reva Singh, JD
Senior Vice President of Policy
AMIA

[5] *Medicare Advantage Plans Denied a Larger Share of Prior Authorization Requests in 2022 than in Prior Years*. Kaiser Family Foundation. August 8, 2024. https://www.kff.org/medicare/press-release/medicare-advantage-plans-denied-a-larger-share-of-prior-authorization-requests-in-2022-than-in-prior-years/#:~:text=Just%20one%20in%2010%20(9.9,that%20were%20overturned%20upon%20appeal.

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Statement for the Record
House Energy & Commerce Subcommittee on Health and
House Ways & Means Committee
Hearing on Health Care Affordability and Insurance Practices
January 22, 2026

Submitted by the American College of Cardiology

The American College of Cardiology (ACC) appreciates the opportunity to submit this statement for the record for today's hearings examining the role of health insurers in driving health care costs and access to care. The ACC represents more than 60,000 cardiovascular professionals dedicated to improving heart health and ensuring patients receive timely, evidence-based care.

Current Landscape and Challenges

Currently, more than half of Medicare beneficiaries are enrolled in Medicare Part C, also known as Medicare Advantage (MA), which is a private plan alternative to traditional fee-for-service Medicare. One of the most significant barriers to affordable, high-quality care for seniors within the MA program is the overuse and abuse of prior authorization. Cardiovascular clinicians consistently identify prior authorization as the number one administrative burden interfering with patient care. These requirements often lead to dangerous delays, inappropriate denials, and unnecessary stress for patients with serious cardiovascular conditions such as heart failure, atrial fibrillation, and coronary artery disease.

Federal oversight bodies have confirmed what clinicians and patients experience every day. The Office of Inspector General (OIG) has found that MA plans routinely deny or delay medically necessary care, including overturning 75 percent of prior authorization denials on appeal and denying more than one million requests each year, many of which involve care that should have been covered.

Consequences of Delays in Care

For seniors enrolled in MA, one of the primary factors driving both poor outcomes and higher costs is the widespread misuse of prior authorization. In cardiology, delays in care can have serious consequences. Conditions like heart failure, atrial fibrillation, coronary artery disease, and cardiomyopathy are time-sensitive and progressive. As a result, such delays can lead to higher emergency department visits, an increase in hospitalizations, or irreversible harm.

Real-world cardiology cases illustrate how prior authorization worsens affordability rather than improving it. For example, seniors experiencing new shortness of breath have had echocardiograms delayed for days, only to end up hospitalized with pulmonary edema before the tests could be performed. Patients with chest pain can endure week-long waits for coronary CT angiography, even when the test is recommended by clinical guidelines, forcing them to undergo unnecessary stress tests or repeat imaging. Even patients who qualify for implantable cardioverter-defibrillators to prevent sudden cardiac death are frequently required to wait weeks for approval from their insurers.

These delays do not reduce health care waste. Instead, they shift care from planned, outpatient, guideline-directed treatment to more expensive emergency and inpatient care, which poses greater risks to patients and costs Medicare significantly more.

Reforming Prior Authorization

Reforming prior authorization could lead to fewer strokes, reductions in heart-failure admissions, fewer preventable heart attacks, and a decrease in sudden deaths. These improved outcomes would also result in lower Medicare spending and a more sustainable health care system.

The ***Improving Seniors' Timely Access to Care Act*** (H.R. 3514) would codify and enhance elements of the Advancing Interoperability and Improving Prior Authorization Processes (e-PA) Rule, finalized by the Centers for Medicare & Medicaid Services (CMS) on January 17, 2024. This bill offers a bipartisan, budget-neutral solution to these issues by modernizing how prior authorization works in MA. The bill would require electronic prior authorization, standardized data and clinical attachments, real-time approvals for routinely covered services, and enforceable timelines for urgent and standard requests. These reforms would allow clinicians to move quickly on tests and treatments that are already well supported by evidence and guidelines, such as echocardiography, coronary imaging, anticoagulation, lipid-lowering therapy, and cardiac rehabilitation. It would also provide CMS with clear authority to require real-time approvals for routinely covered services, enforce decision timeframes for both expedited and standard requests, and strengthen beneficiary protections.

Additionally, the legislation would enhance transparency and oversight by requiring reporting on how MA plans use prior authorization and how often denials are overturned; this is an especially important safeguard given federal findings that MA plans deny and later reverse large numbers of medically necessary services.

Finally, the bill requires the Department of Health and Human Services to report to Congress on program integrity and ongoing improvements, ensuring that these reforms are enforced and that MA plans are held accountable for their practices.

With support from over 300 national and local health care organizations, H.R. 3514 was introduced with broad bipartisan backing. This reflects a shared recognition that seniors should not have to fight their insurance company to receive medically necessary care. The House bill currently enjoys 243 bipartisan

cosponsors, and the Senate companion has 60 cosponsors, highlighting the urgent need for reform in the prior authorization process to improve health outcomes for seniors enrolled in MA.

The ACC urges Congress to advance this legislation as part of its broader efforts to improve health care affordability and restore patients and clinicians to the center of clinical decision-making. When seniors receive the right cardiac care at the right time, lives are saved, and costs are reduced.

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AMERICAN BENEFITS COUNCIL

Statement for the Record

U.S. House of Representatives Committee on Energy & Commerce

Hearing on

Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

Submitted by the American Benefits Council

January 22, 2026

1250 H Street NW Suite 605 Washington DC 20005 202-289-6700 https://www.americanbenefitscouncil.org

PLEASE NOTE: The Council has a new address!

Dear Chair Guthrie, Chair Griffith, Ranking Member Pallone and Ranking Member DeGette:

On behalf of the American Benefits Council ("the Council"), I want to thank you for holding this hearing as part of your important efforts to examine the root causes driving higher health care prices and discuss policies that will lower the cost of care for *all* Americans. This committee has taken significant steps over the last several years to advance bipartisan policies that target the root causes of rising health care costs – namely a lack of transparency and competition and misaligned incentives that drive higher-cost care. **We urge Congress to advance these important policies to make health care more affordable for employers and working families.**

The Council is a national non-profit organization dedicated to protecting employer sponsored benefit plans. The Council represents more major employers—over 220 of the world's largest corporations—than any other association that exclusively advocates on the full range of employee benefit issues. Members also include organizations supporting employers of all sizes. Collectively, Council members directly sponsor or support health and retirement plans covering virtually all Americans participating in employer-sponsored programs.

Providing health coverage to more than 180 million Americans, employers play a critical role in the health care system and drive innovations from which the entire health system benefits. With a vested interest in securing the health and well-being of their employees, employers deliver high-value, innovative health coverage to workers and their families. However, employers are deeply concerned about rising costs and other impediments to value and innovation. Rising health care prices are placing an increasingly large burden on American employers and workers. According to a survey by the Kaiser Family Foundation, annual premiums for employer-sponsored health coverage reached $26,993 in 2025, an increase of 6% from the prior year, with workers, on average, paying $6,805 toward that cost.[1] Employers are bracing for even higher costs this year.[2] This trajectory is unsustainable for employers, employees and their families.

The only way to truly make health care more affordable for employers and working families is to understand and address the root causes of rising spending: (1) misaligned incentives that promote hospital and provider consolidation and higher-cost care and (2) a lack of transparency. Hospital spending is the largest health spending category in the United States, and hospital prices are a primary driver of rising health care costs for employers and workers.[3] Therefore, examining and addressing the factors fueling

[1] Kaiser Family Foundation, 2025 Employer Health Benefits Survey (October 22, 2025)

[2] Mercer, "Employers prepare for the highest health benefit cost increase in 15 years" (September 3, 2025)

[3] U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on*

higher hospital costs is essential to lowering health care costs for all Americans.

While employers continue their efforts to lower health care costs, federal legislative solutions are needed to create a more competitive, transparent health care marketplace and to remove payment distortions that drive higher cost care. Employers want Congress to act *now* to lower health care costs. Specifically, **the Council strongly supports legislation to:**

- **Ensure fair and transparent hospital billing practices**
- **Expand site-neutral payment reforms**
- **Ensure greater transparency in the health care system**
- **Provide greater transparency and oversight of pharmacy benefit managers (PBMs)**
- **Restrict anti-competitive contracting provisions**
- **Modernize the 340B drug pricing program**

RESTRICT HOSPITAL BILLING PRACTICES THAT FUEL CONSOLIDATION AND MASK WHAT SHOULD BE THE APPROPRIATE PAYMENT AMOUNTS

As noted above, hospital spending is the largest health spending category in the United States, accounting for almost one-third of all expenditures. Rising prices for hospital services have contributed to a nearly 50% increase in private health plan spending from 2012 through 2022.[4] This spending is being fueled by hospital consolidation and vertical integration with physician practices. In concentrated markets, prices do not flow from competitive market negotiations, but from the outsized leverage that market concentration affords. Consolidation corrodes the competitive market forces needed to align health care costs with value, resulting in higher costs for plans and patients alike[5] without higher quality or access.[6] At the same time, many private hospital systems are becoming vertically integrated with physician organizations.

Hospital Pricing Data Completeness and Accuracy (October 2, 2024)

[4] U.S. Government Accountability Office, *Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy* (October 2, 2024)

[5] Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physician practices on prices and spending," *Journal of Health Economics* (May 2018)

[6] The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market*, pp. 7 (March 2020)

As large hospital systems purchase physician practices, they can portray services delivered at these sites as "hospital services" as opposed to "professional services" to receive the higher facility reimbursement fee. Hospitals have leveraged the acquisition of physician practices to bill payers — including employer-sponsored group health plans — higher rates by portraying non-hospital-based professional services as if they were delivered in a hospital. This unfair and opaque billing practice serves to incentivize vertical hospital-physician consolidation and increase costs for employers and patients.

Hospitals can use this billing practice because they are not required to specify where services are provided when they bill. The Council strongly supports the Fair Billing Act (S. 2497), bipartisan legislation introduced by Senators Maggie Hassan (D-NH) and Roger Marshall (R-KS), requiring each off-campus outpatient department of a hospital to include a unique identification number on claims for services. This important policy will promote "fair billing" practices and help payors distinguish between sites of service to apply the appropriate payment amount. The policy was included in the House-passed Lower Costs, More Transparency Act from last Congress, and came very close to being included in the year-end 2024 funding package. **We urge Congress to include the Fair Billing Act in any upcoming funding package. This is bipartisan, common-sense action Congress can take now to make health care more affordable.**

EXPAND SITE-NEUTRAL PAYMENT REFORMS

Hospital costs account for 44% of total personal health care spending for the privately insured and hospital price increases are key drivers of recent growth in per capita spending among these individuals.[7] Rising hospital costs are being fueled by hospital and provider consolidation that lead to higher health care costs *without* an increase in quality.[8] After hospitals purchase physician practices, they are able to rename the practices as "hospital facilities" and thereby bill at higher hospital rates (that now include a "facility" fee) for the exact same service. This payment distortion incentivizes provider consolidation, in turn, fueling higher costs.

An important way for Congress to reduce incentives that are leading to increased hospital/provider consolidation — and higher hospital cost care — is to expand site-neutral payment reform. Site-neutral payment reform aligns payment rates for certain services that can be safely delivered regardless of where care is received across the three main sites where patients receive outpatient care: hospital outpatient departments

[7] Rand Corporation, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (2020)

[8] Cory Capps, David Dranove and Christopher Ody, "The effect of hospital acquisitions of physicianpractices on prices and spending," *Journal of Health Economics* (May 2018); The Hamilton Project, *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market*, pp. 7 (March 2020)

(HOPDs), ambulatory surgical centers (ASCs) and freestanding physician offices. According to polling by the Winston Group,[9] voters favor adopting site-neutral payment policies by a two-to-one margin.

The Council urges Congress to expand site-neutral policies for additional services and facilities and to implement site-neutral policies as soon as possible**.** Ending Medicare payment policies that provide incentives for consolidation is a key action Congress can take to increase competition and thereby lower health care costs.

ENSURE GREATER TRANSPARENCY IN THE HEALTH CARE SYSTEM

The Council wishes to express its support for, and emphasize the vital importance of, health care price transparency across the industry. The Council has long been a leader in supporting meaningful, increased health care price and quality transparency and access to data for employer plan sponsors to improve health care value. Transparency is not an end in and of itself. It is, however, a means to fuel competition, track when and where health care prices are relatively higher or increasing and use that information to encourage health care that is more value-driven. An essential element of making health care more affordable for employers and working families is to help them more fully understand what is driving the increase in health care spending so employers can deliver affordable, high-value health care benefits.

Notably, of those employers that have had success in decreasing the rate of health care spending, many have done so by analyzing their own health care data to better understand what health care services are being utilized and how much is being spent on specific health care services, and in turn, using that information to promote higher-value, relatively lower-cost providers. Employers not only need access to their data in a useful manner, but also the freedom to take action.

Despite important legislative and regulatory action to advance health care transparency, impediments remain to meaningful access and utilization of health pricing data. Removing barriers to accessing and using price and quality information is foundational to unleashing the power of transparency to help employers drive lower cost and provide higher value health care. According to the Winston Group poll,[10] more than 80% of voters with employer-sponsored health insurance cited transparency of how much services cost as either the top priority or one of the high priority health care issues Congress should address.

The hospital price transparency (HPT) final rule issued by the U.S. Department of

[9] The Winston Group, *Alliance to Fight for Health Care National Survey* (September 11, 2024)

[10] Id.

Health and Human Services establishes requirements for hospitals operating in the U.S. to establish, update, and make public a list of their standard charges for the items and services that they provide. The fact remains that far too many hospitals across the country remain out of compliance — or *meaningful* compliance — with the hospital price transparency rule.[11] Improving HPT compliance and enforcement is critical to these efforts, including by codifying and strengthening price transparency for hospitals.

Our plan sponsor members are doing their part to support increased transparency. They recognize that access to pricing data is critical to unleashing the power of employers to drive lower cost and higher value health care, and employers have made great efforts to comply with the full range of requirements of the "transparency in coverage" rule. We want to ensure the optimal utility of these requirements to support those employer efforts and support legislation to codify and improve price transparency for group health plans as rulemaking efforts to improve price transparency are ongoing.

We also stress the importance of minimizing burdens on employers and their service provider partners that add cost and complexity but not value or useful information to achieve these goals. Employers want to be able to use health care pricing information as a tool to make more value-driven decisions that bring down the overall cost and improve the quality of healthcare for employees and their families. The Council recognizes that price is just one piece of the puzzle and, in terms of value, the price of the health care service does not always correlate with the quality of care and, thus, equate to better value. We note, however, that while increased price transparency will be most effective when coupled with quality information, price transparency efforts should proceed apace even if quality transparency will take additional time to realize.

REQUIRE GREATER TRANSPARENCY AND OVERSIGHT OF PBMS

We reiterate our support for, and emphasize the vital importance of, health care price transparency across the industry, including the prescription drug pricing system. Employers remain deeply concerned about prescription drug costs across the entire drug pricing system, particularly the cost of specialty drugs. Related to this concern, employers have been focused on areas where there is an absence of appropriate price transparency for prescription drugs across the entire drug pricing system.

In an effort to manage drug costs, employers have implemented innovative strategies while ensuring that employees and families have access to needed drugs and services. Many of these strategies have been developed by, or in concert with, PBMs and other service providers. However, prescription drug costs continue to rise, driven

[11] Families USA, *The Power of Price Transparency: Unveiling Health Care Prices to Promote Accountability and Lower Costs* (April 19, 2023)

by a complex interplay of market dynamics, structural features of the pharmaceutical supply chain, and a lack of transparency. Challenges remain with plan fiduciaries gaining full insight into the amounts and types of revenue that PBMs generate in connection with providing services to a group health plan.

Employers cannot effectively manage prescription drug costs unless they can see the full picture of rebates, fees and other remuneration generated from manufacturers and other parties, drug definition criteria, and amounts charged to pharmacies. Increased transparency for PBMs is needed to help employers and employees make better informed purchasing decisions that result in higher value pharmacy expenditures. The Council strongly supports federal legislation that requires PBMs to provide employers with detailed data on prescription drug spending, including rebates. Increased transparency about rebates and other fees paid by manufacturers to PBMs is essential and must be robust enough to capture PBM aggregate rebates, including those captured by group purchasing organizations.

ELIMINATE ANTI-COMPETITIVE CONTRACTING TERMS

Legislation such as the bipartisan Healthy Competition for Better Care Act (H.R. 6248) restricts anti-competitive contracting provisions that limit employers' efforts to promote high value care. The most important driver of higher prices for hospital care is the rise of regional hospital monopolies.[12] Large hospital systems attempt to leverage their significant market share in forcing plans and issuers to contract with all affiliated facilities and prevent steering patients towards lower-cost, higher quality care. These anti-competitive contract terms in the form of "all-or nothing," "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions foster highly inflated costs and limit a plan sponsor's flexibility in plan design to promote access to high-value care. The Healthy Competition for Better Care Act would increase competition and promote lower costs by restricting such contract terms. We urge Congress to pass such legislation.

MODERNIZE THE 340B PROGRAM

Employers are deeply concerned about the significant cost that explosive growth of the 340B program has imposed on employer-sponsored health plans. Last year, the Council issued a paper[13] explaining how employers, working families and taxpayers are shouldering a significant cost of the 340B drug pricing program's expansion, while the

[12] The Foundation for Research on Equal Opportunity, *Affordable Hospital Care Through Competition and Price Transparency* (January 31, 2020)

[13] American Benefits Council, *GROWTH UNCHECKED: A Call to Action for Policymakers to Reform 340B, to Stop It from Driving Up Health Care Costs for Employers, Working Families and Taxpayers* (February 2025)

program is failing to sufficiently benefit the vulnerable patients it was intended to serve. Employers seek to ensure that the 340B program indeed serves vulnerable patients yet does not raise costs for employer-sponsored health plans. The Council calls upon Congress to carefully consider the impact of the program on employers and working families.

Offering health coverage to more than 180 million Americans, employers are a key stakeholder in legislative efforts to amend the 340B program. The Council has strong concerns that the growth of the 340B program is raising costs for employers and working families by fueling hospital-physician consolidation, affecting discounts in the commercial market and promoting increased use of higher-cost therapies. The Council urges Congress to work with us on legislation to modernize the 340B program without raising costs for employers, employees and taxpayers.

CONCERNS WITH IMPLEMENTATION OF THE NO SURPRISES ACT IDR PROCESS

As you examine the root causes of rising health care costs, we also bring your attention to implementation of the Independent Dispute Resolution (IDR) process under the No Surprises Act. Employers are deeply concerned that implementation of the IDR process is undermining the law's intent to both protect patients from surprise billing and lower health care costs. Instead, the IDR process has generated at least $5 billion in total costs through the end of 2024.[14] This higher spending will likely be reflected in higher overall health costs and consumer premiums in the future. Moreover, it is being driven by a select group of providers who are capitalizing on the process, which has seen far more IDR disputes than anticipated and overwhelmingly results in providers prevailing with median payment determinations over four times the in-network amount. We urge the agencies to take immediate action to strengthen enforcement to ensure only eligible claims are submitted to IDR, increase transparency in arbitration decisions and penalize abuse of the process.

* * * * *

This committee has undertaken substantial bipartisan steps over the past several years to advance important policies to make health care more affordable for employers and working families. We ask the committee to continue to build on those efforts and urge Congress to take prompt and decisive action to enact the policies outlined above. The Council stands ready to assist you in any way possible. Please do not hesitate to reach out with any questions.

Sincerely,

[14] Jack Hoadley and Kennah Watts, *Health Affairs Forefront*, "The Substantial Costs Of The No Surprises Act Arbitration Process" (August 25, 2025)

Ilyse Schuman
Senior Vice President, Health and Paid Leave Policy

AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

January 22, 2026

The Honorable Brett Guthrie
Chairman, House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member, House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jason Smith
Chairman, House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member, House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairmen Guthrie and Smith and Ranking Members Pallone and Neal:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write to thank you for holding what we hope are the first two in a series of hearings on how we can make health care more affordable for all Americans with commercial insurance coverage. Given the significance of this issue to family physicians and the patients they serve, I want to offer the following recommendations and insights from the family physician perspective.

Most Americans are enrolled in health insurance plans administered by commercial insurers. The nation's ten largest insurers cover over half of enrollees in private insurance, Medicaid Managed Care and Fee-for-Service (FFS) programs, and Medicare Advantage plans.[i] As of 2025, the three largest insurance parent companies in the United States are UnitedHealth Group (UHG), Elevance Health (formerly known as Anthem), and CVS Health – all of whom have been invited to be represented here today.

The intent of health insurance is to provide individuals and families with financial protection, improve access to care that may otherwise be unaffordable, and keep consumers' costs down. However, that intent is currently not being realized. More than 90 percent of Americans have health insurance, yet 42 percent report worrying about their ability to pay medical bills. In 2023, one in four insured adults reported delaying or skipping necessary care due to the cost. Additionally, 28 percent of insured adults reported a problem with their plan that directly led to a barrier in accessing care or a negative health outcome; that number is even higher when broken out across employer-sponsored (33 percent) and Marketplace plans (35 percent).[ii] Reported impacts include paying more for a treatment than expected, significant delays in receiving care or being unable to receive the recommended care at all, and a decline in their health.

These stark data points beg the question: if insurance companies aren't meeting their intent of providing financial protection and improved access to care for their enrollees, then what are they doing? Other data might suggest the answer to that is reaping as much profit as

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possible, to the detriment of clinicians, consumers, and the American health care system writ large.

UHG is the largest health care company in the country, earning $14.4 billion in profit in 2024. The company's newly appointed CEO Mr. Stephen Hemsley, one of today's invited witnesses, earns a $1 million base salary but also received a $60 million equity award in non-qualified stock options.[iii] Meanwhile, numerous investigative reports have detailed the lengths to which UnitedHealth will go to achieve cost savings through care denials.[iv,v,vi] In one example, a student with crippling but managed ulcerative colitis (thanks to his physician-recommended medications) had his infusions reviewed because of "a high dollar amount" and then ultimately denied for being "not medically necessary."[vii]

In 2024, Elevance Health made nearly $6 billion in profit. Ms. Gail Boudreaux, also invited to testify today, earned nearly $20.5 million from her role as CEO. The median salary for employees at Elevance during the same year was $55,372 – a pay ratio of 370:1.[viii] CVS Health earned a profit of more than $4.6 billion in 2024[ix] and owns Caremark, the nation's second largest pharmacy benefit manager (PBM) by market share, behind UHG's OptumRx and ahead of Cigna's Express Scripts in third place. A Federal Trade Commission (FTC) report released last year found that these three PBMs marked up certain specialty generic drugs dispensed at their affiliated pharmacies by thousands of percent, and many others by hundreds of percent.[x] These markups allowed them and their affiliated pharmacies to earn more than $7.3 billion in revenue from dispensing drugs at prices far beyond their acquisition costs.

Multi-billion dollar companies delaying and denying medically necessary care simply because of the price tag is deplorable, especially when these same parent companies play a role in inflating those prices. The Academy strongly urges the Committees to use their oversight authorities to closely scrutinize health insurance companies, which are failing to serve the best interests of their enrollees, and take actions to reign in the anti-competitive, anti-patient, and profit-driven practices discussed below.

Insurers Acquiring Primary Care Practices to Maximize Profit

The health care market has become overwhelmingly consolidated in the last decade. In addition to the insurance products and PBMs already mentioned, the parent companies represented here today have their hands in virtually every sector of health care – including owning physician practices and employing clinicians.

Corporate entities, including health plans, now own 27.2 percent of physician practices. From 2019 to 2021, there was a 43 percent increase in the number of corporate-employed physicians and an 86 percent increase in the percentage of corporate-owned physician practices.[xi] In 2021, UHG – in addition to already owning the largest health insurance plan and PBM – became the largest employer of physicians in the country through its subsidiary company, Optum.[xii]

The principal factors fueling the consolidation of primary care practices with health systems, plans, and other corporate entities are financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Physicians are often forced to choose between the stability offered by health systems, payers, or other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians

like me report that independent practice is simply unsustainable. The available evidence supports our experiences: the financial incentives driving and rewarding consolidation, including among payers, are, in many cases, directing resources away from primary care.

Providing high-quality, patient-centered primary care requires a multi-disciplinary team, technology that facilitates advanced data aggregation and population health analytics, and practice management staff to support traditional operational functions such as patient communication, scheduling, prior authorizations, and billing. All of this requires practices to make significant financial investments and commitments to remain competitive. Corporate entities, including payers, have revenue streams from multiple service lines and are better able to afford these escalating practice costs, many of which are created by burdensome requirements from the payers themselves. This creates an environment in which independent primary care practices struggle to make ends meet with the escalating administrative burdens and subsequent costs placed on primary care practices.

The motivation behind the acquisition of primary care practices is the same for both hospitals and insurers – control of cash flow. **Vertical integration can allow primary care to become a leverage point to maximize savings or profit somewhere upstream.** For payers, controlling primary care allows them to oversee and manage care across a patient's care team and settings. With these acquisitions, payers can use primary care services to meet other financial goals, redirecting revenue away from patient care. Although this allows insurers to meet their financial goals, the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. Among other issues, the survey asked about the impact on other aspects of practice, including staffing, management, clinical autonomy, access to resources such as health IT infrastructure, and administrative requirements. Overall, most physicians felt some positive impact on their ability to access resources such as health information technology, billing and patient portals, and telehealth tools. However, these benefits come at a high cost, including diminished clinical autonomy, reduced job satisfaction, and negative impacts to the patient experience. Survey responses included:

- Examples of how post-transaction administrative policies prevented them from offering necessary patient care. For example, comments described scheduling mandates that prevent physicians from providing same-day visits to acute patients and result in month-long (or more) wait times for appointments.
- Several physicians felt that while their own personal productivity metrics increased, overall access and availability to patients decreased.
- Physicians also cited frustration with restrictions on their ability to make referrals to the specialist or entity that they believed would best meet the needs of the patient.
- Other commenters noted that acquisition by a health system resulted in centralized management decisions made without local primary care physician or practice input, resulting in increased administrative burdens, reduced quality, or in some cases, both.

Our survey results align with other external reports indicating physicians experience a drop in clinical autonomy and feel patient care declines post-acquisition. A 2023 survey conducted by NORC found that more than half of employed physicians experienced reductions in the

quality of patient care as a result of a practice acquisition.[xiii] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance.

Acquiring physicians also enables vertically integrated plans to bypass or soften Medical Loss Ratio (MLR) requirements that cap profit. UHG's vertical integration of UnitedHealthcare (UHC) with Optum enables UHG to collect both insurance profits and any profits earned by employed physician groups. Put simply, if UHC pays its owned Optum provider groups more than other contracted providers for the same services and diagnosis codes, UHG would see increased profit. In fact, a recent analysis found that UHC pays Optum providers 17 percent more than non-aligned competitors.[xiv] The same analysis found that in markets where UHC has a higher market share, the payments to Optum physicians are 61 percent higher. This approach games the MLR system by allowing UHC to direct profit beyond the MLR requirements to its parent, UHG, and creates disadvantages to non-Optum physicians by paying its own providers more. This further fuels consolidation as financial concerns are a primary driver of physicians leaving independent practice, as discussed above.

As the physician landscape shifts more toward employment, noncompete agreements in health care can also disrupt patient access to physicians, deter advocacy for patient safety, limit physicians' ability to choose their employer, stifle competition, and contribute to an increasingly concentrated healthcare market. Despite projected physician shortages, health care employers enforce noncompete agreements that intentionally restrict physician mobility and workforce participation. A survey of some AAFP members found that:

- 75 percent report that noncompete clauses have impacted their practice, career, or personal life;
- 46 percent said noncompete clauses limit their job options or mobility; and
- 32 percent said that noncompete clauses make them feel trapped in their current job.

Many family physicians have reported that geographic restrictions in noncompete clauses combined with the highly consolidated nature of most markets force them to choose to uproot their family, commute more than two hours away, or stop practicing entirely should they resign from their position. Noncompete clauses not only reduce competition – they also harm patients by reducing or, in some cases, eliminating access to care.

The AAFP believes restrictive covenants in physician employment contracts disrupt the patient-physician relationship. No physician employment contract should include restrictions which interfere with the continuity of the patient-physician relationship or patient access to care. Congress should pass legislation that prohibits anticompetitive noncompete clauses in physician employment contracts.

Anti-Competitive "Downcoding" Practices Undermining Physician Practice Viability

Insurers have been increasingly engaging in a practice known as "downcoding," which is quietly undermining the financial viability of primary care practices, to the detriment of patients who rely on these physicians for their care. Downcoding occurs when health plans, assign a lower-level evaluation and management (E/M) code than the one that was actually provided by the physician and billed on the claim - without consulting the physician who provided the patient care. This results in a lower payment that physicians are forced to either

accept or pursue costly, time-consuming appeals, which takes additional time and resources away from patient care.

The most recent example of a downcoding program to be implemented was launched by Cigna on October 1. Their new "E/M Coding Accuracy" policy (R49) downcodes visits reported with 99204-99205, 99214-99215, and 99244-99245. Cigna states that downcoding occurs when the insurer believes the primary diagnosis and other claim-based criteria do not indicate that level of E/M reported on the claims.[xv] Two example diagnoses Cigna gives are "earache" and "sore throat."

The AAFP is concerned that automatic downcoding policies fail to reflect the continuity and complexity of care family physicians provide, which often includes managing multiple chronic conditions, coordinating with specialists, addressing behavioral health needs and considering social drivers of health, all within a single visit. These activities are not a function of the diagnosis alone but are representative of the comprehensiveness and complexity of family medicine. This is consistent with Current Procedural Technology (CPT) guidance that clearly states, "The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."[xvi] Taken together, these policies illustrate how downcoding practices can undervalue the comprehensive and relationship-based care that family physicians provide.

The concerns are further compounded by the practical challenges physicians face when attempting to identify and respond to downcoding activity. Downcoding is often only discovered by practices when they notice underpayments for services rendered. In letters to specific payers and AHIP, the AAFP has expressed its concern about this and other aspects of the downcoding programs. We have requested greater transparency regarding the methodologies for identifying targeted individuals and offered our assistance in educating family physicians regarding accurate coding criteria – something that the AAFP regularly offers to all of its members. The Academy strongly supports accuracy in coding and billing practices, and believes that both physicians and health plans should abide by the principles of CPT, especially in a fee-for-service payment system. For physicians, this means selecting the code that most accurately identifies the service performed and documented. For health plans, it means payment for covered services should be based on the codes documented and billed by the physician.

To date, AAFP and its members have not been able to secure any guidelines, standards, or rules from payers with which physicians could educate themselves to improve their billing and documentation in order to avoid having their claims downcoded. Rather, these programs appear to be using algorithms that lack transparency and are applied without full clinical context. **If these programs are designed to ensure accurate billing and prevent fraud, waste, and abuse then these policies should be transparent, fair, and uniformly applied regardless of practice ownership.**

The AAFP sent a letter in November to the FTC, Department of Justice, and Centers for Medicare and Medicaid Services (CMS) urging them to investigate whether these likely anti-competitive practices. We similarly urge the Committees to provide oversight over this

growing practice and pass legislation that, at a minimum, requires clear transparency into the processes and criteria insurers are using and prohibiting the use of automatic algorithms.

In addition to examining the insurance companies using downcoding programs, we strongly urge Congress to investigate the third-party companies that seem to be behind this trend. Why have nearly all insurers suddenly prioritized this particular tactic? What if this isn't an independent, organic effort to improve payment integrity but rather a coordinated revenue strategy driven by a single company in partnership with dozens of payers?

Cotiviti is the data and analytics engine behind many of these so-called "payment integrity" and "downcoding" programs. The self-described mission is as follows: "Cotiviti helps ensure pre- and post-pay claim accuracy by efficiently correcting inappropriate claim coding while validating other suspect claims against medical records, contract terms, and other data."[xvii] The company proudly reports that it "reduced inappropriate spend by more than $9.5 billion in 2024." Here is what their work produces, according to Cotiviti's own materials:

- Identify millions of dollars in prepay "savings"
- Reduce costs from clinically complex claims
- Detect and correct "billing compliance" issues
- Save an estimated 3–4 percent on inpatient spend

And who are Cotiviti's clients? The company is transparent about this as well: "A trusted partner with 23 of the top 25 national payers, and more than 100 unique payer clients in total."[xviii]

Let's be clear: this isn't solely about coding integrity. It's about profit maximization, achieved through opaque algorithms, not transparent processes. There's no defined methodology, no meaningful appeals process, and no regulatory oversight. Everything depends on Cotiviti's proprietary systems, which the company says have been "honed over 20+ years to drive exceptional value for clients."

So why this shift and why now? In recent years, there has been a great deal of scrutiny rightly focused on claims denials, utilization management, and prior authorization. These processes are frustrating and time-consuming for both patients and physicians – and costly for insurers as well. Yet, overturn rates remain high: about 70 percent of denied claims are ultimately overturned and paid.[xix] Appeals drain insurers' resources, and every overturned decision cuts into their revenue.

Enter downcoding: a clever workaround. Instead of denying a claim outright (which can spark an appeal and potential reversal), insurers simply pay it at a lower rate. The decision often comes from a black-box algorithm, with little to no physician input and, importantly, no formal appeals pathway for physicians. In short, this new tactic avoids regulatory scrutiny while preserving some of the financial gains of denial.

Underpayments to Physicians by Medicare Advantage Organizations

Downcoding is just one of the ways that insurers are underpaying physicians. Another way they undermine the financial stability of physician practices is through continuously delaying payments within their Medicare Advantage (MA) lines of business. Each of the parent companies invited to be represented at today's hearings is currently or has previously been a

Medicare Advantage organization (MAO), meaning they contract with CMS to administer Part C plans to eligible individuals.

There are currently no statutory or regulatory requirements dictating the type of payment arrangements MA organizations must have with contracted physicians. While this has the potential to encourage payment model flexibility and innovation, such as capitated payments for primary care, we hear more often from family physicians that they are struggling to get on-time payments from MA plans. As discussed further below, MA organizations use aggressive prior authorization and other utilization management processes that lead both to delayed care for patients and delayed payments for physicians.

One way that Congress can help to address this issue is by implementing prompt payment requirements for MA plans to in-network physicians and other clinicians. We applaud Representatives Doggett and Murphy for their leadership in introducing the bipartisan *Prompt and Fair Pay Act* (H.R. 4559) that would do just this. Specifically, the bill stipulates that MAOs must pay clean claims received within 14 days (if submitted electronically) or 30 days (all other claims). If the MAO does not pay the claim within the defined timeframe, they are also required to pay interest on the claim. Additionally, it provides HHS with enforcement authority and establishes a payment floor of traditional Medicare for MA plan payments to physicians. We support this legislation and encourage its swift passage.

A related issue that we frequently hear from family physicians is that MAOs require them to waive their right to interest on delayed claim payments as part of their contracts. We also encourage Congress to prohibit this unfair practice as it considers opportunities to reform the MA program.

Increased Primary Care Spending Across Payers Can Reduce Health Care Costs

We know that prioritizing primary care not only improves patient health outcomes, but it saves money. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine to call it a "common good."[xx] However, despite the decades of evidence showing that primary care improves population health and saves money, our national investment in it continues to lag.

Although actual amounts vary by payer and across states, research has consistently found unsustainably low levels of primary care investment when using a commonly agreed upon definition of primary care spend. Across all payers, primary care spending has decreased or remained stagnant at low levels over the last decade. In 2021, all payers spent an average of 4.7 or less than five cents of every dollar on primary care. Commercial payers averaged 5.6 percent, while Medicaid and Medicare remained shortly behind at 4.7 and 3.9 percent respectively.[xxi] This pervasive underinvestment in primary care – which evidence frequently shows is high-value and low-cost – is one of the reasons that health care costs continue to skyrocket while health outcomes are not matching the high level of dollars spent.

When we look at health outcomes across the world, we're not doing well by almost any measure. Compared to other high-income, peer nations, the U.S. has higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[xxii] A common theme across countries with better health outcomes and lower

health care costs is that they invest more in their primary care system with estimates placing primary care spending between 12 and 17 percent of total health care spending for these high-performing nations.[xxiii]

Our nation cannot afford to keep these spending trends up. Improving health outcomes and preventing a further explosion of chronic illness requires us to reallocate our existing resources away from expensive sick care and toward prevention, ensuring that patients are incentivized and can afford to seek appropriate care earlier on. As a starting point, the Academy has long advocated for all payers to be required to track and publicly disclose the amount they spend on primary care services. **Specifically, we're calling for consideration of legislation that would require commercial payers and federal health programs to track and annually report data on their primary care spending so we have a clearer picture of the current landscape.**

Many states already have such requirements in place for payers, with others going further to require that payers hit a certain target for primary care spending. For example, Oklahoma requires Medicaid managed care organizations to report their expenses related to primary care services and, by the fourth contract year, devote at least 11 percent to primary care.[xxiv] Meanwhile, Arkansas enacted legislation last year to establish the Arkansas Primary Care Payment Improvement Working Group, charged with producing a report that provides a recommendation for a primary care spending target.[xxv] The Academy strongly encourages federal policymakers to consider such steps that would right-size our nation's primary care investments.

Utilization Management as a Means to Delay Care and Increase Administrative Burden

Interactions with health plans consistently rank high on the list of sources for family physician burden, leading to alarming rates of moral injury, burnout, and mental health challenges. Insurer administrative burden has become such an acute issue that there are legislative efforts recognizing the role it plays in mental health issues for clinicians. The *Dr. Lorna Breen Health Care Provider Protection Reauthorization Act* (H.R. 929 / S. 266), a bill supported by AAFP and numerous other clinician organizations, reauthorizes the only federal program to prevent suicide, occupational burnout, and support for mental health conditions for health care professionals. This bill has been updated to include a provision that highlights the deleterious effects that administrative burden can place on clinicians' mental health and further illustrates the seriousness of this problem.

Utilization management tactics implemented by plans are one of the primary causes of this administrative burden. Specifically, many plans require authorization (prior authorization, or PA) before they will cover a certain service or item for a beneficiary. Prior authorization is described by payers as a cost-containment mechanism, but many patients and physicians alike report that it largely serves to delay and deny appropriate, medically necessary care. One study from the Department of Health and Human Services Office of the Inspector General (HHS OIG) found that Medicare Advantage organizations (MAOs) overturned 75 percent of their own prior authorization and payment denials upon appeal.[xxvi] Another study found that, of denied prior authorization requests, 13 percent met Medicare coverage rules and 18 percent of payment denials met Medicare coverage and billing rules.[xxvii] A July 2023 OIG report found that Medicaid Managed Care Organizations (MCOs) denied one out of every eight (12.5 percent) prior authorization requests in 2019 – a rate even higher than in

Medicare Advantage (5.7 percent). Approximately 2.7 million Medicaid beneficiaries were enrolled in MCOs with prior authorization denial rates greater than 25 percent.[xxviii]

We appreciate recent commitments by insurers to streamline, simplify, and reduce PA, but these efforts are voluntary and subject to no enforcement by anyone other than the plans themselves.[xxix] We believe further action is necessary to meaningfully reform PA across all plans.

In 2024, CMS issued final rules streamlining prior authorization processes across federal payers, including Medicaid and MA. However, Congressional action is still needed to enshrine these much-needed reforms into statute. In May, a bipartisan, bicameral group of lawmakers reintroduced the *Improving Seniors' Timely Access to Care* Act (H.R. 3514 / S. 1816), which would codify these changes to standardize prior authorization processes within MA plans. Specifically, it would require a standard electronic prior authorization process for MA prior authorization requirements and expand beneficiary protections to improve enrollee experiences and outcomes. It would also improve transparency across MA plans and address inappropriate coverage denials. A previous version of this legislation passed the House in the 117th Congress but stalled in the Senate due to a high projected score from the Congressional Budget Office. The bill's sponsors crafted thoughtful changes to the bill in the 118th Congress to ensure the score will be low, if not zero. To meaningfully protect patients and ease burden on the physicians who care for them, **the AAFP urges Congress swiftly enact the *Improving Seniors' Timely Access to Care Act.*** We also strongly urge that these codified requirements be expanded to other health plans, including Medicaid.

Currently, minimal data collection and oversight of prior authorization denials and appeals is being done by state Medicaid agencies. This is largely because federal rules do not require states to collect and monitor data needed to assess access to care, monitor the clinical appropriateness of denials, or require that states publicly report information on plan denials and appeals outcomes. In March 2024, MACPAC convened to discuss denials and appeals within Medicaid managed care. They identified some of the challenges and barriers impeding the ability for individuals to pursue denials and appeals in Medicaid; for example, MCOs are required to mail denial notices, but beneficiaries do not always receive these denial notices in time to pursue an appeal within the allotted time frames.

In light of these findings, MACPAC put forward seven recommendations to improve the appeals and denials process for individuals enrolled in Medicaid. These suggestions included requiring states to establish an independent, external medical review process that can be accessed at the beneficiary's choice and providing beneficiaries with the option to receive electronic denial notices in addition to mailed notices. It also recommended requiring states to collect and report data on denials, use of continuation of benefits, and appeals outcomes, and use the data to improve delivery of care to patients. **The AAFP strongly urges Congress to act upon these MACPAC recommendations to improve the denials and appeals processes for Medicaid beneficiaries** and ensure patients have timely access to medically necessary care as recommended by their physician.

In addition to supporting legislative efforts that aim to streamline the prior authorization process, the AAFP also supports the *Reducing Medically Unnecessary Delays in Care Act*,

(H.R. 2433), which would ensure that prior authorization decisions across health plans are made by licensed, board-certified physicians who use scientific and evidence-based research to make their decisions. It would also require plans to create policies based on medical necessity and written clinical criteria. Through these reforms, clinicians and patients can be assured that prior authorization decisions are made by those with the necessary clinical training and subject matter expertise. This will reduce the incidence of illegitimate prior authorization denials and the need for numerous appeals, therefore reducing the administrative burden for physicians and ensuring that patients are receiving the care they need as soon as possible. We encourage the Committees to consider this proposal as they work on additional accountability measures for insurers.

Further, the Academy has growing concerns about the use of artificial intelligence (AI) to process prior authorization requests. According to a recent survey conducted by the American Medical Association, 61 percent of physician respondents expressed concerns with the expanded use of AI by MA plans for prior authorization. [xxx] Although MA plans claim that the use of AI in this context is intended to expedite the processing of claims, there is evidence to suggest that plans are actually utilizing AI to unduly increase denial of prior authorization requests.[xxxi]

We appreciate that some lawmakers have begun to examine these practices. An October 2024 report released by the Senate Homeland Security Permanent Subcommittee on Investigations found that, after implementing the use of AI to process requests, UHG's PA denial rate increased by over 12% in just two years.[xxxii] The report provided recommendations to CMS to mandate increased transparency by MA plans in their utilization of AI for prior authorization. However, CMS has not formally implemented that recommendation. The AAFP encourages your Committees to continue this examination and build upon this work.

Another common utilization management protocol used by plans is step therapy, whereby patients are required to try one or more insurer-preferred medications or treatments prior to implementing a physician recommendation. Plans claim that step therapy is used to bring down the cost of care for the treatment of numerous conditions. However, the AAFP is concerned that health plans may be prioritizing their financial interests when developing step therapy protocols, which instead delay patients' access to treatments and can result in severe side effects and disease progression for patients. This practice can take weeks or months and can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment.

Research has demonstrated that step therapy requirements prevent patients from adhering to effective medication regimens, which can lead to worse health outcomes.[xxxiii] In addition to its impact on patients' timely access to necessary medication, step therapy places significant administrative burden on physicians, who must navigate different and inconsistently applied protocols and requirements across health plans.

The AAFP believes that step therapy should not be mandatory for patients already on a working course of treatment and that generic medications should not require prior authorization. **We have endorsed the *Safe Step Act* (H.R. 5509), which would reform the inconsistent and opaque use of step therapy practices by insurers.** Specifically, it

would implement transparency guidelines to prevent inappropriate use of step therapy in employer-sponsored health plans and create a clear process for patients and physicians to seek reasonable exceptions to step therapy. We encourage the Committees to work with your colleagues in Congress to advance these necessary reforms.

MA Coding Intensity and Fragmentation of the Patient-Physician Relationship

At the same time that insurance companies are implementing policies to deliberately underpay physicians, many reputable sources have reported that MA plans are receiving substantial overpayments in federal taxpayer dollars through the MA program. Payments from CMS to MA plans are partially determined by a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MAOs are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources.

The AAFP recognizes that risk adjustments are important for ensuring payments to MAOs accurately reflect patient complexity and support access to coverage and care for patients. However, the MA program lacks corresponding incentives to improve the health of its enrolled members, and a growing body of evidence suggests that some MAOs may be overly focused on recording health conditions. As the health status of the MAOs member population worsens, risk scores increase and the MAOs monthly payments increase. This happens regardless of the level of care provided to those plan enrollees.

There is mounting evidence that the expected level of care required for the health status of the plan's enrollees is not being delivered by some MAOs. For example, plans have reported diagnosis codes that are not fully supported by patients' medical records, an indication that patients aren't receiving related or indicated care.[xxxiv] A report released by the Senate Judiciary Committee and Chairman Grassley last week summarized UHG's approach to risk adjustment as a "major profit centered strategy, which was not the original intent of the program."[xxxv] It found that UHG uses "aggressive strategies to maximize [...] risk adjustment scores" and "appears to be able to leverage its size, degree of vertical integration, and data analytic capabilities to stay ahead of CMS's efforts to counteract unnecessary spending related to coding intensity."

An October 2024 HHS OIG report found that diagnoses reported only in enrollees' health risk assessments (HRA) and HRA-linked chart reviews led to an estimated $7.5 billion in MA risk-adjusted payments in 2023. Of that amount, in-home HRAs and HRA-linked chart reviews accounted for nearly two-thirds of the payments. To be clear, in-home HRAs are separate and distinct from home-based primary care (HBPC) delivered by a patient's usual source of care. Many family physicians provide comprehensive, continuous HBPC for often medically complex patients. These visits are both medically necessary and patient-centered, and Congress must ensure that reforms taken to address misaligned incentives in the MA program do not unintentionally impede the delivery of high-value HBPC.

All of these findings raise significant concerns about the validity of diagnoses obtained via in-home HRAs and HRA-linked chart reviews, as well as the ways in which MA plans are fragmenting existing patient-physician relationships. Family physicians frequently report that they had no knowledge of the in-home HRA being conducted or of the diagnoses identified during the HRA. They often only learn of it when their patient mentions a nurse or other

clinician coming to their residence at a later service visit. These experiences are verified by the OIG report finding that most in-home HRAs are conducted by third-party vendors that MAOs partnered with rather than the enrollees' own primary care providers, which may create gaps in care coordination. MedPAC has also questioned the accuracy of diagnoses only obtained through in-home HRAs, noting that diagnoses are often based on enrollee self-reporting or may require verification by diagnostic equipment not present during the visit.[xxxvi]

The OIG report further found that MAOs relied mainly on in-home HRAs to collect certain diagnoses associated with some of the top thirteen health conditions by volume. For example, MAOs used in-home HRAs to diagnose secondary hyperaldosteronism for 74 percent of all enrollees with this diagnosis obtained via an HRA or HRA-linked chart review. Meanwhile, only 3 percent of enrollees received this diagnosis during a facility-based HRA. **For thousands of MA enrollees, the in-home HRA was their only encounter recorded in 2022.** Specifically, the report found that 77 MA organizations generated $60.6 million in payments for 14,103 enrollees who did not have any recorded encounter of receiving tests, supplies, or services other than an in-home HRA. This is particularly concerning as it suggests that MA plans may be adding diagnoses to a patient's chart and maximizing risk-adjusted payments without actually connecting the patient to services and improving their care – *or*, that the diagnoses are inaccurate and thus follow-up services are not required for the patient. Neither of these strategies benefit patients or are a wise use of taxpayer dollars.

The AAFP believes the accuracy of data used for risk adjustment purposes is paramount and that the physicians and other clinicians who serve as the patient's usual source of continuous primary care are best positioned to provide these data. **Third-party assessments or encounters designed solely to identify patient risk factors do not serve the best interest of the patient as they focus on identifying illness over treating it and are potentially disruptive to established patient-physician relationships.** We have encouraged CMS to consider additional guardrails to prevent the use of such third-party assessments and, in the absence of regulatory action, we urge the Committees to consider legislation that would implement such guardrails.

MedPAC projected the federal government would overpay MA plans by $88 billion in 2024. The AAFP is strongly supportive of comprehensive and accurate documentation of all patient's diagnoses and advises members that all coding should comply with the ICD-10-CM coding guidelines. If reports of overpayment are accurate, the AAFP is concerned that significant funding that could support broader, more widely available access to high-quality primary care is being diverted with no benefit to MA enrollees. Some proponents of the MA program argue that the quality of care and patient outcomes are better, but evidence has not consistently supported that. A comprehensive literature review by the Kaiser Family Foundation compared MA and traditional Medicare based on measures of beneficiary experience, affordability, service utilization, and quality. It found "few differences [...] that are supported by strong evidence or have been replicated across multiple studies."[xxxvii]

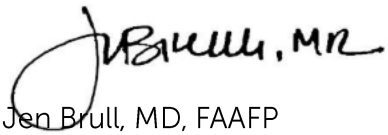
Therefore, the Committees should consider advancing policies to address incentives that create unintended consequences and ensure that payments to MA organizations are being used to connect MA enrollees to high-value services, including comprehensive, continuous

primary care that can help to reduce health care expenditures in the long run. At a minimum, MA plans must be required to coordinate with and disclose any in-home HRAs to a patient's PCP.

In implementing any of the above recommendations or related reforms, Congress should also take actions to prevent MA organizations from failing to invest in and support the provision of high-quality primary care. Specifically, we recommend additional guardrails that will ensure MA organizations do not pass potential revenue reductions onto the physician practices they contract with. Primary care practices continue to struggle with inadequate physician payment rates, staffing shortages, and overwhelming administrative burden. Additional payment cuts, costly system updates, and other downstream effects of these changes could further destabilize the primary care practices Medicare beneficiaries depend on.

Thank you for convening today's hearings and holding health insurance companies accountable for better serving consumers. The AAFP appreciates your attention to these deeply concerning practices and looks forward to partnering with you to implement the proposed reforms to reign in health care costs and prioritize patients and their health outcomes. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,



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American Academy of Family Physicians, Board Chair

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Health Subcommittee

of the

United States House of Representatives

"Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

January 22, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — the American Hospital Association (AHA) appreciates the opportunity to share the hospital field's perspective on how to make health care more affordable for Americans with commercial insurance coverage.

America's hospitals and health systems take deep pride in the role we serve in this country, providing constant, round-the-clock care and we remain unwavering in our commitment to delivering safe and quality care to every patient, in every community. The blue and white "H" symbol is a beacon of healing, hope and health in every community nationwide.

We share the committee's concerns regarding the cost of health care and coverage, and we appreciate your focus on the role insurers play in high and rising costs for American families, taxpayers and employers. For years, the AHA has highlighted how, even when patients have insurance, their access to care is being delayed, disrupted

and denied. Simply put, actions by many commercial insurers erect barriers that make it more difficult for patients to receive timely access to needed medical care.

The following statement highlights what hospitals, clinicians, and patients are experiencing on the ground — and why commercial insurer practices are playing a growing role in driving up costs, creating delays and undermining affordability.

CURRENT LANDSCAPE

To understand what is happening to health care affordability, it is first necessary to understand how dramatically the health insurance market has changed. Today, the seven largest commercial insurers account for over 190 million covered lives — roughly two-thirds of the entire insured population — across various forms of coverage, including Medicare Advantage (MA), employer-sponsored care, Medicaid managed care, and health insurance marketplace plans. Although their stated role is to help patients access care, in reality, they are often described as a frustrating middleman, creating needless obstacles and barriers that delay or prevent patients from seeking the health care they need and deserve.

Horizontal and Vertical Consolidation in the Insurance Market Increases their Bottom Line While Driving up Health Care Costs

Commercial insurance today is a highly concentrated marketplace with a small handful of insurers representing one of the most consolidated sectors of the U.S. economy.

While commercial insurers often deflect scrutiny of their own consolidation practices by pointing the blame at others, including the over 5,000 hospitals that serve a wide range of communities and markets, the data clearly indicates that most regions of the country are dominated by one or two insurers holding outsized market shares. According to the American Medical Association's recent report on health insurance competition, in 91% of metropolitan statistical area (MSAs) markets, at least one insurer had a commercial market share of 30% or greater, while in 47% of MSAs, one health insurer held a market share of at least 50%.[1]

This level of concentration has consequences. Fewer competitors mean fewer choices, narrower networks, higher premiums, and growing leverage to impose policies that shift costs and administrative burdens to patients and providers.

At the same time, commercial insurers have vertically integrated at an unprecedented pace. A recent report from the Senate Judiciary Committee found that UnitedHealth Group — which now employs or manages over 90,000 doctors, representing 10% of all doctors in the country[2] — acquires primary care practices to pressure these clinicians to

[1] https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf
[2] UnitedHealth has 90,000 doctors — 10% of all physicians in U.S.

apply more diagnostic codes to make their patients seem sicker than they actually are to receive higher payments.[3] This unnecessarily drives up health care costs.

Despite their public criticism of hospitals for employing physicians, over the past five years, commercial insurers have acquired roughly 40% more physicians than hospitals — typically through large, multi-practice purchases.[4] Commercial insurers disproportionately target high-margin specialties in densely populated areas. In contrast, when hospitals acquire physician practices, they overwhelmingly take on lower-margin, community-based specialties like family medicine, pediatrics and primary care, often in rural or underserved areas. Many of these practices are financially vulnerable and are facing closure, in part due to the costs of having to comply with burdensome requirements from insurers. These acquisitions are fundamentally about preserving access to care for patients and communities — not about maximizing profits.

In addition, commercial insurers also control a significant share of the pharmacy, pharmacy benefit manager (PBM), and payment vendor markets. These affiliated assets have enabled commercial insurers to enrich themselves at the expense of patients by steering care to owned or affiliated providers and paying their own providers more. A July 2024 Federal Trade Commission interim report found that PBMs owned by large health insurance companies paid their affiliated pharmacies up to 40 times more than they paid competitor pharmacies for the same generic cancer drug, with plans steering patients toward such pharmacies.[5]

Through their business practices, commercial insurers have accrued substantial financial resources while adding significant costs to the health care system. Collectively, just seven of the largest insurers amassed an astounding $34.1 billion in net profit in 2024.[6] And those profits have grown at an extraordinary rate over time. Notably, from 2000 to 2024, UnitedHealth Group's annual revenue increased by 1,795% (+$379 billion), while its net profit increased by 1,857% (+$14 billion).[7]

Fortunately, not all insurers behave the same way. Smaller, community-based regional plans often work closely with providers to deliver coordinated, high-quality coverage. Many operate within integrated delivery systems where insurers and clinicians design coverage rules together to support timely, well-coordinated care. As Congress examines ways to improve affordability, these plans offer a clear model for achieving high-quality coverage without the costly, problematic practices seen among larger insurers.

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[3] UHG Report - Final

[4] https://www.aha.org/news/blog/2025-10-21-physician-practice-acquisitions-what-drives-them-and-implications-consumers-and-payers

[5] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[6] AHA analysis of Generally Accepted Accounting Principles (GAAP) net profit as reported on the quarterly 2024 SEC filings of: Centene, CVS, Cigna, Elevance, Humana, Molina, United.

[7] 2000 financial data from the UnitedHealth Group's Annual Report to Shareholders for the year ended December 31, 2000 (SEC Exhibit 13). 2024 financial data from the UnitedHealth Group 2024 Form 10-K.

INSURERS' PRACTICES LEAD TO INCREASED HEALTH CARE SPENDING AND CARE DELAYS

Prior Authorization and Coverage Denials

The improper application of prior authorization is one of the greatest pain points in the U.S. health care system for patients and providers. Hospitals and health systems have long raised concerns about the excessive use of prior authorization and coverage denials by certain insurers. Unfortunately, it seems like there are stories every day that demonstrate the dire situation some patients and their families face due to an insurer's refusal to cover their care.[8, 9, 10, 11, 12, 13, 14]

Additionally, the prior authorization submission methods required by insurers are outdated. Commercial insurers vary in how they require providers to submit prior authorizations, with providers often required to use antiquated technologies like fax machines for submitting medical information to plans. Recognizing this issue, the Centers for Medicare & Medicaid Services (CMS) released a rule requiring MA and other federally-administered plans to use a standardized electronic process for prior authorization. CMS estimates that simplifying the prior authorization process would save the health care system $16 billion.[15] However, that provision of the rule does not go into effect until 2027, and hospitals have not seen much, if any, relief from the voluntary commitments insurance plans made to improve their prior authorization processes in the spring of 2025.[16]

Altogether, prior authorization costs the U.S. health care system approximately $35 billion annually.[17] Unfortunately, the volume of prior authorizations continues to increase, amplifying provider administrative burden. MA plans issued nearly 50 million prior authorizations in 2023 — up more than 40% since 2020,[18] substantially increasing the cost of caring for patients.

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[8] CBS News piece
[9] They Couldn't Access Mental Health Care When They Needed It. Now They're Suing Their Insurer.
[10] After Series of Denials, His Insurer Approved Doctor-Recommended Cancer Care. It Was Too Late
[11] A man's fight for coverage of spinal surgery to treat debilitating pain
[12] This toddler's medical expenses can hit $3,000 a month. Her family says nearly every insurance claim is a battle
[13] Health Insurers Are Denying More Drug Claims, Data Shows
[14] UnitedHealth said it was too dangerous for him to be discharged. Days later, it denied his care
[15] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[16] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[17] https://www.nytimes.com/2024/03/14/opinion/health-insurance-prior-authorization.html?unlocked_article_code=1.ck0.Acc2.IM7ltCbFp3AE&smid=nytcore-ios-share&referringSource=articleShare&sgrp=c-cb
[18] https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

MA plans — which now cover more than half of all seniors — are supposed to provide coverage for any care that a similar enrollee in Traditional Medicare would receive. However, providers and patients routinely report coverage denials for care that beneficiaries are entitled to, indicating that plans frequently apply more restrictive coverage rules than CMS.

Many of the harms associated with inappropriate coverage denials are highlighted in a striking report by the Department of Health and Human Services Office of Inspector General. MA plans are denying medically necessary, covered services that meet Medicare criteria at an alarming rate. The report found that 13% of prior authorization denials and 18% of payment denials were inappropriate because they met Medicare coverage rules.[19] The report highlights over 50 examples of such cases, including a 78-year-old patient diagnosed with pancreatic cancer who was inappropriately denied radiation treatment. In a program the size of MA with over 32 million enrollees, improper denials at this rate are simply unacceptable.

Negative Impacts on Patient Care

Insurer policies that delay or deny patient care can result in patients who are ultimately sicker and costlier to treat when they finally do receive care. According to a 2024 survey by the American Medical Association, 82% of physicians reported that their patients have abandoned treatment due to plan prior authorization requirements, while 29% reported that prior authorization delays have led to a serious adverse event.[20]

One area where avoidable medical costs are most evident is in post-acute care transfers. Many patients require a transfer to a skilled nursing facility, inpatient rehabilitation facility or long-term acute care hospital as part of their recovery process. However, health plans frequently require prior authorization for these post-acute care transfers. Patients often have to wait days or even weeks for their requests to be processed and approved, which slows down their recovery process and increases costs due to longer hospital stays.

Payment Delays for Approved Care

Hospitals and health systems report significant challenges simply getting paid for the care they provide, even when it has already been authorized by the insurer. An AHA member survey found that 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old. Among the 772 hospitals surveyed, these delays amounted to more than $6.4 billion in delayed or unpaid claims that are more than six months old.[21]

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[19] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[20] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[21] https://www.aha.org/infographics/2022-11-01-survey-commercial-health-insurance-practices-delay-care-increase-costs-infographic

Administrative costs required to get paid for care add significant expense to the health care system. In fact, a recent Council for Affordable Quality Healthcare (CAQH) report found that administrative tasks cost the U.S. health care system about $83 billion annually, with providers absorbing more than 97% of those costs.[22] Combatting inappropriate payment delays and denials also consumes substantial resources, including complying with insurer requests for additional documentation, physician peer-to-peer consultations, and onerous appeal processes. One recent study found that providers spend nearly $18 billion fighting insurers on claims denials that are ultimately overturned and paid.[23] These administrative hurdles divert critical time and resources away from patient care.

Use of Third-Party Vendors

Many of these burdens are amplified by health insurers using third-party vendors (several of which are owned by the same conglomerate parent as the insurer) to process prior authorization and claims transactions. These entities are frequently incentivized with payment models that reward them for the more care they deny, regardless of whether those denials are appropriate or aligned with sound medical science. Additionally, these vendors often use different review criteria and require alternate communication methods than the insurers that they serve, which piles additional unnecessary administrative costs on providers attempting to navigate this morass.

These administrative burdens and delays in care have a direct impact on the affordability of care for patients. Each hurdle requires staff time and resources, costs that ultimately are reflected in the price of patient care.

Increased Burnout Due to Administrative Burdens

Hospitals and health systems are very concerned that insurers are increasing health care costs at the expense of patients and the health care workforce.

The administrative practices insurers rely on have very real consequences for providers. It is not unusual to hear from doctors and nurses about how they spend hours of their day away from the bedside while sitting on the phone urging a patient's insurance company to cover essential medical care. It is no surprise that administrative burden is one of the top contributors to clinician burnout.[24] Nearly 90% of physicians report that

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[22] https://www.caqh.org/blog/new-caqh-report-reveals-significant-differences-in-administrative-costs#:~:text=CAQH%20published%20a%20new%20report,97%20percent%20of%20these%20costs.
[23] https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense
[24] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

prior authorization somewhat or significantly increases physician burnout, which adds to the workforce shortages facing hospitals across the country.[25]

Benefit Design Implications

One of the most common approaches used by payers to reduce premiums is to shift more of the cost of coverage into higher co-pays, deductibles and co-insurance (what is often referred to as "benefit design"). While insurers determine how much patients must pay in cost-sharing, the burden of billing patients falls to providers, and, in many instances, patients simply cannot afford their cost-sharing requirements. To the extent possible, providers absorb these losses through financial assistance policies, but hospitals and health systems do not have sufficient resources to close the gaps created by insurers, which means that some patients end up with medical debt. Hospitals and health systems are committed to helping patients afford their care, and many hospitals report that more than half of all charity care and financial assistance goes to insured patients. However, this financial assistance only goes so far, and it is not free to the health care system.

SPENDING ON HOSPITAL CARE

Commercial insurers often blame rising premiums on hospital costs, but the latest National Health Expenditures data from CMS show that hospitals' share of national health spending has remained stable at just under one-third for decades. The data also confirm that recent spending growth is driven mainly by increased use and intensity of services, not higher prices.[26]

Spending on hospital services reflects advances in diagnostics, therapeutics and other inputs, as well as changes in how care is delivered. Hospital care today looks very different than it did 25 years ago: innovations now allow many patients to survive — and recover from — conditions that once would have been fatal.

Hospitals also care for the highest-acuity patients and provide the most complex services, particularly as lower-acuity care has moved safely to outpatient settings. This care requires costly drugs and devices, highly trained staff, a continuously evolving administrative infrastructure, and 24/7 standby capacity for the most critical needs.

RECOMMENDED SOLUTIONS

To improve affordability of health care for patients, employers and taxpayers, Congress should curb insurer practices that drive unnecessary administrative spending and restrict access to medically necessary care.

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[25] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[26] https://www.healthaffairs.org/content/forefront/growth-national-health-expenditures-s-not-prices-stupid

We urge Congress to take the following steps to relieve the burden imposed by insurers:

Prior Authorization Reform: We urge Congress to pass the **Improving Seniors' Timely Access to Care Act (H.R.3514/S.1816)**. This bill would streamline prior authorization requirements under MA plans by making them simpler and more uniform and eliminating the wide variation in prior authorization methods that frustrate both patients and providers. It also would require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials.

Create Prompt Payment Standards: Congress should establish a uniform federal prompt pay requirement. The AHA urges Congress to pass the **Medicare Advantage Prompt Pay Act (H.R.5454/S.2879)**, which would apply a federal prompt payment standard to MA plans to help ensure that providers receive timely payments for medically-necessary care that has been approved.

Require Transparency in Plan Denial Signatures: Existing MA regulations require health plan clinicians who review and sign-off on adverse medical necessity determinations to have relevant medical expertise in the field of the service being requested. However, there is limited transparency because most reviewers do not sign denial letters. To ensure accountability, the AHA urges Congress to require a medical reviewer's identity and credentials be included as part of an adverse determination or denial notice that would be sent to the patient or provider.

Enhance and Increase Network Adequacy Standards: To minimize barriers, particularly for patients in rural and underserved communities, as well as those in need of behavioral health or post-acute care services, Congress should ensure that health insurers provide robust access to care by implementing or enhancing network adequacy standards or appropriate alternatives based on evidence of prompt access to care.

Protect Timely Access to Post-Acute Care: We urge Congress to protect patient access to medically-necessary post-acute care by mandating that insurers ensure adequate representation of post-acute care providers in networks and streamline prior authorization processes to avoid unnecessary delays.

MA Payment Parity for Critical Access Hospitals: As MA enrollment continues to grow, rural hospitals are under increasing financial strain because MA plans reimburse critical access hospitals (CAHs) at rates below their actual costs. To maintain the financial stability of these hospitals and preserve access to care in rural communities, we support legislation to ensure CAHs receive cost-based reimbursement for MA patients.

Prohibit Coverage "Bait and Switches": We urge Congress to curb practices that erode patients' coverage mid-year, such as insurer policy manual "updates" that change

what services patients can get at a network provider or introduce additional administrative processes meant to delay access to care.

Curtail Inappropriate Downcoding and Payment Reductions by Insurers: We urge Congress to take steps to ensure that insurers reimburse providers at appropriate levels rather than systematically reducing reimbursement and forcing providers to engage in overly burdensome appeals processes.

CONCLUSION

Thank you for your commitment to reducing health care costs for Americans with commercial insurance coverage. We look forward to working with you to support and advance these critical issues.

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January 22, 2026

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Chairman, House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Jason Smith
Chairman, House Committee on Ways and Means
1139 Longworth House Office Building
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The Honorable Frank Pallone Jr.
Ranking Member, House Committee on Energy and Commerce
2323 Rayburn House Office Building
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The Honorable Richard E. Neal
Ranking Member, House Committee on Ways and Means
1129 Longworth House Office Building
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Re: ADA comments for the record for January 22, 2026, hearings with health insurance company CEOs, dental market reforms including ERISA and third-party administrator transparency

Dear Chairman Guthrie, Chairman Smith, Ranking Member Pallone, and Ranking Member Neal:

As the leading authority on oral health in the United States, the American Dental Association (ADA) appreciates the opportunity to provide comments for the record in connection with the House Energy and Commerce and House Ways and Means hearings with chief executive officers of five large health insurance organizations. While the stated focus is overall commercial affordability, these hearings are a timely opportunity to examine market reforms that directly affect patients' access to dental care and the ability of dentists to deliver that care efficiently and transparently.

Commercial dental coverage is commonly structured with substantial cost shifting to families for major services. Large insurers' consumer-facing materials describe a common commercial dental benefit design in which preventive services are covered at higher levels, while major services such as crowns are often covered at around 50 percent, leaving substantial patient cost sharing.[1][2][3] Our ADA policy recognizes that co-insurance is a major contributor to out-of-pocket costs and that significant co-insurance creates cost

[1] UnitedHealthcare, "Dental insurance," accessed Jan. 14, 2026, https://www.uhc.com/dental-vision-supplemental-plans/dental-insurance
[2] Delta Dental, "What Does My Dental Insurance Cover?" DeltaDentalks, accessed Jan. 14, 2026, https://deltadentalks.com/knowledge/what-does-my-dental-insurance-cover
[3] Delta Dental of Ohio, "Dental Benefits for Individuals," accessed Jan. 14, 2026, https://www.deltadentaloh.com/Member/Plans

barriers to care. Additionally, we support coverage of diagnostic and preventive services at 100 percent, without counting those services toward annual maximums.

Against that backdrop, the ADA urges the Committees to use these hearings to obtain concrete, plan-level dental information and to advance reforms that improve transparency, accountability, and competition, particularly in ERISA self-funded arrangements where insurers operate as third-party administrators (TPAs) and where, in practice, plan participants and providers often cannot determine who set the rules that drove a denial, reduction, down coding, bundling, or recoupment.

Below are the ADA's recommended oversight priorities and reform considerations.

1) Require standardized dental affordability and performance reporting (insured and ERISA-administered)

The ADA recommends that the Committees request, at a minimum, standardized plan-level reporting for commercial dental (insured products and ERISA-administered) that enables an apples-to-apples comparison across issuers and products. We support transparency tools for plan purchasers and enrollees, including requiring dental plans to provide an easily accessible summary of benefits on the payer's web portal and specifying core elements that should be included.

At minimum, the Committees should request:

- Premiums and benefit value (including annual maximums, deductibles, co-payments, co-insurance, limitations, waiting periods, out-of-network coverage, and alternate benefit provisions).
- Patient liability drivers, with a focus on co-insurance for major services and the interaction of co-insurance with annual maximums.
- Denial rates, claim reduction rates, overturn rates on appeal, and payment timeliness (see Section 4).

The ADA also supports transparent reporting of Medical (Dental) Loss Ratios (MLR/DLR) for dental plans, including a comprehensive report of plans and enrollees meeting the required ratio.

2) Lift the "TPA veil" in ERISA dental: who set the rules, who is accountable, and who benefits financially

For ERISA self-funded dental arrangements, the Committees should require clarity on governance and accountability, including who controls key policies and outcomes: coverage rules, claim edits and payment policies, downcoding and bundling logic, and appeals decision-making.

Our ADA policy on ERISA plans supports reforms to protect patients and dentists, including:

- Ensuring patients have freedom of choice, including reimbursement for services provided by the dentist of the patient's choice.
- Eliminating missing tooth clauses after one year.
- Establishing meaningful remedies for insurer bad faith.
- Making insurers responsible for negligent utilization review, including negligent reduction or denial of a claim for necessary treatment.
- Providing "substantially equal" external review under ERISA.

In addition, the Committees should require standardized disclosure to plan sponsors of all direct and indirect compensation and incentives tied to claims volume or outcomes. This objective aligns with the broader ADA position that contractual and administrative practices should not obscure responsibility or undermine patients' ability to understand benefit determinations.

3) Stop non-consensual network expansion and "rate leasing" in dental

Network leasing, rental networks, and repricing arrangements raise acute transparency and consent concerns in dental contracting. We feel strongly that dentists should not be forced into new contractual relationships without affirmative agreement.

Our ADA policy on third-party payer contracting practices provides:

- Contract amendments should require the dentist's signature and should be presented as an opt-in contract, with at least 90-days advance notice.
- When a payer uses a dentist's "name, image and likeness" for a new plan or new provider network, the dentist should have the option to opt in.

Accordingly, the ADA recommends the Committees seek policies that:

- Require affirmative, written provider consent before a contracted rate is leased, rented, repriced, or otherwise made available to an entity the dentist did not contract with directly.
- Require clear, advance disclosure to plan sponsors and beneficiaries when dental network access is provided through leased or rented arrangements, including the identity of all entities that can access contracted rates.
- Require that Medicare Advantage plan sponsors have to opt-in in treating Medicare Advantage beneficiaries, rather than being automatically enrolled into Medicare Advantage supplemental dental benefits when a dentist is in-network for their commercial plans.

4) Claims administration reforms: timely payment, clear explanations, licensed review, and limits on recoupments

A. Timely payment and remittance transparency

We support requiring third-party payers to process and pay clean claims within 15 business days, with penalties for failure to do so. The ADA also supports claim reimbursement within 15 business days and preserving a dentist's ability to receive payments by paper check.

B. Standardized explanation of benefit reductions and accountability

When a payer reduces or denies a claim, the patient and provider should be able to understand precisely what happened and why. We are calling for:

- EOB reporting that includes the CDT codes as submitted and a statement indicating how the submitted procedures were adjudicated.
- A national standard grounded in the ADA model EOB statement. Identifying a specific individual acting on behalf of the carrier, with contact information, in correspondence to the patient regarding dental claims.
- Ensuring dentists reviewing claims submissions are licensed in the United States, preferably in the treating dentist's jurisdiction consistent with state law.

C. Post-payment reviews and recoupments

Our ADA policy limits retroactive denials and adjustments and establishes process protections for dentists, including:

- No retroactive denial or adjustment beyond six months from the date the claim was adjudicated, absent fraud or duplicate payment.
- Providing notice with claim and patient identifiers and allowing at least 30-days for the dentist to contest the payers' contention of overpayment.

5) Protect freedom of choice and ensure networks are adequate in practice, not only on paper

We believe a patient's right to choose any licensed dentist must be preserved and oppose arrangements that eliminate or limit freedom of choice. The ADA further opposes closed panel, EPO-only, or DHMO-only approaches as the only dental options available and recommend that sponsors offering such designs also offer a freedom-of-choice plan with equal benefits and permit periodic opportunities to change plans, with premium dollars increasing annually.

Accordingly, we recommend the Committees:

- Demand audit-ready evidence of directory accuracy and appointment availability.
- Require disclosure when network limits may require a patient to change dentists to use coverage.
- Examine how network adequacy is assessed across both insured products and ERISA-administered business, given that self-funded enrollment can materially affect real-world network capacity.

6) Address benefit designs that create predictable cost barriers

The ADA does not support annual or lifetime maximums in dental benefit programs and recognizes total out-of-pocket costs as a barrier to care. When annual maximums are used, the ADA supports requiring issuers to evaluate utilization and out-of-pocket costs annually and to increase annual maximums at least based on the CPI for dental services. This is particularly salient given ongoing increases in the dental services CPI reported by the Bureau of Labor Statistics.[4]

The ADA also supports eliminating waiting periods for children in dental benefit plans.

7) Modernize administration through standards that reduce friction and support affordability

Finally, administrative burdens raise costs for providers and patients. ADA policy supports encouraging movement toward real-time claims adjudication and supporting development of electronic standards for electronic data interchange to enable it. These same principles support Committee inquiry into eligibility and benefits tools, clearer remittance and reduction coding, and interoperability investments that reduce administrative costs and improve patient experience.

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[4] U.S. Bureau of Labor Statistics, "Table 7. Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category and commodity and service group," news release, accessed Jan. 14, 2026, https://www.bls.gov/news.release/cpi.t07.htm

The ADA appreciates the Committees' attention to commercial affordability and urges focused oversight of the dental market, especially where vertical integration and ERISA-administered arrangements can obscure decision-making, limit competition, and shift costs to families. We would be pleased to serve as a resource as the Committee continues this work, or to assist in identifying practicing dentists who can speak directly to how benefit design and financing affect patients' ability to obtain care. If you have any questions, please contact Natalie Hales at halesn@ada.org.

Sincerely,

Richard Rosato, D.D.S.
President

Elizabeth Shapiro, D.D.S., J.D., C.A.E.
Interim Executive Director

NATIONAL ASSOCIATION OF Manufacturers

January 22, 2026

The Honorable Morgan Griffith
Chair
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Re: Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

Dear Chair Griffith and Ranking Member DeGette,

On behalf of the National Association of Manufacturers ("NAM") and the 13 million people who make things in America, thank you for holding today's hearing on health insurance affordability.

The NAM is the largest manufacturing association in the United States, representing small and large manufacturers in every industrial sector and in all 50 states. Manufacturers have a deep commitment to providing health benefits to their workers as it is an effective tool to attract and retain employees and to maintain a healthy and productive workforce, and because they believe it is the right thing to do for the workers who keep America and its economy strong. However, rising health care costs remain a top challenge for the industry. Seventy percent of manufacturers cited health care and insurance costs as their primary business concern in the NAM's most recent Manufacturers' Outlook Survey.[1] Increased costs are disproportionately impacting small and midsize manufacturers, with 77.3% of small (fewer than 50 employees) and 77.6% of medium (50 to 499 employees) companies identifying health care costs as their top concern. In the survey, 94% of manufacturers responded that they expected, or had already seen, an increase in health insurance premiums for 2026. Of those, 11% see premiums rising by more than 20%, an unsustainable increase that neither manufacturers nor manufacturing workers and their families can afford.[2] Despite this challenge, 95% of manufacturing employees are eligible for health insurance benefits, 80% of whom participate in a workplace plan, which underscores the urgent need for action to reduce health care costs for manufacturers and manufacturing workers alike.[3]

Manufacturers appreciate the Subcommittee's commitment to addressing health care affordability through this hearing, which is necessary to shed light on how insurance companies and their vertically integrated subsidiaries play a large role in driving up health care costs for hard-working Americans. The NAM has long advocated for much-needed reforms to bring down health care costs for manufacturers and put more money in workers' pockets:

[1] National Association of Manufacturers, Q4 2025 Manufacturers' Outlook Survey (December 17, 2025). Available at https://nam.org/wp-content/uploads/securepdfs/2025/12/NAM_Q4_2025_Outlook_Write_Up.pdf.
[2] Ibid
[3] Kaiser Family Foundation, *2025 Employer Health Benefits Survey* (Oct. 22, 2025). Available at https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf

- Reform PBMs: PBMs are underregulated middlemen that design, negotiate, and administer prescription drug benefits on behalf of health insurance companies and employers that self-fund health insurance plans for their employees. PBMs contribute to the skyrocketing cost of health care by pocketing manufacturer rebates, tying patient cost-sharing to list prices, using spread pricing structures, and obfuscating their questionable business models. Necessary reforms include increased transparency requirements, the delinking of PBM compensation from the list price of medicines, and full rebate passthrough to plans and their beneficiaries in the commercial market. Manufacturers strongly support the PBM Reform Act (H.R. 4317), introduced by Representative Buddy Carter (R-GA-1), and the DRUG Act (H.R. 2214), introduced by Representative Mariannette Miller-Meeks (R-IA-1), and have long called for passage of the comprehensive reform package that was originally included in the December 2024 continuing resolution.

- Reform the 340B Program: The 340B program was created to provide lower cost medicines and expand care for low-income and underserved patients. Recently, it has rapidly and massively expanded beyond Congress's intent. As covered entities have taken advantage of the program to increase their profits, it has driven up the cost of employer-sponsored insurance ("ESI"). The 340B program allows covered entities to charge patients' insurance the full list price for drugs acquired at 340B prices, which results in patients and employers losing out on rebates and hospitals keeping the spread. The expansion of the 340B program was associated with approximately $23 billion in additional employer-based healthcare expenses in 2023, of which employees paid about $4.5 billion per year in added insurance premiums.[4] An IQVIA study also found that the 340B program increases drug costs for self-insured employers and their workers by 4.2% due to the lost manufacturer rebates on drugs purchased at the 340B price.[5] This corresponds to a $5.2 billion increase in health care costs for self-insured employers.[6] We encourage the Subcommittee to consider reforms to current fee structures, third party administrator behavior, sub-grantee eligibility, patient definition and child site eligibility, and the ways in which patients benefit from the program. Such reforms are needed to return the program to the intent with which Congress created it, while continuing to serve the population it was intended to.

- Expand Eligibility and Contribution Limits for HSAs: HSAs are personal tax-free savings accounts that patients with HDHPs can use to pay for out-of-pocket medical costs. HSAs provide greater flexibility and control over health care and health care costs for manufacturing workers. HSA funds do not expire and are not impacted by a change in employment. Last year, manufacturers supported congressional action to broaden HSA eligibility to include individuals that are covered under a direct primary care service arrangement in H.R. 1—a victory for manufacturers. However, additional reforms, including an increase in contribution limits and greater eligibility, are needed to give more people access to HSAs and to empower them to contribute more tax-free dollars for medical expenses. Manufacturers support the HSA Modernization Act (H.R. 548), introduced by Representative Beth Van Duyne (R-TX-24), and the Flexible Savings

[4] National Pharmaceutical Council, The 340B Drug Purchasing Program and Commercial Insurance Premiums. Available at https://www.npcnow.org/sites/default/files/2025-05/340B%20and%20Employer%20Costs%20White%20Paper.pdf
[5] IQVIA, The Cost of the 340B Program Part 1: Self-Insured Employers. Available at https://www.iqvia.com/locations/united-states/library/white-papers/the-cost-of-the-340b-program-part-1-self-insured-employers
[6] Ibid.

Arrangements for a Healthy Robust America Act (H.R. 2667), introduced by Representative Aaron Bean (R-FL-4), both of which would expand HSA access.

- Encourage Adoption of Individual Coverage Health Reimbursement Arrangements ("ICHRAs"): ICHRAs allow employers to provide tax-free reimbursements to employees for qualified medical expenses, such as monthly premiums and out-of-pocket costs, without offering traditional group health coverage. ICHRAs provide manufacturers financial predictability and flexibility, which is particularly useful for employers that have not previously offered health insurance. ICHRAs also give employees flexibility that enables them to choose the best health plan for them and their families. Depending on location, individual insurance market plans may even cost less than group market premiums. Manufacturers support the Small Business Health Options Awareness Act (H.R. 5498), introduced by Representative Beth Van Duyne (R-TX-24), to increase awareness and the Choice Arrangement Act (H.R. 5463), introduced by representative Kevin Hern (R-OK-1), to incentivize adoption of ICHRAs.

- Codify Association Health Plans ("AHPs"): AHPs allow multiple employers to join together to offer employer-provided group health insurance plans. AHPs provide the bargaining power of larger plans to all the small employers involved to purchase less-expensive health plans and negotiate better rates. Further, insurance companies are mandated to spend a smaller percentage of "large group" premiums on overhead and profit than they do on small group plans, which lowers costs. Manufacturers support the Association Health Plans Act (H.R. 2528), introduced by Representative Tim Walberg (R-MI-7), to codify AHPs.

- Improve Data Transparency and Accessibility: Administering high-quality, affordable health plans requires the collection and analysis of massive amounts of data, a task to which manufacturers dedicate significant resources. Thus, it is critical that employer plan sponsors have user-friendly access to their complete data to make informed choices about their plan's operations. Data gaps make it more difficult for employers to design the highest-quality plans for their workers and require permanent and comprehensive fixes. While health insurance claims data is valuable and readily available, manufacturers need access to additional data beyond claims in order to fully understand if outcomes and quality goals are being achieved. Comprehensive data would enable manufacturers to track and manage chronic conditions, and to measure if various programs emphasizing primary and preventive care are actually improving outcomes across the entire beneficiary population. Additionally, improved transparency, audit, and disclosure requirements between plan sponsors and vendors, if constructed in a way that does not add regulatory burdens for plan sponsors, can help make it easier for plan sponsors to fulfill their fiduciary requirements. Such transparency, specifically price transparency, benefits manufacturing employees' experience in the health care system and enables them to make more informed decisions about their care. Updates to the hospital and insurer pricing files mandated by the No Surprises Act, introduced by Representative Frank Pallone (D-NJ-6) in the 116th Congress, as well as transparency measures that were included in the Consolidated Appropriations Act of 2021 will make data more usable by plan sponsors, which will put better data in the hands of beneficiaries.

In addition to the above reforms, manufacturers encourage the Subcommittee to work closely with colleagues in Congress to strengthen the Employee Retirement Income Security Act of 1974 ("ERISA") and protect its preemption over a patchwork of state regulation. ERISA is the

backbone of ESI and allows manufacturers to provide uniform, yet tailored, benefits to workers across multiple states.

Manufacturers and their workers are increasingly concerned with the rising cost of health care and appreciate this timely hearing to examine health insurance companies' role in this critical issue. We hope you consider the NAM a resource as you continue working to implement these policy recommendations and consider additional solutions to address the cost of health care. We look forward to partnering with the Subcommittee to ensure manufacturers can continue to offer health insurance to their workers, and their families, who work hard every day to power the American economy.

Sincerely,

Jess Wysocky
Director, Health Care Policy

Jake Kuhns
Vice President, Domestic Policy

cc: The Honorable Brett Guthrie, Chair, Committee on Energy and Commerce
The Honorable Frank Pallone, Ranking Member, Committee on Energy and Commerce

Statement for the Record
U.S. House Energy & Commerce Committee Subcommittee on Health
Hearing: Health Care Affordability
January 22, 2026

Lauren Aronson
Executive Director, The Campaign for Sustainable Rx Pricing (CSRxP)

Committee Chairman Guthrie, Committee Ranking Member Pallone, Subcommittee Chairman Griffith, Subcommittee Ranking Member DeGette, and members of the U.S. House Energy & Commerce Committee Subcommittee on Health, the Campaign for Sustainable Rx Pricing (CSRxP) thanks you for the opportunity to submit a statement for the record on our shared goal of improving health care affordability for all Americans. We commend your bipartisan leadership in seeking to address this critically important issue that impacts patients, their families, and taxpayers every day.

CSRxP is a broad-based, nonpartisan coalition of leaders committed to fostering an informed discussion on sustainable drug pricing. Our member organizations represent consumers, employers, health plans, hospitals, nurses, pharmacists, pharmacy benefit companies, and physicians. Our coalition is united behind one goal: to lower the cost of prescription drugs for patients. We are committed to developing bipartisan, market-based solutions that promote competition, improve affordability, and enhance list price transparency while maintaining patient access to innovative medications that improve health outcomes and save lives. We believe innovation and affordability must go hand in hand.

I. Prescription Drug Prices are the Largest Driver of Health Care Spending

U.S. spending on healthcare continues to outpace inflation and wages, placing increasing financial pressure on patients, their families, employers, and federal and state budgets.[1] **The single largest contributor to healthcare spending growth is the excessively high cost of drugs: 24 cents of every health care dollar goes toward prescription drugs.**[2] Spending on prescription drugs is simply unaffordable and unsustainable because of the anti-competitive, price-gouging tactics Big Pharma deploys: drug makers set the list prices of their products too high, routinely raise those prices at unjustifiably high rates, and keep those prices high by gaming the system to block more affordable alternative medicines from entering the market.

[1] Cox et al. Health Care Costs and Affordability. KFF. October 8, 2025.
[2] AHIP. Where Does Your Health Care Dollar Go? October 24, 2024.

Indeed, American patients, families, taxpayers, businesses, and our economy as a whole cannot continue to bear the inexorable and unsustainable growth in prescription drug prices and spending. List prices for drugs at launch have more than doubled since 2021 – with the median list price exceeding $370,000 in 2024 and representing a substantial increase over the median launch prices of $300,000 in 2023 and $220,000 in 2022.[3] List prices are even higher for many gene therapy treatments, with the highest one priced at $4.25 million for a single dose in 2025.[4] Net median annual launch prices have skyrocketed in recent years, growing by 51 percent from 2022 to 2024.[5]

II. Health Care Costs Are High Because the U.S. Pays the Highest Prices

Drug makers raised U.S. prices on at least 872 brand-name drugs to start 2026 – imposing a median price increase of 4 percent, a median price hike that exceeds the current rate of inflation.[6][7] The price increases implemented at the outset of 2026 follow years of unsustainable price increases imposed on consumers and taxpayers by Big Pharma. In 2025, for example, manufacturers raised prices on more than 250 drugs to start the year.[8] In 2022, drug makers raised prices on more than 4,200 drugs by an average increase of 15.2 percent – even faster than the prior year of 11.5 percent.[9] Reflecting these unsustainable pricing trends, the top 25 best-selling prescription drugs in Medicare Part D not selected for price negotiation have nearly doubled in price since entering the market, increasing by an average of 98 percent.[10] Indeed, even after adjustments for rebates, a report from the Department of Health and Human Services (HHS) concluded that **U.S. prices for brand-name drugs are at least 3.2 times higher than those in comparable countries**.[11] The unsustainable drug pricing trends have led to needless spending on prescription drugs in the U.S. overall; in 2024, drug expenditures totaled $467 billion and grew at a rate of 7.9 percent, reflecting years of annual increases in prescription drug spending far exceeding the rate of inflation.[12]

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[3] Beasley, D. Prices for new US drugs doubled in 4 years as focus on rare disease grows. *Reuters*. May 22, 2025.
[4] Becker et al. Updated: Most expensive drugs in the US in 2025. *Fierce Pharma.* August 11, 2025.
[5] Agbool F, Lin GA, Lee W, Wright A, Phillips M, Lee M, Koola Fisher C, Emond SK. Launch Price Access Report. Institute for Clinical and Economic Review, October 23, 2025.
[6] Lupkin, S. Many brand-name drug prices are going up, despite Trump administration deals. NPR. January 14, 2026.
[7] Erman, M. Exclusive: Drugmakers raise US prices on 350 medicines despite pressure from Trump. *Reuters*. January 1, 2026.
[8] Erman, M. Drugmakers to raise US prices on over 250 medicines starting Jan. 1. *Reuters*. December 31, 2024.
[9] HHS Office of the Assistant Secretary for Planning and Evaluation. Changes in the List Prices of Prescription Drugs, 2017 – 2023. October 6, 2023.
[10] Purvis, L. Prices for Top Medicare Part D Drugs Have Nearly Doubled Since Entering the Market. AARP Public Policy Institute. January 2025.
[11] HHS ASPE. Comparing Prescription Drugs in the U.S. and Other Countries: Prices and Availability. January 31, 2024.
[12] Hartman et al. National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated. *Health Affairs*. January 14, 2026.

III. Brand Biologics and Specialty Medicines Drive Spending Growth

Critically, high-priced brand biologics are driving much of the excessive spending on prescription drugs. **Brand biologics made up 5 percent of all prescriptions in the U.S., but comprised 51 percent of total spending on drugs in 2024**.[13] Spending on biologics grew 12.5 percent annually from 2017 to 2021 – a rate that far surpassed the 1.3 percent annual spending growth on traditional small molecule drugs over that same period.[14] In Medicare Part D, prices for biologic medicines have grown more rapidly than traditional drugs, rising by more than 300 percent from 2006 to 2022.[15] Similarly, biologics accounted for nearly 90 percent of spending growth on prescription drugs between 2008 and 2021 in Medicare Part B and accounted for 79 percent of all of Part B drug spending in 2021.[16]

IV. Trump Administration: "A Patient Affordability Crisis"

Despite efforts from the branded pharmaceutical industry to suggest otherwise, drug makers – and drug makers alone – are the drivers of the unsustainable growth in drug prices and excessive spending on prescription drugs today. Drug companies set exceptionally high list prices at launch for new drugs and raise those prices every year, oftentimes at rates that far exceed inflation. Manufacturers impose these extremely high prices on patients and consumers despite the fact that far too many Americans still cannot afford the medications they need to get well and remain healthy.[17] **The anti-competitive, price-gouging practices of Big Pharma have led the FDA to assert that "patient affordability crisis" now exists, "creating insurmountable financial barriers for many Americans who need these life-saving treatments**."[18] Far too often today, Americans experience the unfortunate and unfair choice of purchasing medications and paying their bills for food and housing. Patients and their families simply should never be presented with such a choice.

[13] Food and Drug Administration. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.
[14] IQVIA. Biosimilars in the United States 2023 – 2027: Competition, Savings, and Sustainability. January 31, 2023.
[15] Medicare Payment Advisory Commission. The Medicare prescription drug program (Part D): Status Report. Slide 15. January 11, 2024.
[16] HHS ASPE. Medicare Part B Drugs: Trends in Spending and Utilization, 2008 – 2021. June 9, 2023.
[17] Sparks et al. Americans' Challenges with Health Care Costs. KFF. December 11, 2025.
[18] FDA. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.

V. Congressional Action to Address Pharmaceutical Costs Must Be Part of the Solution

CSRxP again applauds the bipartisan leadership of the Committee in seeking to tackle the healthcare affordability crisis affecting millions of Americans today. **Given the outsized impact that high-priced prescription drugs have on healthcare affordability, CSRxP respectfully urges the Committee to invite Big Pharma's chief executive officers to testify before the Committee to attempt to justify their unjustifiable pricing practices and describe the actions they intend to take to address the "patient affordability crisis."** The American public and policymakers deserve to know and understand why drug makers continue to set prices for their products that are simply unaffordable and unsustainable for patients, families, employers, and taxpayers. Policymakers can use this information to formulate workable solutions to thwart the anti-competitive, price-gouging tactics of Big Pharma so that prescription drugs are affordable and accessible for all who need them.

In conclusion, CSRxP thanks you for the opportunity to submit a statement for the record on improving healthcare affordability for all Americans. Without taking major actions to combat the unsustainable growth in prescription drug prices and spending, the brand pharmaceutical industry will continue to excessively profit from its anti-competitive pricing practices that needlessly increase drug costs and make healthcare unaffordable for the very people who depend on it most. CSRxP looks forward to our continued work with the Committee and the Congress to develop bipartisan, market-based policies that promote transparency, foster competition, and incentivize value to lower costs for consumers and taxpayers while at the same time maintaining access to the treatments that can improve health outcomes and save lives.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR THE RECORD BY

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE (P4ESC)

TO THE

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON THE ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

"LOWERING HEALTH CARE COSTS FOR ALL AMERICANS: AN EXAMINATION OF HEALTH INSURANCE AFFORDABILITY "

January 22, 2026

Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to submit a statement on the record on behalf of the Partnership for Employer-Sponsored Coverage (P4ESC) for the hearing entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability." We appreciate the Subcommittee's focus on affordability and welcome the opportunity to contribute an employer-driven perspective on the core drivers that continue to push health care costs higher for workers, families, and taxpayers alike.

P4ESC is a nonpartisan advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and sectors, and the millions of Americans and their families who rely on employer-sponsored coverage every day. Employer-sponsored health insurance is the single largest source of coverage in our nation.

For more than eighty years, employer-sponsored coverage has been the backbone of our nation's health system. Employers are the primary purchasers of coverage, the principal financiers of health benefits, and fiduciaries responsible for ensuring the plans operate in the best interests of workers and families. Each year, businesses of all sizes contribute vast financial, administrative, and other resources to employees and their families through the employer-sponsored system and have a vested interest in health care quality, value, and system viability.

Moreover, employer-sponsored group coverage holds a distinct advantage over coverage sold in the individual market. Workplace-based coverage groups together employees without regard to their health status, producing larger, more stable risk pools with predictable enrollment and lower premium volatility over time. Employer contributions, controlled entry and exit from the plan, and the ability of younger healthier employees to offset the cost of older or less healthy employees helps keep coverage more affordable across the entire workforce—outcomes that benefit employees, employers, and taxpayers alike.

However, the success of employer-sponsored coverage depends on a market in which insurers operate with transparency, accountability, and incentives aligned with affordability, value and patient care. As health care costs continue to rise, employers are increasingly concerned that market dysfunctions—including opaque data practices, hidden fees, consolidation, and misaligned incentives—are undermining their ability to manage costs and fulfill their fiduciary obligations. These challenges threaten not only employer-sponsored coverage, but also the broader goal of lowering health care costs for all Americans.

Address the Rising Cost of Health Care

Health care costs are simply out of control. In 2024, the United States spent $5.3 trillion on health care, equivalent to about 18 percent of gross domestic product – up from $4.5 trillion and 17.3 percent of GDP in 2022.[1] Employers routinely face hospital prices that exceed more than two-and-one-half times what Medicare pays,[2] with little evidence that these higher prices reflect commensurate improvements in quality or outcomes. For decades, employers of all sizes have raised concerns about medical cost growth that far outpaces population growth and aging, [3] and small business owners have consistently cited health care costs as one of their most significant operating challenges.[4] Greater congressional and regulatory oversight of escalating health care costs and persistent market failures is long overdue.

According to the Centers for Medicare and Medicaid Services (CMS), health care spending is highly concentrated. Hospital care, physician services, and prescription drugs alone account for **more than 60 percent of total national health expenditures**, while no other spending category

[1]Centers for Medicare & Medicaid Services. *National Health Expenditure Data: NHE Fact Sheet.* CMS, updated 24 June 2025, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.
[2] Whaley, Christopher M., et al. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative.* RAND Corporation, RR-A1144-2-v2, Dec. 10, 2024, https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.
[3] The Peter G. Peterson Foundation. "*Why Are Americans Paying More for Healthcare?*" *Peter G. Peterson Foundation*, 12 Aug. 2025, https://www.pgpf.org/article/why-are-americans-paying-more-for-healthcare/.
[4] National Federation of Independent Business. *About NFIB.* NFIB, https://www.nfib.com/about-nfib/. Accessed 20 Jan. 2026.

exceeds five percent.[5] This concentration underscores that affordability challenges are being driven primarily by a limited number of sectors, rather than by diffuse or unavoidable cost pressures across the system.

Employers have also long been concerned about consolidation across the health care sector and its impact on prices, competition, and transparency. **P4ESC commends the Subcommittee for advancing provisions in the *Consolidated Appropriations Act, 2026* (CAA) that strengthen transparency and enhance congressional oversight of dishonest billing practices among hospitals and physician practices. We support policies in the CAA that expand price transparency across all stakeholders, including pharmacy benefit managers (PBMs), health plans, and hospitals. P4ESC also supports uniform application of site neutral payment policies and honest billing requirements to deter location-based gaming of coverage.**

Address Misaligned Incentives Which Drive Consolidation

As employers work to manage rising health care costs, they are increasingly concerned that large insurer incentives are not aligned with affordability or value. One such concern is the structure of the medical loss ratio (MLR), which is often described as a consumer protection but can, in practice, reward higher overall spending rather than cost containment. Because MLR is calculated as a percentage of premium revenue, insurers can increase absolute revenue as premiums rise, so long as they remain above the statutory threshold. This dynamic weakens incentives to aggressively negotiate prices, reduce unit costs, or challenge provider consolidation—particularly in markets where employer choice among insurers is limited. Actuarial and policy analyses have long noted that MLR requirements do not directly incentivize efficiency and may, in some circumstances, reinforce cost growth rather than constrain it.[6]

These incentive concerns are compounded by consolidation in the health insurance market. Numerous studies have shown that health insurance markets remain highly concentrated across much of the country, limiting employer leverage and reducing competitive pressure on premiums and service quality.[7] In many regions, employers, particularly small and mid-sized businesses,

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[5] Centers for Medicare & Medicaid Services. *National Health Expenditures 2024 Highlights.* CMS, 2025, https://www.cms.gov/files/document/highlights.pdf.
[6] Rigney, Grant. "*Gaming the Medical Loss Ratio: How Health Insurers Turn Consumer Protections into Corporate Windfalls*." *Free Market Health Care Forum* OppBlog, 16 Dec. 2025, https://freopp.org/oppblog/gaming-the-medical-loss-ratio-how-health-insurers-turn-consumer-protections-into-corporate-windfalls/.
[7] United States Government Accountability Office. *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation.* GAO-25-107450, Government Accountability Office, 22 Sept. 2025, https://www.gao.gov/products/gao-25-107450

have access to only one or two viable carrier options.[8] As insurers grow larger and more vertically integrated, employers increasingly encounter standardized, take-it-or-leave-it contract terms and diminished responsiveness to requests for transparency, flexibility, or innovation. Federal analyses have repeatedly found that market concentration weakens competition and can contribute to higher prices, a concern that is particularly acute in employer-sponsored coverage, where switching costs are high and plan stability matters for workers and families.[9]

Employers are also deeply concerned about persistent barriers to accessing timely, usable data necessary to manage health benefits effectively. Although employers are the primary purchasers and fiduciaries of employer-sponsored plans, insurers frequently restrict access to claims, pricing, and utilization data or provide it in formats that are delayed, incomplete, or difficult to analyze. Without meaningful data access, employers cannot effectively monitor plan performance, evaluate network value, identify wasteful spending, or fulfill their fiduciary responsibilities under the *Employee Retirement Income Security Act* (ERISA). Federal guidance has emphasized the importance of plan sponsor oversight of service providers,[10] yet persistent gaps in data access continue to limit accountability and prevent the market from functioning as intended.[11]

The rapid vertical integration of insurers with pharmacy benefit managers, specialty pharmacies, and other health care intermediaries further complicates these challenges. While integration is often justified as a means of improving coordination, it has also introduced conflicts of interest and opaque financial arrangements that make it difficult for employers to understand where health care dollars are actually going. The Federal Trade Commission,[12] academic researchers,[13] and other government entities[14] have shown how practices like spread pricing, rebate retention

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[8] American Medical Association. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets.* American Medical Association, 2024, https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.

[9] United States Government Accountability Office, *Health Care Consolidation*, GAO-25-107450.

[10] United States Department of Labor, Employee Benefits Security Administration. *Understanding Your Fiduciary Responsibilities Under a Group Health Plan.* U.S. Department of Labor, 2025, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.

[11] United States, House of Representatives, Committee on Education and the Workforce. *House Report 118-260: Health Data Access, Transparency, and Affordability Act of 2023.* 118th Cong., 1st Sess., 1 Nov. 2023, https://www.congress.gov/committee-report/118th-congress/house-report/260.

[12] Federal Trade Commission. *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs.* Interim Staff Report, June 2024. https://www.ftc.gov/reports/pharmacy-benefit-managers-powerful-middlemen-inflating-drug-costs.

[13] Commonwealth Fund. *What Pharmacy Benefit Managers Do and How They Contribute to Drug Spending.* 17 Mar. 2025, https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending.

[14] United States Government Accountability Office. *Pharmacy Benefit Managers: Use of Spread Pricing and Related Practices.* GAO-24-105476, April 2024. https://www.gao.gov/products/gao-24-105476.

and associated fees, and steering towards vertically consolidated entities can drive up costs for employers and patients while making it harder to see where the health care dollars are going. These practices erode trust, reduce competition, and impair employers' ability to act in the best interests of plan participants.

Taken together, these dynamics—misaligned insurer incentives, consolidation, data opacity, and vertical integration—have allowed inefficient spending to persist even as premiums and out-of-pocket costs continue to rise. Employers are routinely told that premium increases are driven by "medical trend," yet they are given little visibility into how insurers are actively working to lower prices, improve value, or challenge cost growth within the system. **P4ESC encourages the Subcommittee to continue to support policies that will increase employers' access to their own data, like strengthening the *Consolidated Appropriations Act, 2021* "no gag clause" requirement that mandates insurers provide plan sponsors access to their own claims data. P4ESC additionally urges the Subcommittee to support policies that will provide transparency to the hidden fees that are often levied on plan sponsors without their knowledge, driving up the overall cost of coverage.** Without greater transparency and accountability, cost pressures are increasingly shifted onto workers and families through higher premiums, higher deductibles, and constrained wage growth. Addressing these issues is essential to preserving the affordability and sustainability of employer-sponsored coverage and to ensuring that the private insurance market works as intended for those who depend on it.

Uphold the tax treatment of employer-sponsored coverage

The Federal Tax Code has long favored employer-sponsored coverage. The value of coverage provided to employees and their dependents is not recognized as income to the employee. This tax code preference has been challenged by some policy makers interested in funding other priorities or shifting our health care system to an individual-based system. P4ESC strongly cautions Congress not to disrupt what has worked so well through the years.

The exponential growth in our nation's employment-based health coverage system can be traced back to a cap on wages initiated during World War II to help stifle inflation. Employers began offering fringe benefits – such as health insurance – to offset the limit on wages and attract employees. This approach has supported coverage for more than 80 years. The direct benefits and federal spending offsets of employer-provided coverage result in an annual net social impact of $1.5 trillion, driven by increased labor participation, business formation, increased health coverage, and reduced federal health subsidies.[15] Each dollar of federal expenditure – the tax

[15] Mulligan, Casey B. *The Value of Employer-Sponsored Health Insurance.* National Bureau of Economic Research Working Paper No. 28590, March 2021, https://www.nber.org/papers/w28590.

revenue foregone for employer-provided coverage – yields approximately $5.34 in benefits for covered employees and their families.[16]

Policymakers and regulators will face great difficulty in constructing a cap on the tax exclusion. A cap approach based on a regionally adjusted national average would not work for larger groups, which are almost universally experience-rated. Some of the larger groups have older or less healthy employees with higher rates of utilization, and consequently, more expensive plans. Smaller employers with older employees with higher utilization might also be disproportionately affected. A cap would hit employees covered by these plans more harshly than others. All employers and employees would see their FICA contributions increase with higher recognized wages due to a cap on the tax exclusion.

Taxing health insurance benefits is not just impractical, it is unjust. Employees are already shouldering substantial tax burdens. Taxing their health insurance as income would further burden employees, effectively amounting to a new and unappreciated tax hike.

Preserve ERISA Preemption

The *Employee Retirement Income Security Act* (ERISA) was enacted in 1974 to encourage voluntary employee benefit plans (particularly retirement and health benefits) and to promote uniformity in these plans across state boundaries. ERISA preempts the application of state laws that "relate to" these employer-sponsored plans. ERISA does not preempt the states from regulating health insurers or health insurance products. ERISA also does not preempt state laws of general applicability, such as taxes. In its 50-year history, ERISA has worked well and effectively to the benefit of employees and employers. ERISA is the foundation of employer-based coverage.

Multistate employers seek to build an equitable workplace culture by providing uniform and affordable benefits to their employees regardless of where they live. Employers also want to be able to administer these benefits in an efficient, consistent manner. Uniform design and administration of benefits promotes substantial efficiencies and significantly reduces health care costs for employees and employer plan sponsors.

Unfortunately, states and local governments are increasingly passing laws that challenge ERISA's preemption framework. For example, Seattle's "pay-or-play" ordinance effectively dictates employer health care spending levels and layering on new disclosure mandates that

[16] Joint Committee on Taxation's Estimates of Federal Tax Expenditures For Fiscal Years 2019-2023; The Bureau of Economic Analysis' National Income and Product Accounts (Table 6.11)

undermine national uniformity. Unfortunately, the courts have allowed this city ordinance to stand adding to the increasing patchwork of state and local laws.

P4ESC urges Congress to ensure that ERISA's preemption principle remains strong and intact, particularly given the growing number of state laws in recent years that challenge ERISA preemption. Congress must stand firm against these state inroads against ERISA preemption.

Conclusion

P4ESC commends the Subcommittee for making significant progress towards addressing many of these issues this Congress through enacting the first major reforms to high-deductible health plans and health savings accounts (HSAs) in more than 20 years. The passage of the ***Primary Care Enhancement Act*** increases affordability for patients by allowing them to participate in a direct contracting arrangement and use their HSA to pay for their direct primary care arrangement. Additionally, HSA reforms that are now law include permanent first dollar coverage for telehealth services and greater access to HSAs in marketplace coverage. We encourage Congress and the administration to prioritize additional HSA reforms.

P4ESC is the leading defender of employer-based coverage. We respectfully ask that lawmakers consider return on investment for employer-sponsored coverage as they consider health care legislation, and that lawmakers work to strengthen employer-sponsored health care by championing policy to increase affordability for patients. Employers have a significant stake in developing and implementing health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout the 119th Congress. If you or your staff would like to meet with members of P4ESC, please contact P4ESC's Executive Director, Taylor Hittle.[17]

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Statement for the Record

Submitted to Committee on Energy and Commerce

Health Subcommittee

Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

January 22, 2026

By: David Merritt, Senior Vice President of External Affairs

We know Americans are struggling with the high cost of health care, from the mom who doesn't pick up a prescription because of the price to the worker who skips a visit to the doctor because they can't afford it. Those are the unfortunate challenges too many Americans face when the prices for medical care and medications continue to rise far faster than everyday costs like gas and groceries. Families see and feel those higher health care costs every day in the form of higher premiums.

The Blue Cross Blue Shield Association (BCBSA) and Blue Cross and Blue Shield (BCBS) Plans share the Committees' ongoing commitment to improving access to and lowering costs of health care for all Americans. We thank the Chairman and Ranking Member for holding this important series of hearings to discuss how to lower costs.

BCBSA is a national federation of 33 independent, community-based and locally operated BCBS Plans that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. Almost 180 million Americans receive insurance through their jobs making employer-provided coverage the foundation of affordable care in this country. Blue Plans cover over 83 million employees and their dependents, including 18 million union workers, retirees and dependents and many Fortune 100 companies. In addition, Blue Plans collectively cover 8.3 million Americans through the individual market, 5.3 million through Medicare Advantage, 6.8 million through standalone Medicare Part D plans and 10.9 million through Medicaid.

Health insurance providers have an important role to play to help ensure that patients receive the care they need at the most affordable cost, which is why BCBSA is laser-focused on tackling the root causes of rising costs. Creating real change will require actions at every level by every leader in health care, and we are working in partnership with hospitals, pharmaceutical companies and policymakers to create savings

that lower premiums. We stand ready to work even more closely with the members of this committee and everyone with a shared commitment to lower costs because we know Americans expect us to lead and drive solutions together that make coverage more affordable.

The Root Causes of Rising Costs

Rising health care costs are driven by many factors across a complicated health care system: hospital prices, drug costs, advances in technology, changing regulations and how health care is financed and administered.

Premium rates are based on expected medical costs and utilization of services. When underlying costs and utilization rise, premiums follow. Unfortunately, trends in medical spending and the price of medical care continue to go up:

- Drug spending was up 10% in 2024, driven by high launch and list prices for specialty drugs.[1]
- Spending on weight loss drugs, GLP-1s, increased nearly 40% in just one year.[2]
- According to the Bureau of Labor Statistics, hospital prices have increased 281% since 2000.[3]

A study published in Health Affairs this month using CMS data noted that half of the growth in health care spending in 2024 was driven by high utilization of health care services. Adding to these pressures are the costs we pay for an explosion of new AI technologies designed to drive revenue for providers, as well as inefficient and ineffective government processes.

A financial lifeline that millions of Americans rely on to cover these higher costs is the individual health care tax credit. With the expiration of the enhanced health care tax credit at the end of 2025, CMS data shows 800,000 fewer people enrolled in plans offered through the individual marketplace for 2026. We expect that number to grow as more people allow their coverage to lapse when they receive their first, higher bill at the end of January. Typically, healthier people are the first to drop coverage when prices rise, taking the gamble that they won't need coverage. That leaves the marketplace with a smaller and less balanced pool of enrollees, which will further increase premiums for those who remain covered.

More broadly, BCBS Plans negotiate with drug manufacturers and health care providers every day to secure the lowest possible prices for the 118 million members we serve. We play this critical role on behalf of patients because out of every premium dollar, more than 80 cents go directly to pay for the medical care and prescription drugs they need. So, our negotiations directly reduce the premium prices that patients pay.

We know that explaining the reasons behind rising costs won't fix the problem, which is why we are taking real action and driving real solutions that will.

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[1] U.S. Drug Spending Up 10.2% in 2024, with Weight Loss Drugs Remaining Top Driver-ASHP

[2] National trends in prescription drug expenditures and projections for 2025 | American Journal of Health-System Pharmacy | Oxford Academic

[3] www.bls.gov

The Blues Affordability Roadmap

Our number one priority is to lower costs for the people we serve. Our roadmap outlines nearly $1 trillion for Congress in potential savings over 10 years. These commonsense solutions can deliver lower costs for patients, consumers and taxpayers by curbing excessive hospital markups, lowering prescription drug prices and streamlining unnecessary administrative burdens. When those underlying costs of care are lower, health insurance premiums will be lower as well.

Congress can take strong action right now to lower premiums and out-of-pocket costs for patients, particularly for those who purchase coverage on their own. The December expiration of the enhanced health care tax credits has led to immediate price spikes for many of the 25.2 million people enrolled in the market. Congress should create a short-term fix for families that rely on those enhanced credits now, while making other improvements to the individual marketplace as well as addressing the underlying causes of premium increases.

On reasonable hospital billing, Medicare should require unique national provider identifiers (NPIs) for off-campus, hospital-owned offices to verify care sites and enforce correct payment rates. Passing S. 2497,[4] the Fair Billing Act, sponsored by Sens. Maggie Hassan (D-NH) and Roger Marshall (R-KS), would add critical transparency and, according to the Congressional Budget Office,[5] reduce direct spending by $403 million and increase government revenue by $1.9 billion over 10 years.

Building on the NPI fix, Congress should expand site neutral policies that protect Medicare patients from higher bills simply based on where they were treated — and who owns the facility. Congress can lower health care costs through fair and reasonable billing practices, such as applying site neutral payments for hospital outpatient departments, which would end these unreasonable markups and save the country and taxpayers nearly $500 billion over 10 years.[6]

BCBSA strongly supported the Administration's first step advancing site neutral reform when the Centers for Medicare & Medicaid Services (CMS) lowered out-of-pocket costs for patients receiving physician-administered drugs. We urge Congress to expand these reforms to other Medicare services, so patients never pay more simply because of where they receive care.

Congress must also act to lower drug prices by driving more competition, more patient choice and faster access to lower-cost generics. For example, pharmaceutical companies delay patient access to lower-cost generic and biosimilar drugs by filing numerous additional patents to extend the exclusivity of a brand-name drug. Passing S. 1041, Affordable Prescriptions for Patients Act, sponsored by Sens. John Cornyn (R-TX) and Richard Blumenthal (D-CT), would cut through the 'patent thicket,' provide more lower-cost choices for patients and save hardworking taxpayers $1.8 billion over 10 years.[7] This

[4] United States Congress, Fair Billing Act. 2025, S.2497 - 119th Congress (2025-2026): Fair Billing Act | Congress.gov | Library of Congress.
[5] Congressional Budget Office. "Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act | Congressional Budget Office." Congressional Budget Office, 2023, www.cbo.gov/publication/59825.
[6] Harmonic Consulting. "Savings Estimates for Solutions to Reduce Spending on Health Care and Private Insurance Premiums: 2025 Update." January 2025. https://www.bcbs.com/media/pdf/BCBSA_affordability_solutions_for_the_health_of_america_2025_update.
[7] Congressional Budget Office Cost Estimate. "At a Glance S. 150, Affordable Prescriptions for Patients Act of 2023." June 13, 2024. https://www.cbo.gov/system/files/2024-06/s150.pdf.

legislation and other bipartisan reforms would bring lower-cost generic and biosimilar competitors to market more quickly by closing patent and regulatory loopholes.

Fixing the Broken Independent Dispute Resolution (IDR) Process

The No Surprises Act was meant to protect patients from unexpected medical bills. But its system to settle payments between hospitals and insurers — Independent Dispute Resolution or IDR — is being abused. IDR was intended to be used as a backstop, with CMS originally estimating 17,000 cases annually. Last year, more than 2.2 million cases were sent through the IDR process.[8] Our research found that nearly 40% of those submitted cases were not eligible for the process, yet half of those still result in determinations.[9] The consequence of this broken process is higher costs for patients and employers.

In many cases, the determinations do not reflect local market prices at all. For example, CMS data shows one health plan offered $1,388 in arbitration for an emergency department consultation, which was already above the median in-network rate of $1,195. This offer was also well above the Medicare rate of just $370.[10] Somehow, the arbitrator sided with the provider's request of more than $250,000 — 150,000% higher than Medicare.[11] This is just one example of thousands like it. And when providers prevail in more than 85% of cases,[12] receiving payments averaging more than 450% of the rates negotiated and agreed to with in-network providers,[13] everyone pays more.

Recent research showed the broken process added at least $5 billion in health care spending in just two years. As these trends continue to rise and as these costs ripple through the system, they result in higher premiums and higher out-of-pocket costs.[14]

To ensure the No Surprises Act works as intended, CMS needs to implement targeted, commonsense reforms:

- Finalize the IDR Operations Final Rule, implementing a dynamic IDR portal to improve efficiency and transparency in the process.
- Discourage improper filings by introducing an upfront eligibility fee for initiating parties to reduce ineligible disputes.
- Increase transparency by requiring arbitrators to share submissions and provide detailed rationales as part of the final decisions.
- Create a formal process for parties to challenge arbitration outcomes before CMS.
- Monitor arbitrator performance and develop penalties for arbitrators that show bias or poor performance.
- Track patterns of abuse by providers and their vendors to curb manipulation of the system.

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[8] https://www.cms.gov/nosurprises/policies-and-resources/reports
[9] https://www.ahip.org/news/press-releases/new-ahip-bcbsa-survey-shows-nearly-40-of-providers-surprise-billing-disputes-are-ineligible-under-no-surprises-act
[10] https://www.cms.gov/nosurprises/policies-and-resources/reports
[11] https://www.cms.gov/nosurprises/policies-and-resources/reports
[12] *Ibid*.
[13] https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process
[14] *Ibid*.

These changes would better align incentives and curb abuse by those who are gaming the system. That will help lower costs for everyone.

The Blues are Creating Lower-Cost Options for Patients

BCBSA and several Blue Plans helped create CivicaScript to bring affordable versions of commonly prescribed but highly priced generic medicines to the market, increasing competition. A study in the *New England Journal of Medicine* found that CivicaScript's generic prostate cancer drug saved patients nearly $1,000 a year. Earlier this month, Civica began to offer affordable insulin pens with the lowest list price in the current long-acting insulin market — capped at $55 per box of five pens for consumers, compared to $150–$500 per box.[15]

We also connect families to lower cost, high-quality specialty care through our centers of excellence program. The Blue Distinction Center+ designation covers eight different specialties, including cancer care and transplants. To earn this designation, a facility needs a history of delivering exceptional results at lower costs. Members are saving 23% on spine surgery and 30% on knee/hip replacements.

The Blues are Promoting Preventive Care

The Blues are working closely with hospitals and physicians to shift away from fee-for-service medicine and toward paying for quality care. Blue High Performance Networks reward providers for keeping patients healthy rather than ordering more tests. Our research shows this model reduces the total cost of care by an average of 11%.[16]

Blue Plans are working to improve health and lower costs by covering preventive screenings like mammograms and colonoscopies at zero cost to patients. These screenings help detect cancer at an earlier stage and avoid invasive tests and treatments. Early detection improves outcomes and can cut treatment costs by up to two-thirds. We have seen the data: An ounce of prevention is worth a pound of cure. We strongly encourage members to access these services and promote their availability directly to members, from websites, member portals and onboarding materials to personalized reminders, on social media and direct member outreach.

The Blues are Taking on Fraud, Waste and Abuse

Fraud, waste, and abuse contributes to the mounting cost of health care and undermines trust in the health care system. As health insurance providers, Blue Plans play a unique role helping identify, eliminate and prevent fraud, waste and abuse. Every BCBS company operates Special Investigation Units (SIUs) that use data analytics, claims reviews and referrals to identify and uncover suspicious billing patterns and behaviors. SIUs conduct comprehensive investigations when potential misconduct is detected, and findings support overpayment recovery and inform administrative or criminal actions.

[15] https://www.bcbs.com/news-and-insights/article/new-era-of-lower-cost-insulin
[16] https://www.bcbs.com/about-us/programs-initiatives/blue-high-performance-network

BCBSA's National Anti-Fraud Department supports these efforts, overseeing antifraud activities and enhancing BCBS systemwide SIU operations through a robust framework of information sharing, investigative collaboration along with government and industry partnerships. From 2020 through 2024, BCBS company SIUs completed more than 67,000 investigations, collectively recovering and preventing losses exceeding $22 billion. This critical work helps keep premiums low, returning value to beneficiaries.

More can and should be done to prevent fraud, waste, and abuse. BCBSA has long advocated for stronger program integrity measures in public programs. In September 2024, we urged Congress to address unauthorized individual market enrollees, with most of our recommendations having been made into law. We continue to support:

- Tougher penalties for fraudulent brokers
- Expanding multi-factor authentication for brokers and consumers
- Enhanced eligibility checks as consumers move between Medicaid and marketplace coverage

We also support significant steps that this Congress and Administration have taken to combat fraud, waste and abuse and bring more accountability to the health care system, including:

- **CMS Actions:**
  - Social Security Number-based identity verification
  - Suspended 850 brokers for unauthorized enrollments
  - Introduced 3-way calling to block bad actors
  - Ended marketplace tax credits for dually enrolled Medicaid/CHIP consumers
  - Finalized 2025 Marketplace Integrity and Affordability Rule limiting special enrollment periods, requiring a minimum payment to prevent auto-renewal into zero-cost plans, and improving income eligibility checks
- **Congressional Actions**:
  - The *One Big Beautiful Bill Act* ended automatic reenrollment and presumptive eligibility, tightened all eligibility verifications and required full repayment of excess tax credits.

BCBSA also applauds the creation of the Wasteful and Inappropriate Service Reduction (WISeR) Model, which directly targets low-value and fraudulent claims for high-risk, high-growth services in Original Medicare, and we support CMS's new Fraud Defense Operations Center, which uses data analytics, investigative expertise and AI to stop improper payments before they occur.

Addressing fraud, waste and abuse is an important component of strengthening our health care system and should remain a focus; however, it is not sufficient to control rising health care costs. Meaningful, sustainable cost reduction will also require policies that address the root causes of rising costs.

We will continue to use the tools available to us to bring down costs when drug makers and providers drive prices up. And we stand ready to work with Congress to tackle the root causes of our nation's health care affordability crisis. We also are eager to partner on a bipartisan agreement to extend health care tax

credits for the millions of Americans who rely on them. If you have any questions or would like to discuss this issue further, please contact me or my colleague, Amanda Schwartz, associate vice president of government relations, at Amanda.Schwartz@bcbsa.com.

Sincerely,

David Merritt

Senior Vice President, External Affairs

Blue Cross Blue Shield Association

BUSINESS

UnitedHealth pays its own physician groups 17% more than outside ones, study shows

Finding suggests UnitedHealth may be skirting a rule to curb insurers' profits

Adobe

By Tara Bannow Nov. 3, 2025

Hospitals and Insurance Reporter

UnitedHealth Group pays its own physician practices much more than it pays competing practices, a new study finds, reinforcing STAT's own analysis on the subject and presenting fresh evidence that the conglomerate may be skirting a rule designed to curb health insurer profits.

UnitedHealth's insurance arm, UnitedHealthcare, pays practices under its UnitedHealth-owned Optum umbrella 17% more on average for common services than it pays non-Optum practices in the same region, according to the study, published Monday in Health Affairs. In areas where its insurance arm has a large market share, it pays Optum practices 61% more.

The study's lead author, Daniel Arnold, said his research was inspired in part by STAT's reporting from last year, which found that UnitedHealthcare paid 13 of 16 Optum practices more than others in the same market, ranging from as little as 3% more to 111% more. UnitedHealth paid the other three practices less than the market average. UnitedHealth paid roughly two times the market average for some common services, STAT found.

The Affordable Care Act upended the health insurance business model by forcing companies to spend a certain amount of premium revenue on their members' care or pay it back to them, a rule known as the medical loss ratio. In response, health insurers rushed to acquire companies in other lines of business so they could shift profit from their insurance arms to other areas where profit is not capped.

"It's a fairly big penalty that a lot of insurers don't want to have to face, and this is a way to avoid that," said Arnold, a senior research scientist at Brown University. "We criticize them for doing this, but this is the way the rules are set up and it almost makes sense."

In a statement, UnitedHealth called the study "flat-out wrong" and said it cherry-picks data. The company said UnitedHealthcare pays Optum Health consistently with other providers in the market, "which is essential for staying competitive." UnitedHealth also said the study's funders, Arnold Ventures and the Commonwealth Fund, are biased.

The study states that the funders had no role designing or conducting the research or presenting the results.

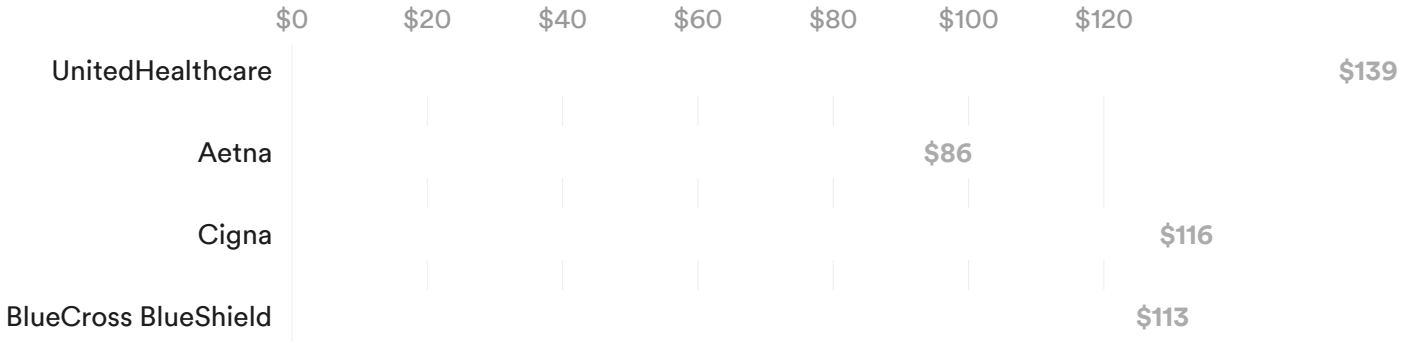
Another reason UnitedHealth may be paying its doctors more is so that it can use some of that money to add resources to its Optum practices so they can attract more patients and take business from competing physician groups, Arnold said. Independent doctors STAT interviewed last year said that dynamic was threatening their practices' viability.

For years, UnitedHealth's vertical integration strategy was a success that others tried to emulate. The company, the country's largest health insurer, now has some 90,000 doctors under its umbrella, a pharmacy benefit manager, and hundreds of surgery centers. But more recently, it's become something of a liability as UnitedHealth faces a Department of Justice antitrust investigation over how its physician and insurance divisions interact.

The authors of the new study found that in areas where UnitedHealthcare has a greater than 25% market share, the payment gulf increased to 61%.

UnitedHealthcare pays more to Optum providers than rivals

Unadjusted prices paid to Optum for a moderate-intensity office visit in 2024



Note: "Moderate-intensity office visit" refers to CPT code 99214, which is an established patient office visit lasting 30–39 minutes.
Chart: J. Emory Parker/STAT ● Source: Arnold and Fulton (2025) Health Affairs

Interestingly, UnitedHealthcare paid all physician practices — both those it owns and those it doesn't own — more than other insurers did. It paid Optum doctors 62% more than other insurers, and non-Optum doctors 38% more than other insurers did. The 17% headline number represents the relative difference between those numbers. That's surprising in part because it suggests UnitedHealth isn't using its size to push down prices and secure better deals for its health insurance customers.

The new study used federal "Transparency in Coverage" data, where health insurers publish the negotiated prices they paid to in-network providers starting in 2022. It analyzed the prices employer-sponsored and individual plans paid for 12 high-cost, high-volume procedures across several specialties, plus two codes for office visits. The sample included about 385,000 prices across roughly 21,000 physician practices in 28 regions. The other insurers included were Aetna, Cigna, and Blue Cross Blue Shield.

One limitation of the study was that it only included 705 instances where UnitedHealthcare paid Optum providers, which is less than 1% of the total sample.

While no one can say with certainty that UnitedHealth is gaming the medical loss ratio without looking into their books, some researchers feel confident that's what's happening. Matthew Fiedler, a senior fellow at Brookings who was not involved in the new study, said it's unlikely that UnitedHealth's doctors are making more money than doctors at independent practices. Instead, he said he suspects those higher payments go to UnitedHealth's bottom line.

"United is not paying the Optum practices more because it wants to increase the compensation of the physicians that work at those practices, United is paying these practices more because it is a way to hide money from the medical loss ratio regulations without actually parting with those dollars," Fiedler said.

Martin Gaynor, an economics professor emeritus at Carnegie Mellon University, said there's no publicly available data that shows how UnitedHealth is actually using those higher payments to its own practices, but research like this adds weight to the theory that it's done to game the medical loss ratio rules.

"When United, and they're not the only insurer who has done this, owns all kinds of firms, doctor practices prominent among them, then they're in a position to simply shift money over to these practices," said Gaynor, who wasn't involved in the new study. "On paper, they're complying with the medical loss ratio. It makes it look like they're not earning a lot of profit. But of course that's just a shell game."

Gaynor, who until last year served as a special advisor to the DOJ's antitrust division, said there's more work to be done with respect to studying health insurers' vertical integration tactics.

"I don't think the authors claim, and I would agree with them, that this is the be-all end-all of studies and empirical evidence on this," he said.

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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

House Committee on Energy and Commerce
Subcommittee on Health

January 22, 2026

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market. Health insurance provides access to needed medical and preventive care and protects against the risk of unanticipated costs, thereby helping to keep coverage affordable.

The key driver of health insurance affordability is the underlying cost of health care itself. AHIP appreciates the Subcommittee's focus on strategies to improve health care affordability for American families and stands ready to collectively find ways to reduce costs while not compromising on quality and access. Rising health care costs are putting a strain on household budgets, making it imperative to pursue policies that deliver meaningful relief while preserving access to high-quality care. Maintaining health care affordability is essential for the 24 million Americans in the individual market, 35 million Americans who choose Medicare Advantage (MA), the 180 million hardworking Americans and their families who rely on employer-provided coverage, and the 65 million who receive their care through comprehensive, risk-based Medicaid managed care.

AHIP is committed to working with the Subcommittee to address the core drivers of health care affordability across markets and throughout the entire health care system. As such, AHIP's statement for the record focuses on how health plans are taking action to ensure Americans have access to affordable coverage as well as actions Congress can take to address the root causes of rising health care costs and alleviate immediate cost crises. Taken together, these actions can help make health care more affordable, accessible, and responsive to patient needs across the country.

What Is Driving Premiums Higher

Health insurance exists to protect individuals and families from the unpredictable costs of medical care, ensuring they have access to the services they need without facing financial hardship. Health plans play a critical role in improving affordability, quality, and outcomes through negotiating lower prices, coordinating care effectively, promoting preventive care, and reducing avoidable complications. Health plans are doing everything in their power to shield Americans from the high and rising costs of medical care. With health insurance, consumers

have the peace of mind they will be protected no matter what their health care costs will be in a given year, but this depends on a healthy pool of individuals with varying health care needs.

At the same time, health plans function as part of a complex health system, in which the underlying costs of services – such as hospital care, physician services, and prescription drugs – continue to rise, driving the premiums consumers pay higher. A new report by the Centers for Medicare & Medicaid Services (CMS) shows that health care spending nationwide grew by 7.2 percent in 2024, reaching a record $5.3 trillion.[1]

Health insurance premiums (i.e., the amount enrollees pay for health insurance coverage each month) help cover the costs of the medical care patients receive, improving health care affordability, access and quality for everyone. By bringing together a large, diverse group of individuals into a risk pool, health plans spread the financial risk to offset the costs of sicker, higher-expense members from healthier, lower-expense members, making coverage more stable and affordable. In some markets, risk adjustment further balances the risk by increasing funds for plans with sicker populations, keeping premiums stable and fair. Together, these mechanisms ensure that premiums are directed where they're needed most.

While health plans use market-based tools like negotiation to decrease costs, they are also dependent on the prices set by drugmakers, hospitals and physician groups. Nearly 85 percent of Americans' premium dollars directly goes to covering the cost of hospital-based services, prescription drugs, physician fees and other medical services.[2] When prices for these treatments and services go up, the premium consumers pay for their coverage must rise to keep pace.

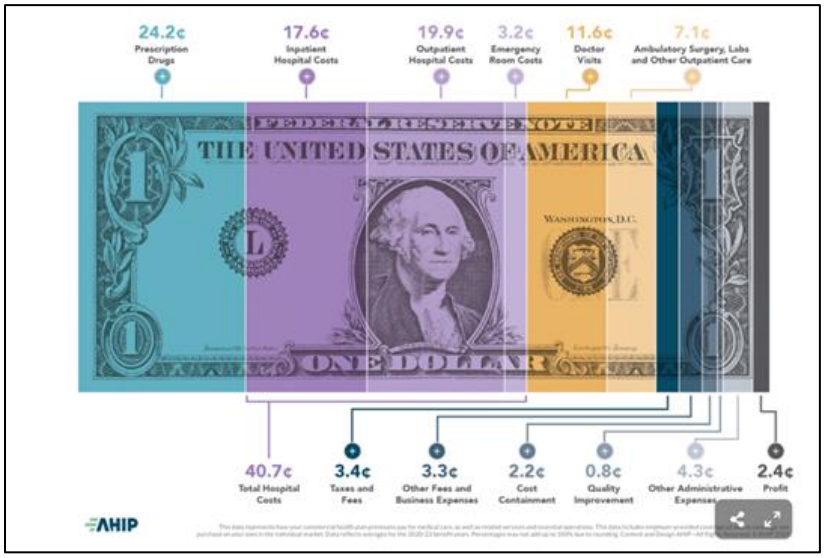

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://www.ahip.org/resources/where-does-your-health-care-dollar-go.

[1] https://www healthaffairs.org/doi/full/10.1377/hlthaff.2025.01683
[2] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

The remainder of Americans' premium dollar goes to improving quality, efforts to contain costs, taxes and fees; only 2.4 percent goes to profit. Health plans' profits and administrative costs are capped under federal law, the only segment of the health care system subject to such a requirement. Health plans' profit margin was 0.8 percent in 2024.[3] In 2023, the net income of health plans accounted for about 0.5 percent of total U.S. health expenditures ($4.9 trillion, per CMS data).[4] By comparison, the pharmaceutical industry averages 15-20 percent margins.[5]

While prescription drug pricing is a major driver of premium growth in 2026, site of care differences, private equity–driven billing practices, and hospital consolidation also contribute significantly to rising prices. AHIP looks forward to working with the Subcommittee in addressing these market loopholes and misaligned incentives that lead to higher costs for every American.

While health plans continue to work to lower costs and protect Americans from the rising medical expenses, it is imperative that policymakers address the root causes of higher health care costs across the entire health care system in order to take meaningful steps in making coverage more affordable. AHIP welcomes the opportunity to discuss common-sense solutions with the Subcommittee on ways to lower costs for everyone.

Advancing Affordability Through Strong Prevention and Effective Safeguards

Even with the system's increasing cost pressures and growing regulatory barriers, health plans are working diligently to improve patient affordability and to safeguard Americans from the high costs of medical care. For example, health plans partner with independent practices and create value-based arrangements in order to increase access to quality care while reducing unnecessary costs, including those that are driven by unwarranted and wasteful utilization.

Health plans are working to make care more affordable by promoting preventive care such as cancer screenings, encouraging healthy lifestyle choices including healthy food and physical activity, and ensuring access to recommended vaccines. These efforts can help reduce the burden of both chronic diseases as well as preventable infectious diseases and keep individuals and communities healthier. Health plans have also prioritized improving the prior authorization process. This section highlights how these efforts together can lower costs and support better health for the people they serve.

1) Addressing Chronic Disease Prevention and Management

Meaningfully addressing the drivers of preventable chronic disease requires tailored support and strong collaboration across the health care system. Health plans are uniquely positioned to drive effective prevention efforts through their close engagement with patients, providers, employers,

[3] https://content.naic.org/sites/default/files/2024-annual-health-industry-commentary.pdf
[4] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data
[5] https://www.gao.gov/products/gao-18-40

community-based organizations, and policymakers. Together, they can lead efforts that improve health outcomes and reduce avoidable costs, supporting greater affordability across the system.

AHIP encourages policymakers to modernize policies that promote healthy behaviors, strengthen value-based care models focused on chronic disease prevention, support technology and data interoperability to better enable coordinated patient care, and provide greater flexibility for benefit designs that help people prevent and manage chronic conditions.

2) Vaccine Coverage and Preventing Costly Illnesses

Vaccines are important both for Americans' health and financial stability. Health plans are committed to maintaining and ensuring affordable access to vaccines. Health plan coverage decisions for immunizations are grounded in each plan's ongoing, rigorous review of scientific and clinical evidence, and continual evaluation of multiple sources of data.

As plans navigate an evolving health care landscape, maintaining robust immunization coverage continues to be a top priority for protecting both individual and community health. While health plans continue to operate in an environment shaped by federal and state laws, as well as program and customer requirements, the evidence-based approach to coverage of immunizations will remain consistent.

AHIP welcomes further discussion with the Subcommittee on vaccine coverage and identifying other ways to prevent costly illnesses to keep health care more affordable for all.

3) Simplifying Prior Authorization

Prior authorization is an important safeguard to help ensure care is safe, evidence-based and as affordable possible.

Health insurance plans have announced a series of commitments to streamline, simplify and reduce prior authorization. Building on health plans' existing efforts, these new actions are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers. These commitments are being implemented across insurance markets, including for those with MA, Commercial coverage, and Medicaid managed care consistent with state and federal regulations, and will benefit nearly 270 million Americans.[6] AHIP looks forward to working with the Subcommittee and sharing progress on health plans' commitment to improve prior authorization this spring.[7]

4) Modernizing Information Technology to Improve Care and Reduce Costs

AHIP supports the goal of promoting the seamless flow of data among appropriate health care stakeholders to benefit all Americans. Patient care should be high-quality, high-value and

[6] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[7] https://www.ahip.org/news/articles/2026-will-bring-progress-on-simplifying-prior-authorization

delivered by providers and health plans working together, supported by emerging technologies and the smooth exchange of reliable health information.

To achieve this, AHIP urges the Subcommittee to explore policies that support the promotion of secure, interoperable data exchange as well as safe and transparent use of artificial intelligence (AI) that can help reduce burden and costs in the health care system. At the same time, it is critical to safeguard against policies that could stifle innovation, negatively impact patient privacy and adversely influence market dynamics.

AHIP looks forward to partnering with the Subcommittee to address the ways policymakers and stakeholders across the health care system can help improve health information exchange and help make coverage more affordable.

A Path Forward on Affordability

Nothing is more important than helping Americans access the care they need at prices they can afford. This section details how Congress can take action to address the root causes of affordability, the immediate cost crisis in the individual market, and preserve the value of MA.

Addressing the Root Causes of Higher Health Care Costs

1) Prescription Drug Pricing

Prescription drugs are the largest driver of increased premium costs in the commercial market. AHIP's health care dollar shows that 24.2 cents of every premium dollar goes to prescription drugs.[8] In addition, drug spending is expected to be a key driver of premium growth in 2026, due to rising unit prices, costly new gene and cell therapies, and growing demand for weight-loss medications.[9]

Prescription drug prices are set by pharmaceutical manufacturers. These brand drugmakers continue to raise prices for Americans while discounting prices in Europe.[10] On January 1, 2026, drugmakers raised prices on 350 drugs – 100 more drugs than in 2025.[11] These increases drive up premiums and raise costs at the pharmacy counter for American patients.

Drug prices would be lower with more generic and biosimilar competition, but brand manufacturers abuse the patent system to create ever-longer monopolies. AHIP urges Congress to stop the widespread abuse of the drug patent system that prevents competition and keeps U.S. drug prices far too high. Congress can build on bipartisan momentum for market-based solutions and pass legislation to help end abusive practices like patent thicketing.

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[8] https://www.ahip.org/resources/where-does-your-health-care-dollar-go
[9] https://www.ahip.org/news/articles/dont-let-health-care-tax-credits-expire-whats-at-stake-for-millions
[10] https://www rand.org/pubs/research_reports/RRA788-3 html
[11] https://www reuters.com/business/healthcare-pharmaceuticals/drugmakers-raise-us-prices-350-medicines-despite-pressure-trump-2025-12-31/

Researchers have also highlighted how other anti-competitive patent tactics from drug manufacturers contribute to $40 billion in unnecessary drug spending annually.[12] As such, Congress should consider additional reforms by addressing product hopping, enhancing Federal Trade Commission enforcement, and stopping pay-for-delay deals that lead to unjustifiably high-priced drugs.

Greater competition from interchangeable biosimilars would reduce prices and increase patient access to innovative therapies. Congress should pass legislation that would cut the red tape delaying interchangeable biosimilar approvals. To speed generic approvals, Congress should require the Food and Drug Administration (FDA) to provide clear answers to generic manufacturers with questions about their applications, ending limits on FDA communications that slow generic approvals.[13]

2) Site-Neutral Reforms

The prices providers charge for identical services and treatments vary wildly depending on location, ownership or provider market power. Historically, Medicare has paid a higher amount for comparable services that are provided in a hospital outpatient department than in a physician's office. For example, medical imaging services are typically priced significantly higher in hospital settings versus other settings, such as outpatient imaging centers or a physician's office. This higher payment structure has created a perverse incentive for hospitals to acquire physician practices and convert them to off-campus, provider-based hospital outpatient departments. This allows certain providers to charge patients more with no demonstrable difference in care or outcomes. [14,15]

These practices increase premiums and out-of-pocket costs and make care less affordable for all patients and consumers. AHIP's health care dollar also shows that outpatient hospital costs (e.g., going to a hospital for an MRI or visiting a specialist in a hospital outpatient department) account for nearly 20 percent of Americans' premiums.

One common-sense solution to bring down these costs is enacting site-neutral payment reforms to ensure American patients receiving the same service from the same entity in the same geography are charged the same price. Estimates show that expanding site-neutral payments in Medicare would generate annual savings of $4.9 billion in Medicare savings and $1.2 billion in beneficiary cost-sharing savings.[16] Furthermore, if site-neutral payment expansion were applied in the commercial market, it would reduce annual spending by $58 billion.[17]

AHIP encourages Congress to work together on site-neutral payment reform, a solution with bipartisan support that would take America one step closer to a modern health system.

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[12] https://www.economicliberties.us/our-work/the-costs-of-pharma-cheating/
[13] https://accessiblemeds.org/resources/blog/end-brand-name-drug-delay-generic-competition/
[14] https://pubmed ncbi.nlm nih.gov/33784540/
[15] https://jamanetwork.com/journals/jama/article-abstract/2800656
[16] https://www medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[17] https://journals.sagepub.com/doi/10.1177/00469580241275758

3) Surprise Medical Bills

A fragmented health care system – combined with the rapid expansion of private equity ownership – has intensified out-of-network billing, balance billing and opaque pricing that harms consumers. Private equity-backed provider groups often rely on aggressive billing strategies, including remaining out-of-network or exploiting payment disputes, to maximize their revenue at the expense of American consumers.

While the *No Surprises Act* was intended to protect patients from the financial burden of expensive surprise medical bills and reduce the cost of care for employers and working families, a recent AHIP/BCBSA survey found that 39 percent of provider disputes submitted under the law are ineligible while the certified IDR entities entrusted to oversee arbitration only found 17 percent ineligible.[18] This 22-point gap is the quantifiable measure of the health care costs of IDR entity failure representing hundreds of thousands of disputes that should have been rejected but were instead improperly processed, generating fees for the IDR entities and driving up costs in unwarranted final payment determinations.

IDR entities are paid to process disputes that are deemed eligible. They are financially disincentivized from acting as strict gatekeepers, because ruling a claim ineligible terminates their revenue stream for that dispute. These entities then further undermine the process by disregarding many of the legal and regulatory requirements of the process, including the qualified payment amount (QPA) or benchmark amount for the disputed service, before issuing final payment determinations without any explanation or rationale for the decision. Congress created a detailed process for calculating, verifying, and communicating QPAs during the IDR process, while the IDR entity is supposed to be the most responsible for ensuring appropriate out-of-network amounts are reasonable and closely correlated to fair market rates, as measured by the QPA. Instead, the median payment determination by IDR entities is 459 percent of the QPA, far from the intent of Congress to lower costs through the *No Surprises Act*.[19]

This has created unnecessary costs of an estimated $5 billion that ultimately drive-up premiums for consumers, employers, and unions.[20] Health care costs are already increasing year after year due to underlying market dynamics. Changing fundamental market dynamics is a tall order, but adding entirely unnecessary costs to an already bloated health care system by creating an arbitration process that allows a handful of private equity giants to reap seemingly endless financial windfalls by mastering a rigged system must be fixed. The arbitration system is not achieving the law's goals, adds no value to patients' care, but instead adds new costs for American consumers. It increases costs, not lowers, and we should be building upon approaches that benefit consumers and patients.

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[18] https://www.ahip.org/news/press-releases/new-ahip-bcbsa-survey-shows-nearly-40-of-providers-surprise-billing-disputes-are-ineligible-under-no-surprises-act

[19] https://www healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process

[20] *Ibid.*

4) Hospital Consolidation

Decades of research underscores the impact of hospital consolidation on rising costs for Americans. Hospital markets are increasingly dominated by a few large systems, with three-fourths of U.S. metro areas classified as highly or very highly concentrated.[21] Consolidation increases hospital systems' market power, allowing them to demand higher prices from health plans and employers that in turn contribute directly to higher premiums. Total hospitals costs, including inpatient, outpatient and emergency department care, now account for 40 percent of every health care dollar Americans spend. Furthermore, research shows that hospital consolidation does not lead to improved quality of care nor does it deliver better value.[22]

To that end, AHIP urges Congress to pursue policies that strengthen hospital competition through a fair and transparent marketplace, rein in hospital price markups, and protect consumers from price gouging by fostering choice, higher-quality services, and ultimately, lower costs.

Immediate Actions Congress Can Take to Shield Americans from Rising Health Care Costs

1) Build a Bridge for 24 Million Americans Counting on the Health Care Tax Credits

Lower- and middle-income Americans are facing a cost crisis after the expiration of the health care tax credits. These credits have supported working families, sole proprietors, small-business employees, family farmers, rural residents, and others without access to employer coverage or Medicaid. The Joint Committee on Taxation confirms that low- and middle-class families will experience the greatest cost burden, with 95 percent of tax credits going to households earning under $200,000, and most benefiting families earning less than $80,000.[23]

The tax credits dramatically expanded the affordability of Marketplace coverage, helping enrollment more than double and driving the uninsured rate to historic lows. But their expiration will shrink and weaken the Marketplace risk pools, as healthier enrollees drop coverage in response to sharply higher premiums. As these healthier individuals exit, the remaining pool becomes sicker and more expensive on average, contributing to the increases in premiums for 2026 and beyond.

This shift in the risk pool makes it even more important to understand how the tax credits flow through the system. The tax credits go straight to lowering an enrollee's monthly premium bill, ensuring that it is used exclusively for reducing the cost of that person's coverage. Enrollees must pay and stay current on their remaining share to keep their coverage - and then reconcile the amount of credit they received at tax filing, paying back any excess if their income was higher than expected. This guarantees that every dollar of tax credit is accounted for and used exactly as intended.

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[21] https://hmi.healthcostinstitute.org/#HMI-Concentration-Index
[22] https://www nejm.org/doi/10.1056/NEJMsa1901383
[23] https://punchbowl news/jct-aca/

Furthermore, significant steps have been taken to strengthen program integrity efforts as state and federal marketplaces determine consumers' eligibility for financial assistance and enrollment.[24] Multi-factor authentication and other common-sense reforms can build on these decisive actions to prevent unauthorized enrollment. Health plans have long supported strong program integrity measures and support continuous improvements to protect consumers and taxpayers from potential fraud.

To further ensure accountability and protect consumers, federal law places strict limits on how Marketplace plans can use premium dollars. Plans must spend at least 85 percent of group premiums and 80 percent of individual premiums on medical care. If those thresholds are not met, health insurers must pay rebates to consumers. These medical loss ratio (MLR) requirements have made clear that the premium dollars directly support patient care rather than unchecked profit – and since 2012, consumers have received rebates from insurers totaling over $14 billion, with the most recent payments issued in 2025 totaling nearly $1.2 billion rebated to Marketplace enrollees.[25,26]

However, there is still time for Congress to take action to address the expired tax credits for the 2026 plan year and make coverage more affordable for millions of Americans. AHIP urges Congress to take bipartisan action as quickly as possible to build a bridge for the hardworking Americans who rely on the enhanced tax credits by pairing extension with additional program integrity measures starting in 2026. If Congress acts, health plans will work quickly with federal and state regulators to ensure consumers can access their more affordable coverage options as soon as possible.

2) Preserve the Availability and Affordability of MA Benefits

CMS is currently considering updates for Plan Year 2027 for the annual MA Rate Notice, which shapes premiums, benefits, and overall affordability for beneficiaries and taxpayers. Particularly as medical costs steadily rise, AHIP urges policymakers to strengthen and protect MA as a critical choice for the 35 million Americans who choose it for its better services, better access to care, and better value than fee-for-service (FFS) Medicare.[27]

MA delivers significant cost savings through high-quality care, and robust chronic disease management. A key feature of MA is the comprehensive benefits it offers – such as coverage for prescription drugs, vision, hearing, dental, and wellness – all while capping out-of-pocket costs and thus, driving savings. Importantly, MA delivers better outcomes, with fewer hospitalizations and average annual savings of over $3,400 on out-of-pocket costs and premiums compared to

[24] https://www.ahip.org/news/articles/ahip-urges-congress-to-pair-tax-credit-extension-with-additional-program-integrity-measures
[25] https://www kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/
[26] https://www.cms.gov/files/document/2024-rebates-state.pdf
[27] https://www.ahip.org/value-of-medicare-advantage

FFS.[28, 29] Additionally, 95 percent of MA beneficiaries report high rates of health care satisfaction and access to care.[30]

MA also delivers on cost-savings for the U.S. taxpayer, strengthening Medicare's long-term solvency through its high-value, coordinated care at costs that are consistently lower than FFS Medicare.[31] MA helps alleviate Medicare beneficiary cost growth and reduce pressure on the Hospital Insurance Trust Fund through reducing avoidable hospitalizations, effectively managing chronic conditions, and investing in innovative care models that generate savings. As such, sustaining and strengthening MA is an essential component in promoting long-term Medicare solvency and deliver better care at a better cost for America's seniors and individuals with disabilities.

Policymakers also need accurate data and sound analyses when considering policy changes affecting the millions who choose MA. Recent data show that FFS Medicare costs would be 9.8 percent higher if FFS beneficiaries were required to be enrolled in both Part A and Part B, and if FFS Medicare were required to provide a maximum out-of-pocket limit – both of which are required under MA.[32] The Subcommittee can help guarantee the use of accurate data and methodology in the government's comparisons of the MA and FFS programs by passing H.R.4093, the *Apples-to-Apples Comparison Act*.[33] By requiring CMS to more accurately compare costs, the bill would help to ensure that seniors and individuals with disabilities have clearer, more reliable information in order to select coverage that fits their needs.

To keep pace with rapidly increasing utilization and medical spending,[34] AHIP urges policymakers to prioritize policies in Plan Year 2027 and beyond that strengthen MA for those who rely on it and take care to avoid policies that would result in benefit cuts or cost increases for MA beneficiaries.

Conclusion

AHIP thanks the Subcommittee for the opportunity to comment on policies that seek to improve health care affordability, including addressing the expired health care tax credits to keep coverage within reach for millions of Americans. AHIP looks forward to working with the Subcommittee in identifying and implementing practical policy solutions to make the health care system more affordable for people and sustainable for the country.

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[28] https://ahiporg-production.s3.amazonaws.com/documents/AHIP_EC_Health_Sub_Medicare_Hearing_Statement_1.8.26.pdf
[29] https://bettermedicarealliance.org/news/medicare-advantage-beneficiaries-spend-nearly-3500-less-per-year-than-fee-for-service-beneficiaries-on-out-of-pocket-health-care-costs/
[30] https://bettermedicarealliance.org/publication/state-of-medicare-advantage-2025/
[31] https://www.ahip.org/resources/ma-practices-extend-the-medicare-trust-fund-solvency-while-enhancing-health-outcomes-2
[32] https://www.ahip.org/resources/the-value-of-medicare-advantage-versus-fee-for-service
[33] https://www.congress.gov/bill/119th-congress/house-bill/4093
[34] https://www.cms.gov/files/document/highlights.pdf

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Association of American Medical Colleges
Statement for the Record
before the
Energy & Commerce Health Subcommittee
Lowering Health Care Costs for All Americans:
An Examination of Health Insurance Affordability
January 22, 2026

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to submit this statement for the record regarding the hearing entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability" before the House Energy and Commerce Committee on January 22, 2026. The AAMC welcomes the chance to share the perspective of academic medicine and to work with you as you evaluate policies that will slow the rising costs of health care.

Health care costs have dramatically risen in recent years due to myriad factors, including inflation, labor costs, exponential drug price increases, supply chain issues, and administrative factors.[2] Academic health systems and teaching hospitals, despite feeling the acute impact of these factors, have continued the pursuit of their missions of high-quality patient care, physician and workforce education and training, life-saving medical research, and community collaboration.

AAMC members continue to grapple with historic workforce shortages, unprecedented capacity challenges, inadequate reimbursement from payers, supply chain disruptions, rising expenses such as labor costs, pending cuts to the Medicaid program, and the looming risk of other harmful Medicare payment cuts. According to the Medicare Payment Advisory Commission (MedPAC), hospitals' overall fee-for-service Medicare margins fell to a record low of -11.6% in 2022, and this downward trend is expected to continue.[3] The recently passed One Big Beautiful Bill Act (OBBBA, P.L. 119-21) will also pose new challenges for our members as they contend with significant Medicaid payment losses and a potential surge in newly uninsured patients. AAMC-

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

[2] Health Care Costs and Affordability. Kaiser Family Foundation, *October 8. 2025.*

[3] Medicare Payment Advisory Commission, *December 2023 Report*, https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf.

member health systems and teaching hospitals, despite experiencing Medicare margins that average -18.2%, continue to be asked to do more with fewer resources, and many are near their breaking point.[4] This is directly reflected in recent activities to offset mounting losses caused by reductions in research funding and anticipated Medicaid cuts at AAMC member institutions. Since January 22, 2025, we have seen 12 members conduct layoffs, four members with unit closures or full closures, and one merger.

While academic health systems and teaching hospitals continue to grapple with balancing a delicate model that preserves their missions and ensures continued patient access to care, it is worth noting that there are parts of the health care ecosystem that are not similarly impacted and, in fact, seem to prosper in even the hardest of times. The largest commercial health insurers post tens of billions of dollars in profit while facing claims that they are limiting access to patient care through prior authorization or automatic initial denials that some have cited as questionable.[5] AAMC members report particularly egregious instances of delayed and denied payments, retroactive denials, narrow networks, and insufficient reimbursement; practices to which hospitals must dedicate vast resources to handle. Constant battles with insurance companies simply to get needed care to patients are taxing not only on hospital resources, but they also weigh heavily on patients.

Premiums across the nation continue to skyrocket, rising 53% from 2014 to 2024.[6] Exacerbating this problem is the expiration of the enhanced premium tax credits (EPTCs) on Dec. 31, 2025. This poses a serious threat to academic health systems and the patients and communities they serve, as steep premium hikes will result in millions of Americans having to forgo insurance. This potential increase in the uninsured rate is expected to further compound hospitals' uncompensated care burden, exacerbating the financial pressures already facing academic health systems and teaching hospitals.

High premiums, administrative hurdles, and convoluted plan designs make it harder for patients to access care. When care is delayed or denied, the costs of treatment ultimately go up. The largest plans in the US continue to point at hospital prices as the primary driver of costs of care, but fail to consider their own emphasis on implementing policies that return maximum value to their shareholders. For AAMC member institutions, their focus is on caring for their patients and communities.

The AAMC recognizes that our health care system is complex and that cost drivers are multifaceted. We appreciate your willingness to investigate key drivers of health care costs and develop policy solutions. As you seek to address the rising costs of care, we ask that you consider the following:

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[4] AAMC analysis of FY2022 Hospital Cost Reporting Information System (HCRIS) released in July 2024. AAMC membership data, September 2024.
[5] Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care.
[6] https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#b80a5be7-6ddd-4d81-b9af-3126336155ca

Address the Overuse and Misuse of Prior Authorization

Prior authorization is a utilization management tactic deployed by insurers to determine whether a given service or item will be covered. While prior authorization is used across all types of coverage, its use in the Medicare Advantage (MA) program has become increasingly burdensome and has drawn widespread concern for its overuse and potential misuse. Medicare beneficiaries have historically experienced limited prior authorization in traditional Medicare. However, MA enrollees face frequent denials, often for medically necessary care. In 2023 alone, more than 50 million prior authorization requests were submitted to MA plans, and although only 11.7% were appealed, 81.7% of those appeals resulted in a full or partial overturn, suggesting the original denials were often unjustified.[7] Some MA plans deny large volumes of claims, often using automated algorithms or artificial intelligence, only to reverse them later upon appeal.

The impact on patients is profound. They must navigate complex appeals processes and delays that can lead to personal financial challenges, worsened outcomes, or, in the most tragic cases, death while awaiting approval for necessary treatment. The burden also extends to physicians, who must "re-prove" the medical necessity of care they have already determined appropriate. Academic health systems, teaching hospitals, and faculty physicians report that they face immense administrative burdens and extended delays in securing prior authorization approvals and payments. Often, they must employ teams of staff specifically to manage prior authorization and denials, adding significant, wasteful costs to the system and effectively siphoning funds that could be used to support their mission-related work. Even MA plans have recognized the broken and burdensome prior authorization process, as evidenced by their recent pledge to "streamline, simplify, and reduce prior authorization."[8] Ultimately, patients may develop distrust of the health care system as they struggle with obstacles to receiving their medically necessary care. The AAMC believes that addressing issues with the prior authorization process will benefit patients and strengthen our health care system.

The AAMC has long supported efforts to reform MA prior authorization practices, including the bipartisan Improving Seniors' Timely Access to Care Act of 2025 (H.R. 3514/S. 1816). We also applaud the Centers for Medicare and Medicaid Services (CMS) for advancing deeply needed regulatory requirements that reflect many bipartisan aspects of that legislation. We urge Congress to support further reforms that limit inappropriate denials, prohibit algorithmic overreach, and center the process around clinical judgment and patient health. These protections will become increasingly important as CMS implements the Wasteful and Inappropriate Service Reduction (WISeR) model, which will implement prior authorization in traditional Medicare in six pilot states.

We also support including Level 1 denial rates in MA Star Ratings to give beneficiaries and policymakers a clearer picture of how often MA plans reverse their own decisions, which will elucidate the reliability of initial determinations.

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[7] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023
[8] Health Plans Take Action to Simplify Prior Authorization, June 23, 2025.

Create a Prompt Pay Standard in MA

AAMC member academic health systems and teaching hospitals consistently report that they frequently face delayed payments from insurers, particularly in the MA program. While hospitals provide services as quickly as possible to patients, insurers routinely drag out the process of payment when possible. According to an American Hospital Association survey, 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old, amounting to more than $6.4 billion in delayed or denied claims that were more than six months old.[9] While insurers reap the interest off of holding on to patients' premium dollars, hospitals are left with services rendered and unpaid, which imposes further financial burden on hospitals already operating on thin margins, and could ultimately result in reductions in patients' access to care.

The AAMC supports the Medicare Advantage Prompt Pay Act (H.R. 5454/S. 2879), which would apply a federal standard to promptly pay claims. The legislation would impose clear and enforceable prompt payment standards on MA plans. Specifically, plans would be required to reimburse no less than 95 percent of "clean claims," as defined in the bill, within 14 days for services provided by in-network clinicians and within 30 days for out-of-network care. The bill would also strengthen oversight by authorizing civil monetary penalties for plans that fail to meet these timelines and by mandating public reporting of compliance metrics, including data on timely claims payment.

Expand Transparency and Oversight of MA Data

As MA now covers over half of Medicare beneficiaries, Congress must ensure that the same level of data transparency and access available in traditional Medicare applies to MA. Currently, MA encounter data is incomplete, lacks payment details, and its availability is often delayed. Researchers, regulators, and stakeholders cannot fully evaluate MA plan performance without robust, real-time data.

To ensure transparency and optimal data analysis, the AAMC recommends that Congress urge CMS to:

- Publish standardized encounter data, including cost and payment information;
- Expand access to Limited Data Sets (LDS) for researchers, not just Research Identifiable Files (RIFs);
- Collect and report granular prior authorization metrics, including denial rates, timeliness, service categories, and outcomes;
- Require public reporting on the use of algorithms and AI in utilization management, including how these tools are used, what data they are trained on, and whether they result in disparities or adverse outcomes.

[9] https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf

Reject Cuts to Hospital Outpatient Departments
As you seek to reduce costs in the health care system, we strongly urge you to reject permanent so-called "site-neutral" Medicare payment cuts to off-campus outpatient departments, which would disproportionately impact teaching hospitals, including those serving rural and other medically underserved communities. Although teaching hospitals represent only 5% of U.S. hospitals, we estimate they would be responsible for nearly half of the payment cuts associated with a variety of site-neutral proposals. These facilities treat patients with significantly higher clinical and social complexity than physician offices or ambulatory surgical centers and must meet enhanced licensing, regulatory, and accreditation standards. Policies that ignore these differences will limit patient access to life-saving outpatient drug administration and other critical services, especially for Medicare beneficiaries who rely on hospital-based care.

Protect Access to Specialty and Subspecialty Care
Many AAMC academic health systems and teaching hospitals have reported being excluded from plan networks, which limits patients' access to specialized, complex care. Insurers are increasingly relying on narrow networks to meet network adequacy requirements, which is harmful to high-need patients and those in rural and underserved areas. Congress should ensure reimbursement policies support both in-network and out-of-network access to care and prevent financial disincentives that undermine provider participation.

Additionally, plans are increasingly offering high-deductible health plans, which have shown to be confusing and inadequate for patients who have difficulty understanding their cost-sharing obligations under the convoluted plan design. Patients will seek care from an in-network provider and receive a high medical bill, often believing that they have received a "surprise" bill, when in fact, their cost-sharing obligation is astronomical and unaffordable. The threat of these high bills is enough for patients to avoid seeking treatment, sometimes until it is too late and even more expensive. The AAMC urges you to ensure that plans provide adequate coverage and that cost savings do not come at the expense of losing access to comprehensive, affordable care.

Investigate Insurer Consolidation and Its Effect on Patient Access, Quality, and Costs
In recent years, there has been a significant increase in insurer consolidation, which can lead to the exercise of market power, harming consumers and providers. A recent study found that 73% of the MSA-level markets were considered highly concentrated according to federal guidelines, 90% of MSA-level markets had at least one insurer with a commercial share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.[10] Another recent study showed that the top three large-group insurers hold an average of 82.2% of the market share in each state.[11] Mergers and acquisitions involving health insurers raise antitrust concerns. With so much market share, insurers have the ability to increase health insurance premiums above competitive

[10] American Medical Association. Competition in health insurance: A comprehensive study of U.S. markets, 2023. (amaassn.org). https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.
[11] Association of American Medical Colleges Research and Action Institute. Why Market Power Matters for Patients, Insurers, and Hospitals (May 1, 2024). https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-marketpower-matters.

levels. In addition, it enables them to reduce reimbursement rates to physicians, hospitals, and other providers below competitive levels, ultimately harming consumers.[12] This lower reimbursement may result in a reduction in the type of services offered by physician practices and hospitals, or even closure.

In addition to insurer-to-insurer horizontal consolidation, increasingly, insurers have been vertically integrating with pharmacies and pharmacy benefit managers (PBMs), which leads to anticompetitive practices. Four PBMs, all of which are owned by major insurers, make up 70 percent of the PBM market share.[13] One key function of PBMs is to negotiate discounts with drug manufacturers to reduce the costs for payers and consumers. Having the plan, the PBM, and the pharmacy consolidated under one entity may raise health spending by driving patients to use higher-priced drugs in exchange for discounts from the drug manufacturers and preferred placement on the plan's formulary. Additionally, PBMs and payers often will steer patients to their own pharmacies in their network, which in turn limits patient access and could lead to higher out-of-pocket costs.[14] These networks often exclude hospital-operated retail and specialty pharmacies, restricting the ability of patients to have their prescriptions filled at convenient and accessible locations. The AAMC urges you to investigate insurer consolidation and its impact on patient access, quality, and costs.

Improve Oversight of Supplemental Benefits and Plan Marketing
The AAMC recognizes that supplemental benefits in MA can play an important role in meeting social and clinical needs. However, plans must be accountable for how they administer and advertise these benefits. We urge Congress to support CMS efforts to:

- Ensure that Special Supplemental Benefits for the Chronically Ill (SSBCI) are evidence-based and equitably distributed;
- Improve transparency and limit misleading marketing practices by brokers;
- Monitor and enforce compliance with mid-year benefit notifications and access standards.

Strengthen Quality Measurement and Equity Standards in MA
Finally, Congress should ensure that MA quality reporting is comprehensive and timely. This includes expanding CMS authority to assess and report quality measures across all MA populations, not just those used for Star Ratings.

We appreciate the opportunity to offer our perspective and look forward to working with the Subcommittee as it considers policies that affect the nation's health care system, medical education, and public health. For further questions, please contact Ally Perleoni, AAMC director, government relations at aperleoni@aamc.org.

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[12] Id.
[13] Guardado, Jose R. American Medical Association. Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf
[14] Kakani P, et al. Use of and Steering to Pharmacies Owned by Insurers and Pharmacy Benefit Managers in Medicare. JAMA Health Forum. 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC11724340/.

January 7, 2026

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson and Leader Jeffries:

AARP, which advocates for 125 million Americans age 50 and older, urges Congress to immediately pass the three-year extension of tax credits to reverse the massive price hike in health insurance premiums that is putting health care out of reach for too many older Americans. Last week, due to Congressional inaction, millions of older Americans saw their health insurance costs skyrocket, with some people being asked to pay more than 30% of their income for health care. Nobody can afford that. We appreciate the bipartisan efforts that have gone into moving this legislation to the floor, and we urge its immediate adoption.

Nearly 5 million Americans aged 50-64 get their health care through the Marketplaces. Americans in this age group face the greatest pressures in health care: they have more health care needs but are not yet eligible for Medicare. Due to federal age rating rules, insurance premiums for this age group are already *three times higher* than those of younger people. Older Americans are the individuals hit hardest by today's higher premiums.

AARP recently highlighted some of the Americans who are impacted, including small business owners whose health care is in jeopardy. They are not wealthy people – without the enhanced premium tax credits that expired at the end of 2025, a couple with a household income of just $85,000 is now completely ineligible for help in paying for their health coverage.

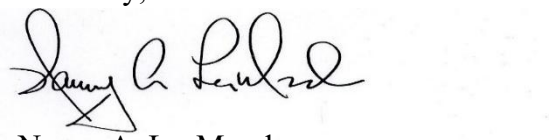
Without the additional help that Congress allowed to expire last week, the sticker shock consumers are facing is drastic. For example, a 60-year-old couple earning an annual household income of approximately $85,600 (just above 400% FPL) is now facing these types of premium increases on top of what they were already paying:

- Texas- Annual premiums increase by **$26,757, or 31% of their income**
- Idaho- Annual premiums increase by **$17,754, or 21% of their income**
- Oregon- Annual premiums increase by **$19,843**, **or 23% of their income**
- South Dakota- Annual premiums increase by **$25,382**, **or 30% of their income**
- Florida- Annual premiums increase by **$27,613, or 32% of their income**

Americans simply cannot handle those kinds of increases, especially at a time when family budgets are stretched thin. We urge Congress to pass the three-year extension of these supports.

If you have any questions, please feel free to contact me or have your staff contact Brendan Rose on our Government Affairs team at brose@aarp.org.

Sincerely,



Nancy A. LeaMond
Executive Vice President and
Chief Advocacy & Engagement Officer

KFF The independent source for health policy research, polling, and news.

ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire

Authors: Justin Lo, Larry Levitt, Jared Ortaliza, and Cynthia Cox

Published: Sep 30, 2025

Affordable Care Act (ACA) enhanced premium tax credits are set to expire at the end of this year. Enhanced premium tax credits were introduced in 2021 and later extended through the end of 2025 by the Inflation Reduction Act. The enhanced tax credits both increased the amount of financial assistance already eligible ACA Marketplace enrollees received as well as made middle-income enrollees with income above 400% of federal poverty guidelines newly eligible for premium tax credits.

Since the introduction of the enhanced premium tax credits, enrollment in the Marketplace has more than doubled from about 11 to over 24 million people, the vast majority of whom receive an enhanced premium tax credit. If enhanced tax credits expire, many Marketplace enrollees will continue to qualify for a smaller tax credit, while others will lose eligibility altogether and be hit by a “double whammy” of losing their entire tax credit and being on the hook for rising premiums.

Since 2014, the ACA has capped how much subsidized enrollees pay for their health insurance premiums at a certain percent of their income, on a sliding scale, with the

federal government covering the remainder in the form of a tax credit. Enhanced tax credits work by further lowering the share of income ACA Marketplace enrollees pay for a plan. For example, with the enhanced tax credits in place, an individual making $28,000 will pay no more than around 1% ($325) of their annual income towards a benchmark plan. If the enhanced tax credits expire, this same individual would pay nearly 6% of their income ($1,562 annually) towards a benchmark plan in 2026. In other words, if the enhanced tax credits expire, this individual would experience an increase of $1,238 in their annual premium payments net of the tax credit.

Table 1

ACA Marketplace Enrollees Will Pay More for Benchmark Coverage if Enhanced Tax Credits Expire

Required Contribution Percentages With and Without Enhanced Tax Credits for an Individual

Individual | Family of Four

Household income	Premium Payment, % of income (annual amount) — Enhanced Tax Credits	2026 Tax Credits	Annual Dollar Increase
$18,000 (115% FPL)	0% ($0)	2.1% ($378)	$378
$22,000 (141% FPL)	0% ($0)	3.6% ($794)	$794
$28,000 (179% FPL)	1.2% ($325)	5.6% ($1,562)	$1,238
$35,000 (224% FPL)	3% ($1,033)	7.5% ($2,615)	$1,582
$45,000 (288% FPL)	5.5% ($2,475)	9.6% ($4,311)	$1,836
$55,000 (351% FPL)	7.3% ($4,010)	10% ($5,478)	$1,469
$65,000 (415% FPL)	8.5% ($5,525)	No tax credit	Varies

Note: FPL stands for Federal Poverty Level. Required contribution percentages refer to the maximum share of income ACA Marketplace enrollees are required to pay for a benchmark plan. The "2026 Tax Credits" scenario represents the required contribution percentages that

plan. The "benchmark" scenario represents the required contribution percentage that will be in place for 2026 if enhanced tax credits are not renewed. Premium increases will vary for enrollees with incomes over 400% of poverty based on family size, age, and location.

Source: KFF analysis of 26 CFR § 601.105 Rev Proc 2023-29 and Rev Proc 2025-25

KFF

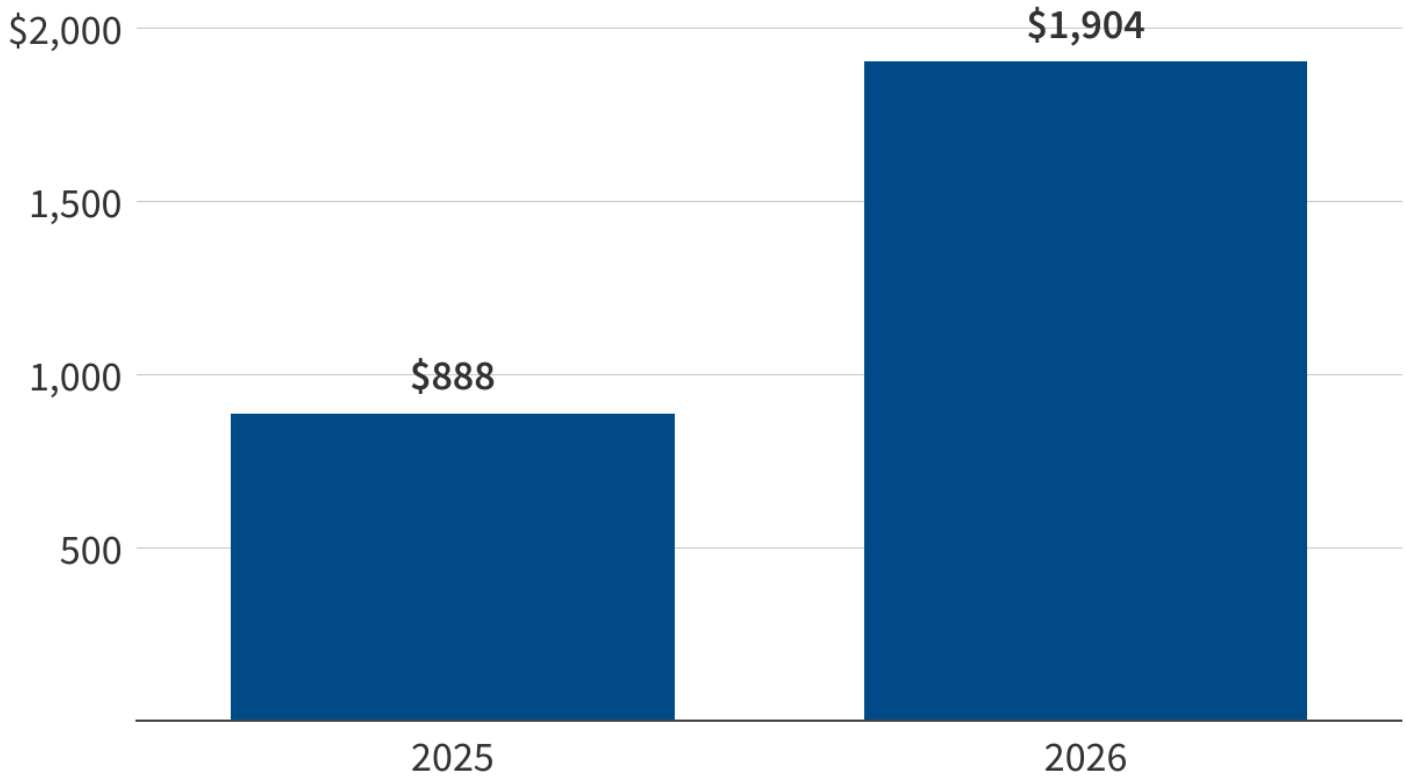
A previous KFF analysis, based on data released by the federal government, showed the enhanced premium tax credits saved subsidized enrollees an average of $705 annually in 2024, bringing their annual premium payment down to $888. Without the enhanced premium tax credits, annual premium payments in 2024 would have averaged $1,593 (over 75% higher than the actual $888). More recent data have not been released.

Based on the earlier federal data and more recent other publicly available information, KFF now estimates that, if Congress extends enhanced premium tax credits, subsidized enrollees would save $1,016 in premium payments over the year in 2026 on average. In other words, expiration of the enhanced premium tax credits is estimated to more than double what subsidized enrollees currently pay annually for premiums—a 114% increase from an average of $888 in 2025 to $1,904 in 2026. (The average premium payment net of tax credits among subsidized enrollees held steady at $888 annually in 2024 and 2025 due to the enhanced premium tax credits).

Figure 1

Premium Payments in 2026 Will More than Double if ACA Enhanced Premium Tax Credits Expire

Annual Out-of-Pocket Premium Payments for Affordable Care Act Marketplace Enrollees, 2025 and 2026



Note: The average premium payment is among people currently receiving a tax credit in 2025. The 2026 average premium payment assumes gross premiums increase of 18% for those who lose tax credit eligibility.

Source: KFF analysis of 2024 and 2025 Open Enrollment Period State-Level Public Use File and 2024 Open Enrollment Report

KFF

The increase in premium payments with expiration of the enhanced premium tax credits is even higher than previously estimated for two reasons:

- Trump administration changes to tax credit calculations, and
- Rising 2026 premiums.

The Trump administration made changes to the way tax credits are calculated, which were finalized in the ACA Marketplace Integrity and Affordability rule. The required contribution levels that will be in place for 2026 if the enhanced tax credits are not renewed will be higher relative to the required contribution levels calculated under the original methodology based on rules in effect at the time. This means that enrollees are expected to pay a higher share of their income towards a benchmark premium plan in 2026 than they otherwise would have. Additionally, inflation in private insurance premiums has led to higher premium contribution levels than previously expected.

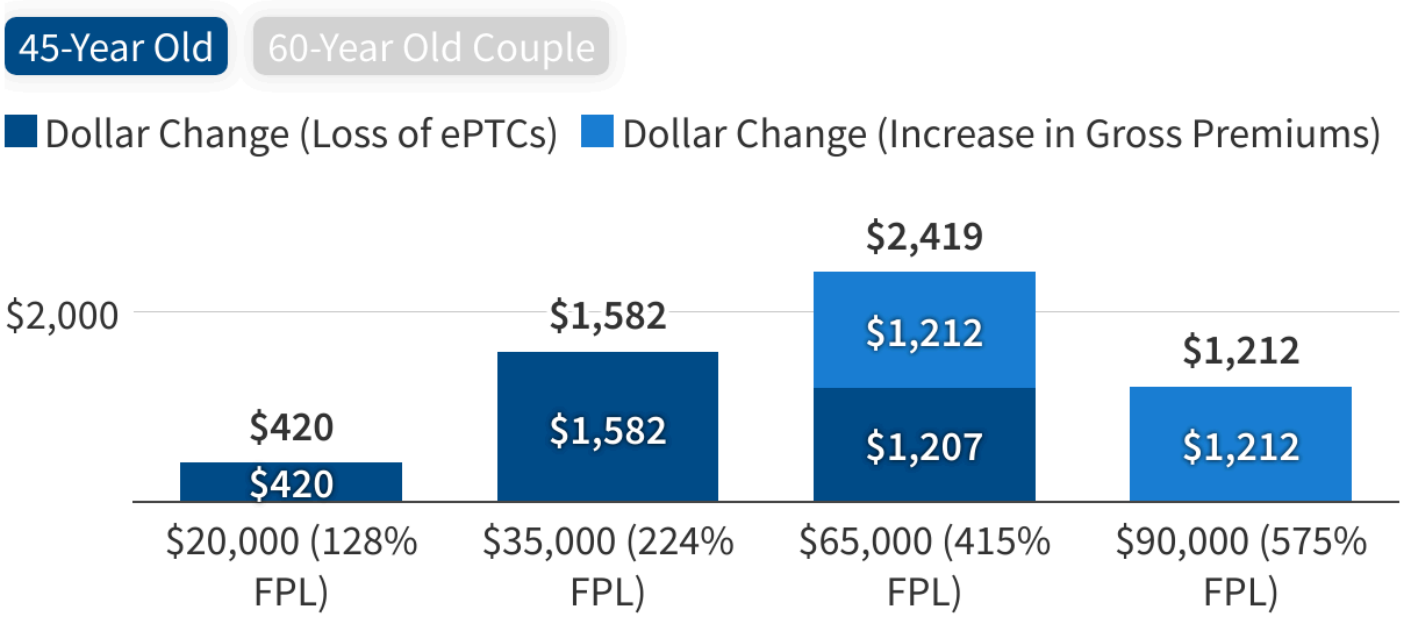
Additionally, insurers in the ACA Marketplace are proposing to raise their rates by a median of 18%. Fueled by rising health care costs and the expiration of the enhanced premium tax credits, insurers are proposing the largest rate increases in 2026 since 2018, the last time uncertainty over federal policy changes contributed to sharp premium increases. As premiums increase, the enhanced tax credits provide additional savings to enrollees that receive them. This means that middle-income enrollees, whose payment for a benchmark plan is currently capped at 8.5% of their income and will lose financial assistance altogether, will have to cover the cost of premium increases in addition to the amount their tax credits would have previously covered to keep their same plan.

Enrollees across the income spectrum can expect big increases in premium payments

Figure 2

Annual Premium Payments Would Increase for Subsidized Enrollees by an Average of $1,016 (114%) if Enhanced Premium Tax Credits Expire

Dollar Change in Average Annual Premium Payment for Benchmark Silver Plan if Enhanced Premium Tax Credits Expire, 45-Year Old



Note: 2025 poverty guidelines that will be in place for the 2026 plan year were used to calculate required contributions. 2025 national average benchmark silver premium for a 45-year old was used for this analysis. Required contribution levels for 2026 were used to calculate premium payments for the expiration scenario. Scenarios account for premiums growing by an average of 18% in 2026.
*The required contribution for a 45-year old making $90,000 is greater than the cost of the benchmark silver plan; they are ineligible for subsidies under the Inflation Reduction Act.
Source: KFF analysis

KFF

Enrollees with incomes above 400% of poverty will be subject to large increases in premium payments if enhanced premium tax credits expire. On average, a 60-year-old couple making $85,000 (or 402% FPL) would see yearly premium payments rise by over $22,600 in 2026, after accounting for an annual premium increase of 18%. This would bring the cost of a benchmark plan to about a quarter of this couple's annual income, up from 8.5%. Meanwhile, a 45-year-old earning $20,000 (or 128%

FPL) in a non-Medicaid expansion state would see their premium payments for a benchmark plan rise from $0 to $420 per year, on average, from the loss of enhanced premium tax credits. About half (45%) of ACA Marketplace enrollees have incomes between 100-150% of poverty, about a fourth (28%) have incomes between 150-250% of poverty, and roughly 1 in 10 have incomes above 400% of poverty.

Methods

The average savings by income group for 2024 were taken from the 2024 Open Enrollment report. The average yearly premium savings from enhanced premium tax credits (ePTC) for enrollees under 400% FPL were defined as the sum of the differences between the required contribution amounts with and without ePTC, using the estimated percent of plan selections with ePTC by income category and assuming a uniform income distribution within each category. To extrapolate to 2026, income was inflated by the ratio of the 2025 federal poverty guidelines to the 2023 federal poverty guidelines for an individual in the continental US. For each income category, the savings were assumed to grow as the ratio of the savings between 2026 and 2024. Due to a provision in the reconciliation bill related to subsidized ACA Marketplace eligibility for immigrants, no enrollees under 100% FPL are assumed to receive premium tax credits in 2026 and are thus not included in the calculation of average savings. For enrollees at or above 400% FPL, savings were defined as difference between the average unsubsidized premium and 8.5% of the average individual income, the required contribution under the enhanced tax credits for enrollees in this income category. For 2026, the average unsubsidized premium was assumed to be 18% higher than the 2025 average unsubsidized premium, based on analysis of rate filings. Calculations assume that there are no changes in plan selection, family composition, income relative to FPL, and geography between 2024 and 2026. The annual premium payment for 2026 comprises the estimated savings from enhanced tax credits in 2026 and the average premium payment among subsidized enrollees in 2025 obtained from the 2025 Open Enrollment State-Level Public Use File. State-funded subsidies might offset some increases of premiums but are not accounted for in the estimation. Numbers from the Open Enrollment report for estimated consumer APTC savings due to the ARP and IRA by income category (Table 8) were reported as whole numbers; a Monte Carlo method was

used to account for this rounding, keeping all observations that rounded to the grand mean listed in the report.

ACAP
Association for Community Affiliated Plans

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Leanne Berge, Chair | Margaret A. Murray, Chief Executive Officer

Statement by Margaret A. Murray, CEO, ACAP

January 22, 2026

Committee on Energy and Commerce Health Subcommittee Hearing: Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

and

Committee on Ways and Means: Full Committee Hearing with Health Insurance CEOs

Dear Chairman Guthrie and Chairman Smith; Ranking Member Pallone and Ranking Member Neal; Chairman Griffith and Ranking Member DeGette; Chaiman Buchanan and Ranking member Doggett; and Members of the Committees:

The Association for Community Affiliated Plans (ACAP) respectfully submits the following statement for the record in response to the Committee on Energy and Commerce Health Subcommittee hearing titled Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability and the Committee on Ways and Means' Full Committee Hearing with Health Insurance CEOs.

ACAP is a national trade association representing 90 not-for-profit Safety Net Health Plans. Our member plans provide coverage to more than 30 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and the ACA Marketplaces.

Summary of ACAP's Statement

While we elaborate on these positions in greater detail in this letter, we include a summary of our remarks in this section. ACAP is in strong agreement with the Committee that health care affordability is a real and perennial concern for patients, states, and federal health programs.

ACAP plans are acutely aware of the integral role managed care plays in health care affordability. Patients are best served when programs reward quality and savings, and Safety Net Health Plans are united in their mission to strengthen the safety net and the programs they serve.

Through strong integration with local provider networks, mission orientation, and local focus, ACAP members consistently contain costs, promote quality, incentivize high value care, and support the smooth functioning of the clinical safety net. They also spend a larger part of their premium dollars on clinical care and system improvements and consistently score among the highest in the nation on quality.

Medicaid, Medicare, and health insurance Marketplaces protect families from surging medical costs and unexpected financial shocks. A key goal for expanding Medicaid was to make health coverage affordable for working people with low incomes – **the Medicaid**

expansion is associated with increases in coverage, decreases in unpaid medical bills,[1] and an increase in access to high-value preventive care.[2] And it is well-documented that enhanced premium tax credits (ePTCs) enabled workers and families who lacked access to affordable, employer-sponsored coverage to purchase private insurance coverage. The ePTCs ensured that no consumer paid more than 8.5%[3] of their income for their health insurance premiums. **Without ePTCs, many consumers, faced with higher net premiums, will be forced to drop coverage.**

As consumers confront price growth and a changing health system, it is crucial that these vital programs be protected and strengthened to in turn protect the health and finances of American families.

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[1] Hu L., Kaestner R., Mazumder B., Miller S., Wong A. **The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing.** *Journal of Public Economics* **163** (May 7 2018): 99–112. https://www ncbi nlm nih.gov/pmc/articles/PMC6208351/

[2] Antonisse L., Garfield R., Rudowitz R. **The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review.** *Kaiser Family Foundation*, Mar 17 2020. https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review

[3] KFF. **Explaining Health Care Reform: Questions About Health Insurance Subsidies**, October 2024. https://www kff.org/affordable-care-act/explaining-health-care-reform-questions-about-health-insurance-subsidies/

Not-for-profit, Community-based Safety Net Health Plans (SNHPs) Play a Key Role in the Affordability of Public Health Programs

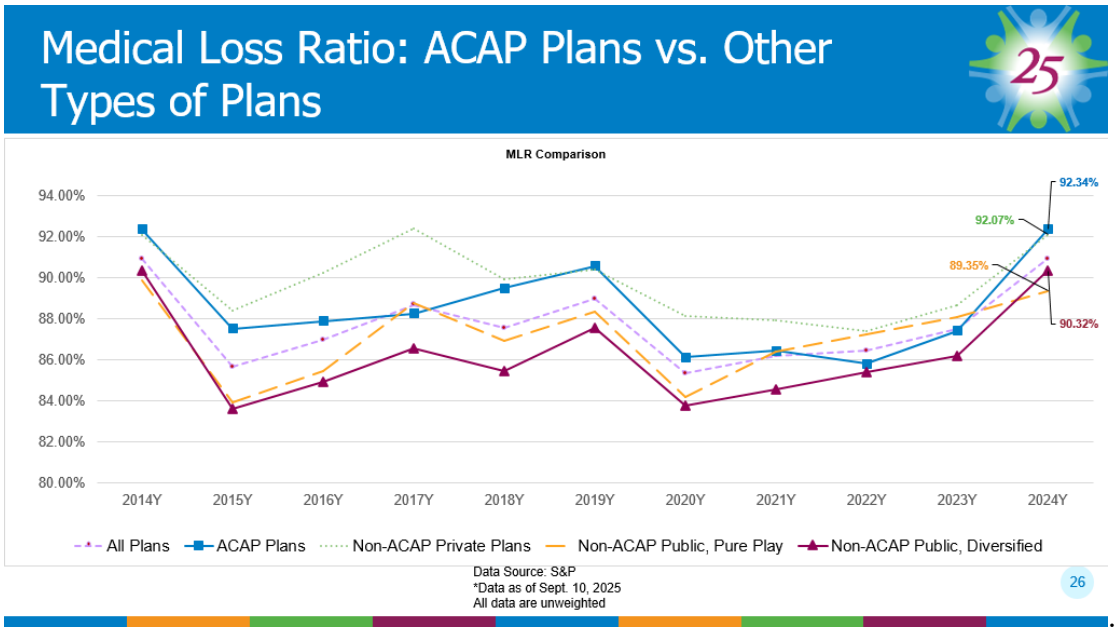
Not-for-profit Safety Net Health Plans (SNHPs) share a mission to provide high-quality health care to people with low incomes and complex health care needs. These plans steadfastly support the Medicaid program, as well as Medicare and the health insurance Marketplaces, during good times and bad. In contrast, for-profit plans tend to enter and exit state Medicaid and other markets based on economic trends.

Safety Net Health Plans Deliver High Value and Low Costs

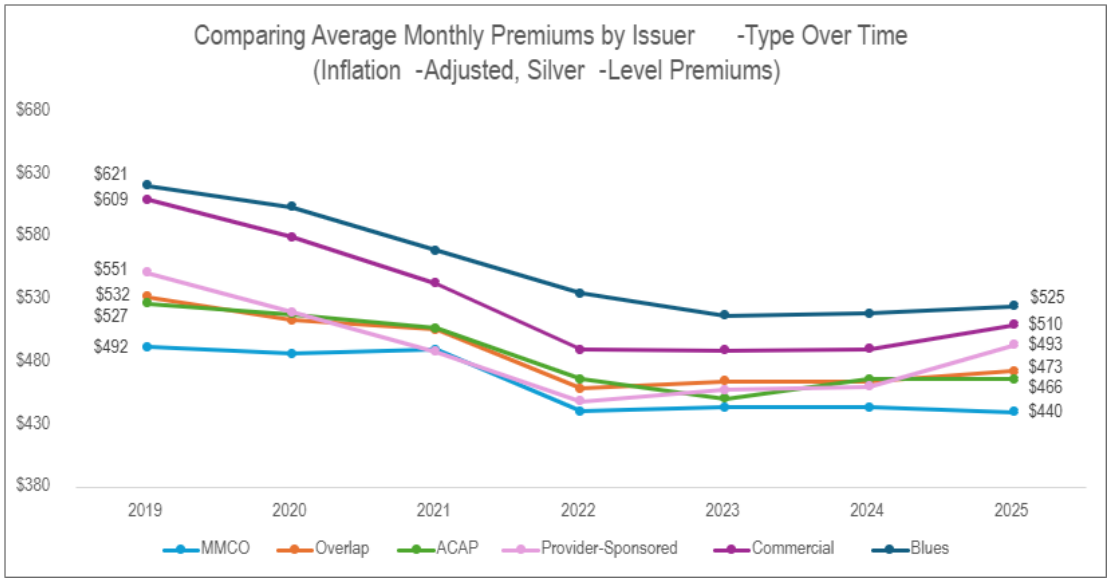
ACAP plans offer high value in Medicaid managed care. According to ACAP's analysis of NCQA Quality Compass data, on average, ACAP-member plans outperform other national-level plans on a majority of health quality indicators.

SNHPs also offer better value for beneficiaries and states than other Medicaid health plans, consistently spending a higher share of premium dollars on medical care than other types of managed care plans. (See the line chart below or here showing 10 years of medical loss ratios (MLR) across different categories of Medicaid health plans. The blue line represents **ACAP plans, which had an aggregate 92.4 percent MLR in 2024.**) This pattern also holds in the Marketplace. In 2024, only 3 percent of ACAP plans owed MLR rebates in the individual market, compared with a quarter of non-ACAP plans.[4,5]

[4] **Issuers Owing Rebates for 2024**, September 2025. https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources
[5] **HIX Compare Datasets 2014-2026**, 2025. https://hix-compare.org/



Additionally, **SNHPs consistently offer some of the lowest premiums in the Marketplaces**. See the line chart below, in which ACAP plans are green, which illustrates that ACAP plans, and Medicaid-focused plans in general, have consistently offered consumers among the most affordable premiums for silver-level coverage. The data come from an ACAP analysis of RWJF's HIX Compare datasets and are adjusted for inflation.



Safety Net Health Plans have a unique mission and expertise in delivering high-quality health care services to low-income individuals and vulnerable populations, regardless of whether

they are Medicaid or Marketplace enrollees. Many Marketplace enrollees share characteristics with low-income enrollees in Medicaid, and some families experience "split eligibility," with children covered in Medicaid and CHIP and parents in Marketplace coverage. **"Overlap plans" that offer both Medicaid Managed Care and Marketplace coverage often charge lower premiums, driving down premiums in counties where they operate**, as well as reducing the most harmful effects of "churn" by providing same-plan continuity between Medicaid and the individual market.[6] In 2025, in 86 percent of rating areas with an overlap plan operating in both Medicaid and the Marketplace, that overlap plan offered either the lowest or second-lowest silver-level premium for a 27-year-old.[7]

Additionally, ACAP plans deliver high-quality, integrated coverage for individuals who receive coverage through multiple programs. More than 12 million people who have Medicare coverage are also enrolled in Medicaid. These "dual eligibles" are more likely to live with multiple chronic conditions and need care coordination to maintain their health and independence. More than 40 SNHPs serve dual eligibles through Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs). Safety Net Health Plans play a pivotal role in the D-SNP program, particularly in the integrated D-SNP market. Close to 40 percent of all Medicare beneficiaries enrolled in a fully integrated D-SNP (FIDE SNP) are enrolled in a Safety Net Health Plan. ACAP supports the long-term sustainability of the D-SNP program for dual eligibles.

With an average MLR of 96 percent, ACAP's Safety Net Health Plan D-SNP members direct more dollars to medical care and less to overhead than do non-ACAP D-SNPs.

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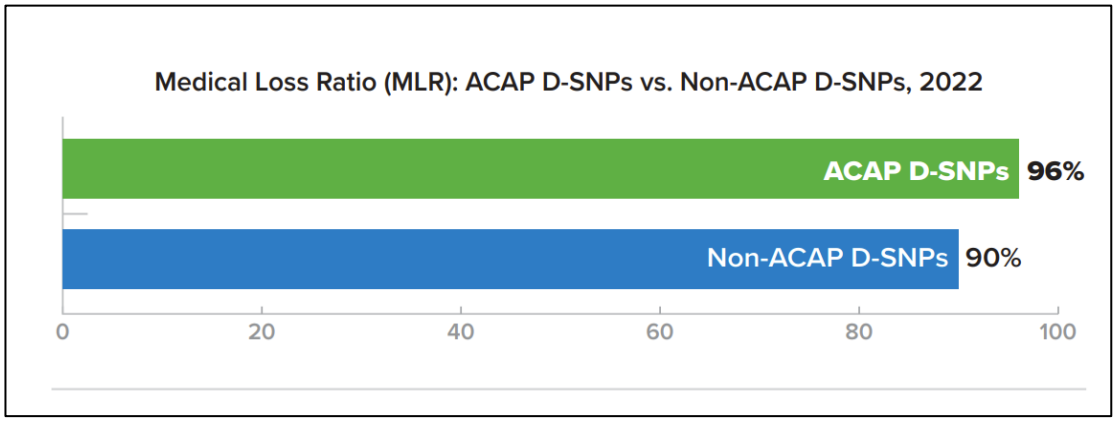
[6] Hempstead, K and Seirup, J. *Overlap Plans Could Become An Important Option To Promote Continuity Of Care And Contain Health Care Costs During A Recession.* Health Affairs Blog, May 2020. https://www healthaffairs.org/do/10.1377/hblog20200511.314433/full/

[7] HIX Compare Datasets 2014-2026, 2025. https://hix-compare.org/



Local Focus

ACAP plans are a crucial part of the competitive landscape for managed care. SNHPs are overwhelmingly small, regional nonprofits that serve as an important counterweight to centralized, consolidated national plans which tend to be for-profit, shareholder-focused and may exit and enter markets depending on profitability. Consolidation among Medicaid managed care plans is increasing.[8,9]

Many community plans are provider- or county-owned, and function in coordination with the wider safety net provider ecosystem in their communities by lowering abrasion and promoting efficiency.

Program Stewardship

This focus on efficiency is evident in the way SNHPs function. **Research has found not-for-profit plans such as Safety Net Health Plans are significantly more likely to perform at a higher level than for-profit health plans on measures of preventive care.**[10]

Further, SNHPs promote timely primary and preventive care services and work with primary care providers to ensure that preventive services are available and used by members. This

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[8] Monson M., Bella M. **Supplier Concentration In Medicaid Managed Care: A Cause For Concern.** *Health Affairs Forefront*, January 29, 2025. https://www.healthaffairs.org/content/forefront/supplier-concentration-medicaid-managed-care-cause-concern

[9] Li B., Layton T.J. **Medicaid Managed Care: Substantial Shifts In Market Landscape And Acquisitions, 2006–20.** *Health Affairs* **44, no. 7** (July 2025): 862-868. https://www healthaffairs.org/doi/full/10.1377/hlthaff.2024.01111

[10] McCue M., Bailit M. *Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide.* The Commonwealth Fund, June 2011. http://tinyurl.com/hts7g9d

helps to avoid inappropriate, costly visits to the emergency room. Few, if any, fee-for-service programs provide such needed care coordination.

This focus on appropriate and timely care extends to plans' careful stewardship of public funds. SNHPs work extensively to identify and prevent potential fraud, waste and abuse (FWA) in every market they serve. In Medicaid, this takes many forms, from early identification of possible FWA in applied behavioral analysis services, and reporting to state agencies, to creation of novel audit processes that reduce waste and ensure the most appropriate use of federal and state dollars. ACAP welcomes statutory changes in H.R. 1 to improve state coordination and data fidelity – ensuring prevention of any capitation payments for deceased enrollees and up-to-date provider enrollment information.

Within the Marketplace, the vast majority of ACAP plans have not reported issues with fraud, waste, and abuse, although some saw evidence of unauthorized plan switching during 2024. In response, CMS introduced new processes to limit unauthorized plan switching, and both H.R. 1 and the Marketplace Integrity and Affordability Rule have also introduced measures expected to further reduce improper enrollment, including annual income verification before receiving tax credits, eliminating income-based Special Enrollment Periods, preventing tax credits for individuals who have not filed their taxes and reconciled in the previous year, and reducing the standard of evidence for agents to a "preponderance of evidence."

Medicaid, Marketplaces Protect Consumers' Health and Finances

Medicaid

A key goal for expanding coverage in the Medicaid program was to put affordable coverage within reach for working people with low incomes – the evidence is overwhelming that Medicaid expansion has been a success in that regard.

Health policy researchers consistently find **that Medicaid expansion is associated with increases in coverage, decreases in unpaid medical bills,[11] and an increase in access to high-value preventive care**.[12]

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[11] Hu L., Kaestner R., Mazumder B., Miller S., Wong A. **The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing.** *Journal of Public Economics* **163** (May 7 2018): 99–112. https://www ncbi nlm nih.gov/pmc/articles/PMC6208351/

[12] Antonisse L., Garfield R., Rudowitz R. **The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review.** *Kaiser Family Foundation*, Mar 17 2020. https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review

These benefits have not just accrued to Americans' pocketbooks, but to their health and well-being. **Medicaid expansions "reduced the mortality of the low-income adult population by 2.5 percent,**" according to a recent working paper published in the National Bureau of Economic Research.[13]

ACAP has concerns that the new cost-sharing requirement for Medicaid expansion enrollees in H.R. 1 that require states to impose copayments of up to $35 for many services, with a familywide out-of-pocket maximum of up to 5 percent of a family's income, will reduce health care affordability for many families and will pose a significant monetary burden for individuals on the financial margins. Similarly, we are worried that community engagement requirements threaten to separate millions from health coverage and disrupt the health care ecosystem more broadly.[14]

Marketplace

Open Enrollment ended January 15th without an extension of the enhanced premium tax credits (ePTCs), resulting in a doubling of average net premiums.[15] It is well-documented that ePTCs enabled workers and families who lacked access to affordable, employer-sponsored coverage to purchase private insurance coverage. The ePTCs ensured that no consumer paid more than 8.5 percent of their income for their health insurance premiums.[16] Without ePTCs, many consumers, faced with higher net premiums, were forced to drop coverage.

Early 2026 enrollment is already reflecting the affordability cliff. In 2025, the individual market saw record enrollment numbers of 24.2 million, which had included nearly 4 million new consumers, many of whom churned from Medicaid after redeterminations resumed.

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[13] Wyse A., Meyer B.D. **Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults.** *NBER Working Paper* No. 33719 (May 2025). https://www nber.org/papers/w33719

[14] Congressional Budget Office. **Supplemental Cost Estimate: Medicaid Provisions of Public Law 119-21.** *Congressional Budget Office*, Oct 2025. https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%20_0.pdf

[15] Justin Lo et al. **ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire.** *KFF*, September 2025. https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/

[16] KFF. **Explaining Health Care Reform: Questions About Health Insurance Subsidies**, October 2024. https://www kff.org/affordable-care-act/explaining-health-care-reform-questions-about-health-insurance-subsidies/

Meanwhile, CMS reports that 2026 plan selections are 1.5 million below the end of last year's Open Enrollment, with declines among both new and returning consumers.[17]

ACAP plans are feeling this acutely. Many reported sharp early declines in new membership, down 39, 41, 60, 75, and even 80 percent compared to last year, despite robust marketing campaigns.

Plans have also reported higher rates of active terminations, up to 30 percent above expectations. Auto-renewals remain in place until plans receive termination records mid-January. Consumers who do not pay invoices by January 31st enter a 90-day delinquency process, with terminations finalized by late March. Plans won't see full impact until then, and higher non-payment and disenrollment rates are expected to continue into 2027.

Among those maintaining coverage, plans are seeing significant shifts in metal tiers. Some described modest changes of 10 percent, while others reported increases as high as 150 percent more bronze plan enrollment as consumers buy down to lower-cost, higher-deductible options. While buying down may reduce costs for younger, healthier consumers, it will increase overall costs for most others. For further information, please see the Wakely analysis on the impacts of plan-shifting, broken down by age, health status, FPL, and residence, which shows that individuals with health care needs will actually see an increase in the total cost of their care if they buy-down to a lower tier coverage option.[18]

As premiums rise, younger and healthier individuals are the first to drop coverage, worsening the risk pool and raising costs for everyone.

Unaffordable Marketplace premiums and Medicaid disenrollment threaten to destabilize families' health care budgets and will likely force many into the financial precarity of uninsurance; with predictable increases in medical debt and uncompensated care.

Conclusion

The Medicaid, Marketplace, and Medicare programs are a vital link to affordable coverage for American families. Against a backdrop of rising health care costs and fiscal uncertainty, policies that have extended the reach and affordability of these programs should be protected. Medicaid expansion, and the extension of Marketplace ePTCs, are two policies that both

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[17] Ortaliza, Jared. **ACA Signups Are Down, But Still an Incomplete Picture.** *KFF,* January 2026. https://www kff.org/quick-take/aca-signups-are-down-but-still-an-incomplete-picture/

[18] Cohen et al. **Member Cost-Shifting Implications of Enhanced Premium Tax Credit Expiration**. *Wakely Consulting Group*, September 2025. https://communityplans.wpenginepowered.com/wp-content/uploads/2025/08/Wakely_ACAP-EPTC-Expiration-Effects_9.15-ACAP-FINAL.pdf

work toward a shared and laudable end—putting health care within reach for working Americans.

ACAP plans know the transformative effect of high-quality coverage on consumers' health and finances because they see it every day in their communities. Mission-driven Safety Net Health Plans drive affordability and quality in our nation's health care safety net and stand ready to work with Congress to develop solutions that protect these programs and the beneficiaries who are empowered by them.

ACS CAN Urges Congress to Immediately Extend the Enhanced Premium Tax Credits to Avoid a Health Care Affordability Crisis

AN ACS CAN SURVIVOR VIEWS SURVEY RELEASED LAST WEEK FOUND THAT NEARLY 3 IN 4 CANCER PATIENTS AND SURVIVORS WHO RELY ON THE MARKETPLACE FOR COMPREHENSIVE COVERAGE RISK LOSING ACCESS TO LIFESAVING CARE

December 10, 2025

WASHINGTON, D.C. – As the deadline approaches for people to enroll in Marketplace coverage that starts January 1, 2026, the American Cancer Society Cancer Action Network (ACS CAN) is urging the Senate and the House to come together in a bipartisan way to pass legislation extending the enhanced premium tax credits and work to address the health care affordability crisis. If Congress fails to pass the extension and allows the tax credits to expire on December 31, millions of people, including cancer patients and survivors, will lose their only option for affordable, comprehensive health insurance.

Lisa Lacasse, president of ACS CAN, released the following statement:

"Research clearly shows that having comprehensive health insurance is one of the most significant factors in surviving a cancer diagnosis. For two years, ACS CAN has been calling on Congress to come together to ensure the enhanced premium tax credits that made it possible for millions of people to access affordable, quality health insurance, some for the first time, remain in place. Without congressional action, the imminent expiration of the enhanced premium tax credits will push affordable health insurance out of reach for millions of people, including cancer patients and survivors.

"Last week, ACS CAN released a **Survivor Views (https://www.fightcancer.org/releases/new-survey-finds-nearly-3-4-cancer-patients-and-survivors-who-rely-marketplace)** survey that paints a dire picture of what's to come for cancer patients and survivors who rely on health care tax credits to lower their monthly premiums if Congress allows the enhanced tax credits to expire. We encourage members of Congress to consider the consequences of failing to act and to prioritize the health and wellbeing of their constituents.

"ACS CAN is once again calling on Congress to work together to extend these tax credits as quickly as possible. In most states, people must enroll in a Marketplace plan by December 15 to have coverage on January 1, 2026, so the clock is ticking to prevent a national health care affordability crisis. Without access to the health care they need to get well and stay well, people will live sicker and die sooner."

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WASHINGTON, D.C.

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DECEMBER 2, 2025

New Survey Finds Nearly 3 in 4 Cancer Patients and Survivors who Rely on the Marketplace for Comprehensive Coverage Risk Losing Access to Lifesaving Care if the Enhanced Premium Tax Credits are not Extended (/releases/new-survey-finds-nearly-3-4-cancer-patients-and-survivors-who-rely-marketplace)

The American Cancer Society Cancer Action Network (ACS CAN) today released results from a survey exploring the impact of the enhanced premium tax credits on cancer patients and survivors who rely on the Marketplace for comprehensive health insurance coverage.

Read more →

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Health Subcommittee

of the

United States House of Representatives

"Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

January 22, 2026

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — the American Hospital Association (AHA) appreciates the opportunity to share the hospital field's perspective on how to make health care more affordable for Americans with commercial insurance coverage.

America's hospitals and health systems take deep pride in the role we serve in this country, providing constant, round-the-clock care and we remain unwavering in our commitment to delivering safe and quality care to every patient, in every community. The blue and white "H" symbol is a beacon of healing, hope and health in every community nationwide.

We share the committee's concerns regarding the cost of health care and coverage, and we appreciate your focus on the role insurers play in high and rising costs for American families, taxpayers and employers. For years, the AHA has highlighted how, even when patients have insurance, their access to care is being delayed, disrupted

and denied. Simply put, actions by many commercial insurers erect barriers that make it more difficult for patients to receive timely access to needed medical care.

The following statement highlights what hospitals, clinicians, and patients are experiencing on the ground — and why commercial insurer practices are playing a growing role in driving up costs, creating delays and undermining affordability.

CURRENT LANDSCAPE

To understand what is happening to health care affordability, it is first necessary to understand how dramatically the health insurance market has changed. Today, the seven largest commercial insurers account for over 190 million covered lives — roughly two-thirds of the entire insured population — across various forms of coverage, including Medicare Advantage (MA), employer-sponsored care, Medicaid managed care, and health insurance marketplace plans. Although their stated role is to help patients access care, in reality, they are often described as a frustrating middleman, creating needless obstacles and barriers that delay or prevent patients from seeking the health care they need and deserve.

Horizontal and Vertical Consolidation in the Insurance Market Increases their Bottom Line While Driving up Health Care Costs

Commercial insurance today is a highly concentrated marketplace with a small handful of insurers representing one of the most consolidated sectors of the U.S. economy.

While commercial insurers often deflect scrutiny of their own consolidation practices by pointing the blame at others, including the over 5,000 hospitals that serve a wide range of communities and markets, the data clearly indicates that most regions of the country are dominated by one or two insurers holding outsized market shares. According to the American Medical Association's recent report on health insurance competition, in 91% of metropolitan statistical area (MSAs) markets, at least one insurer had a commercial market share of 30% or greater, while in 47% of MSAs, one health insurer held a market share of at least 50%.[1]

This level of concentration has consequences. Fewer competitors mean fewer choices, narrower networks, higher premiums, and growing leverage to impose policies that shift costs and administrative burdens to patients and providers.

At the same time, commercial insurers have vertically integrated at an unprecedented pace. A recent report from the Senate Judiciary Committee found that UnitedHealth Group — which now employs or manages over 90,000 doctors, representing 10% of all doctors in the country[2] — acquires primary care practices to pressure these clinicians to

[1] https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf
[2] UnitedHealth has 90,000 doctors — 10% of all physicians in U.S.

apply more diagnostic codes to make their patients seem sicker than they actually are to receive higher payments.[3] This unnecessarily drives up health care costs.

Despite their public criticism of hospitals for employing physicians, over the past five years, commercial insurers have acquired roughly 40% more physicians than hospitals — typically through large, multi-practice purchases.[4] Commercial insurers disproportionately target high-margin specialties in densely populated areas. In contrast, when hospitals acquire physician practices, they overwhelmingly take on lower-margin, community-based specialties like family medicine, pediatrics and primary care, often in rural or underserved areas. Many of these practices are financially vulnerable and are facing closure, in part due to the costs of having to comply with burdensome requirements from insurers. These acquisitions are fundamentally about preserving access to care for patients and communities — not about maximizing profits.

In addition, commercial insurers also control a significant share of the pharmacy, pharmacy benefit manager (PBM), and payment vendor markets. These affiliated assets have enabled commercial insurers to enrich themselves at the expense of patients by steering care to owned or affiliated providers and paying their own providers more. A July 2024 Federal Trade Commission interim report found that PBMs owned by large health insurance companies paid their affiliated pharmacies up to 40 times more than they paid competitor pharmacies for the same generic cancer drug, with plans steering patients toward such pharmacies.[5]

Through their business practices, commercial insurers have accrued substantial financial resources while adding significant costs to the health care system. Collectively, just seven of the largest insurers amassed an astounding $34.1 billion in net profit in 2024.[6] And those profits have grown at an extraordinary rate over time. Notably, from 2000 to 2024, UnitedHealth Group's annual revenue increased by 1,795% (+$379 billion), while its net profit increased by 1,857% (+$14 billion).[7]

Fortunately, not all insurers behave the same way. Smaller, community-based regional plans often work closely with providers to deliver coordinated, high-quality coverage. Many operate within integrated delivery systems where insurers and clinicians design coverage rules together to support timely, well-coordinated care. As Congress examines ways to improve affordability, these plans offer a clear model for achieving high-quality coverage without the costly, problematic practices seen among larger insurers.

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[3] UHG Report - Final

[4] https://www.aha.org/news/blog/2025-10-21-physician-practice-acquisitions-what-drives-them-and-implications-consumers-and-payers

[5] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[6] AHA analysis of Generally Accepted Accounting Principles (GAAP) net profit as reported on the quarterly 2024 SEC filings of: Centene, CVS, Cigna, Elevance, Humana, Molina, United.

[7] 2000 financial data from the UnitedHealth Group's Annual Report to Shareholders for the year ended December 31, 2000 (SEC Exhibit 13). 2024 financial data from the UnitedHealth Group 2024 Form 10-K.

INSURERS' PRACTICES LEAD TO INCREASED HEALTH CARE SPENDING AND CARE DELAYS

Prior Authorization and Coverage Denials

The improper application of prior authorization is one of the greatest pain points in the U.S. health care system for patients and providers. Hospitals and health systems have long raised concerns about the excessive use of prior authorization and coverage denials by certain insurers. Unfortunately, it seems like there are stories every day that demonstrate the dire situation some patients and their families face due to an insurer's refusal to cover their care.[8, 9, 10, 11, 12, 13, 14]

Additionally, the prior authorization submission methods required by insurers are outdated. Commercial insurers vary in how they require providers to submit prior authorizations, with providers often required to use antiquated technologies like fax machines for submitting medical information to plans. Recognizing this issue, the Centers for Medicare & Medicaid Services (CMS) released a rule requiring MA and other federally-administered plans to use a standardized electronic process for prior authorization. CMS estimates that simplifying the prior authorization process would save the health care system $16 billion.[15] However, that provision of the rule does not go into effect until 2027, and hospitals have not seen much, if any, relief from the voluntary commitments insurance plans made to improve their prior authorization processes in the spring of 2025.[16]

Altogether, prior authorization costs the U.S. health care system approximately $35 billion annually.[17] Unfortunately, the volume of prior authorizations continues to increase, amplifying provider administrative burden. MA plans issued nearly 50 million prior authorizations in 2023 — up more than 40% since 2020,[18] substantially increasing the cost of caring for patients.

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[8] CBS News piece
[9] They Couldn't Access Mental Health Care When They Needed It. Now They're Suing Their Insurer.
[10] After Series of Denials, His Insurer Approved Doctor-Recommended Cancer Care. It Was Too Late
[11] A man's fight for coverage of spinal surgery to treat debilitating pain
[12] This toddler's medical expenses can hit $3,000 a month. Her family says nearly every insurance claim is a battle
[13] Health Insurers Are Denying More Drug Claims, Data Shows
[14] UnitedHealth said it was too dangerous for him to be discharged. Days later, it denied his care
[15] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability
[16] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[17] https://www.nytimes.com/2024/03/14/opinion/health-insurance-prior-authorization.html?unlocked_article_code=1.ck0.Acc2.IM7ltCbFp3AE&smid=nytcore-ios-share&referringSource=articleShare&sgrp=c-cb
[18] https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

MA plans — which now cover more than half of all seniors — are supposed to provide coverage for any care that a similar enrollee in Traditional Medicare would receive. However, providers and patients routinely report coverage denials for care that beneficiaries are entitled to, indicating that plans frequently apply more restrictive coverage rules than CMS.

Many of the harms associated with inappropriate coverage denials are highlighted in a striking report by the Department of Health and Human Services Office of Inspector General. MA plans are denying medically necessary, covered services that meet Medicare criteria at an alarming rate. The report found that 13% of prior authorization denials and 18% of payment denials were inappropriate because they met Medicare coverage rules.[19] The report highlights over 50 examples of such cases, including a 78-year-old patient diagnosed with pancreatic cancer who was inappropriately denied radiation treatment. In a program the size of MA with over 32 million enrollees, improper denials at this rate are simply unacceptable.

Negative Impacts on Patient Care

Insurer policies that delay or deny patient care can result in patients who are ultimately sicker and costlier to treat when they finally do receive care. According to a 2024 survey by the American Medical Association, 82% of physicians reported that their patients have abandoned treatment due to plan prior authorization requirements, while 29% reported that prior authorization delays have led to a serious adverse event.[20]

One area where avoidable medical costs are most evident is in post-acute care transfers. Many patients require a transfer to a skilled nursing facility, inpatient rehabilitation facility or long-term acute care hospital as part of their recovery process. However, health plans frequently require prior authorization for these post-acute care transfers. Patients often have to wait days or even weeks for their requests to be processed and approved, which slows down their recovery process and increases costs due to longer hospital stays.

Payment Delays for Approved Care

Hospitals and health systems report significant challenges simply getting paid for the care they provide, even when it has already been authorized by the insurer. An AHA member survey found that 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old. Among the 772 hospitals surveyed, these delays amounted to more than $6.4 billion in delayed or unpaid claims that are more than six months old.[21]

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[19] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[20] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[21] https://www.aha.org/infographics/2022-11-01-survey-commercial-health-insurance-practices-delay-care-increase-costs-infographic

Administrative costs required to get paid for care add significant expense to the health care system. In fact, a recent Council for Affordable Quality Healthcare (CAQH) report found that administrative tasks cost the U.S. health care system about $83 billion annually, with providers absorbing more than 97% of those costs.[22] Combatting inappropriate payment delays and denials also consumes substantial resources, including complying with insurer requests for additional documentation, physician peer-to-peer consultations, and onerous appeal processes. One recent study found that providers spend nearly $18 billion fighting insurers on claims denials that are ultimately overturned and paid.[23] These administrative hurdles divert critical time and resources away from patient care.

Use of Third-Party Vendors

Many of these burdens are amplified by health insurers using third-party vendors (several of which are owned by the same conglomerate parent as the insurer) to process prior authorization and claims transactions. These entities are frequently incentivized with payment models that reward them for the more care they deny, regardless of whether those denials are appropriate or aligned with sound medical science. Additionally, these vendors often use different review criteria and require alternate communication methods than the insurers that they serve, which piles additional unnecessary administrative costs on providers attempting to navigate this morass.

These administrative burdens and delays in care have a direct impact on the affordability of care for patients. Each hurdle requires staff time and resources, costs that ultimately are reflected in the price of patient care.

Increased Burnout Due to Administrative Burdens

Hospitals and health systems are very concerned that insurers are increasing health care costs at the expense of patients and the health care workforce.

The administrative practices insurers rely on have very real consequences for providers. It is not unusual to hear from doctors and nurses about how they spend hours of their day away from the bedside while sitting on the phone urging a patient's insurance company to cover essential medical care. It is no surprise that administrative burden is one of the top contributors to clinician burnout.[24] Nearly 90% of physicians report that

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[22] https://www.caqh.org/blog/new-caqh-report-reveals-significant-differences-in-administrative-costs#:~:text=CAQH%20published%20a%20new%20report,97%20percent%20of%20these%20costs.
[23] https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense
[24] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf

prior authorization somewhat or significantly increases physician burnout, which adds to the workforce shortages facing hospitals across the country.[25]

Benefit Design Implications

One of the most common approaches used by payers to reduce premiums is to shift more of the cost of coverage into higher co-pays, deductibles and co-insurance (what is often referred to as "benefit design"). While insurers determine how much patients must pay in cost-sharing, the burden of billing patients falls to providers, and, in many instances, patients simply cannot afford their cost-sharing requirements. To the extent possible, providers absorb these losses through financial assistance policies, but hospitals and health systems do not have sufficient resources to close the gaps created by insurers, which means that some patients end up with medical debt. Hospitals and health systems are committed to helping patients afford their care, and many hospitals report that more than half of all charity care and financial assistance goes to insured patients. However, this financial assistance only goes so far, and it is not free to the health care system.

SPENDING ON HOSPITAL CARE

Commercial insurers often blame rising premiums on hospital costs, but the latest National Health Expenditures data from CMS show that hospitals' share of national health spending has remained stable at just under one-third for decades. The data also confirm that recent spending growth is driven mainly by increased use and intensity of services, not higher prices.[26]

Spending on hospital services reflects advances in diagnostics, therapeutics and other inputs, as well as changes in how care is delivered. Hospital care today looks very different than it did 25 years ago: innovations now allow many patients to survive — and recover from — conditions that once would have been fatal.

Hospitals also care for the highest-acuity patients and provide the most complex services, particularly as lower-acuity care has moved safely to outpatient settings. This care requires costly drugs and devices, highly trained staff, a continuously evolving administrative infrastructure, and 24/7 standby capacity for the most critical needs.

RECOMMENDED SOLUTIONS

To improve affordability of health care for patients, employers and taxpayers, Congress should curb insurer practices that drive unnecessary administrative spending and restrict access to medically necessary care.

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[25] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[26] https://www.healthaffairs.org/content/forefront/growth-national-health-expenditures-s-not-prices-stupid

We urge Congress to take the following steps to relieve the burden imposed by insurers:

Prior Authorization Reform: We urge Congress to pass the **Improving Seniors' Timely Access to Care Act (H.R.3514/S.1816)**. This bill would streamline prior authorization requirements under MA plans by making them simpler and more uniform and eliminating the wide variation in prior authorization methods that frustrate both patients and providers. It also would require MA plans to report on their use of prior authorization, including the use of artificial intelligence in prior authorization and the rate of approvals and denials.

Create Prompt Payment Standards: Congress should establish a uniform federal prompt pay requirement. The AHA urges Congress to pass the **Medicare Advantage Prompt Pay Act (H.R.5454/S.2879)**, which would apply a federal prompt payment standard to MA plans to help ensure that providers receive timely payments for medically-necessary care that has been approved.

Require Transparency in Plan Denial Signatures: Existing MA regulations require health plan clinicians who review and sign-off on adverse medical necessity determinations to have relevant medical expertise in the field of the service being requested. However, there is limited transparency because most reviewers do not sign denial letters. To ensure accountability, the AHA urges Congress to require a medical reviewer's identity and credentials be included as part of an adverse determination or denial notice that would be sent to the patient or provider.

Enhance and Increase Network Adequacy Standards: To minimize barriers, particularly for patients in rural and underserved communities, as well as those in need of behavioral health or post-acute care services, Congress should ensure that health insurers provide robust access to care by implementing or enhancing network adequacy standards or appropriate alternatives based on evidence of prompt access to care.

Protect Timely Access to Post-Acute Care: We urge Congress to protect patient access to medically-necessary post-acute care by mandating that insurers ensure adequate representation of post-acute care providers in networks and streamline prior authorization processes to avoid unnecessary delays.

MA Payment Parity for Critical Access Hospitals: As MA enrollment continues to grow, rural hospitals are under increasing financial strain because MA plans reimburse critical access hospitals (CAHs) at rates below their actual costs. To maintain the financial stability of these hospitals and preserve access to care in rural communities, we support legislation to ensure CAHs receive cost-based reimbursement for MA patients.

Prohibit Coverage "Bait and Switches": We urge Congress to curb practices that erode patients' coverage mid-year, such as insurer policy manual "updates" that change

what services patients can get at a network provider or introduce additional administrative processes meant to delay access to care.

Curtail Inappropriate Downcoding and Payment Reductions by Insurers: We urge Congress to take steps to ensure that insurers reimburse providers at appropriate levels rather than systematically reducing reimbursement and forcing providers to engage in overly burdensome appeals processes.

CONCLUSION

Thank you for your commitment to reducing health care costs for Americans with commercial insurance coverage. We look forward to working with you to support and advance these critical issues.

American Lung Association Applauds House Passage of Bill to Extend Healthcare Tax Credits; Urges Senate to Act Immediately on Bipartisan Solution

Washington, D.C. | January 8, 2026

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Just now, the U.S. House of Representatives passed a bipartisan bill which, if enacted, would extend the enhanced healthcare tax credits for three years. American Lung Association President and CEO Harold Wimmer released the following statement:

“The American Lung Association applauds the House of Representatives for coming together to protect healthcare for millions of people across America. Having access to quality and affordable healthcare is important in keeping all families healthy, and is especially important for people living with asthma, chronic obstructive pulmonary disease, lung cancer and other lung diseases.

“More than 24 million people now receive their healthcare coverage through the Affordable Care Act Marketplace, which is a record high. Because Congress let the enhanced healthcare tax credits expire at the end of 2025, people’s monthly premiums are, on average, more

than doubling. Open enrollment ends on January 15, and patients are running out of time for Congress to reach a deal.

“The American Lung Association urges the Senate to follow suit and finalize a bipartisan deal that extends enhanced healthcare tax credits and maintains all patients’ access to quality, affordable healthcare without additional barriers. These tax credits will protect healthcare for millions and improve the health of our nation.”

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About the American Lung Association
The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research. The work of the American Lung Association is focused on four strategic imperatives: to defeat lung cancer; to champion clean air for all; to improve the quality of life for those with lung disease and their families; and to create a tobacco-free future. For more information about the American Lung Association, which has a 4-star rating from Charity Navigator and is a Platinum-Level GuideStar Member, call 1-800-LUNGUSA (1-800-586-4872) or visit: Lung.org. (http://lung.org./) To support the work of the American Lung Association, find a local event at Lung.org/events. (https://www.lung.org/get-involved/events)

KFF The independent source for health policy research, polling, and news.

Claims Denials and Appeals in ACA Marketplace Plans in 2023

Authors: Justin Lo, Michelle Long, Rayna Wallace, Meghan Salaga, and Kaye Pestaina

Published: Jan 27, 2025

The Affordable Care Act (ACA) requires insurers to report transparency data for all non-grandfathered health plans sold on and off the Marketplace, including fully-insured and self-insured employer group health plans. The law requires data to be available to federal and state insurance regulators and to the public. However, federal implementation of this requirement has so far been limited to qualified health plans (QHP) offered on the federally facilitated Marketplace (HealthCare.gov) and does not include QHPs offered on state-based Marketplaces or group health plans. This brief analyzes federal transparency data released by the Centers for Medicare and Medicaid Services (CMS) on claims denials and appeals for non-group qualified health plans (QHPs) offered on HealthCare.gov in 2023. A downloadable working file based on CMS's public use file is available on the right-hand side of this brief.

Key Takeaways

Insurers of qualified health plans (QHPs) sold on HealthCare.gov denied 19% of in-network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all claims.

The in-network denial rate ranged from 1% to 54%. There was significant variation by insurer and by state.

Of limited information available on in-network claims denial reasons, the most common reason cited by insurers was “Other” at 34% followed by administrative reasons (18%), excluded service (16%), lack of prior authorization or referral (9%), and only 6% based on lack of medical necessity.

Consumers rarely appeal denied claims (fewer than 1% of denied claims were appealed) and when they do, insurers usually uphold their original decision (56% of appeals were upheld).

Marketplace enrollees filed 5,000 external appeals in 2023, or 3% of all upheld internal appeals. Due to the suppression of small values, the rate at which external appeals were upheld could not be calculated.

Introduction

The impact of claims denial is widely recognized by enrollees. The 2023 KFF Survey of Consumer Experiences with Health Insurance found that 58% of insured adults said they have experienced a problem using their health insurance, including denied claims. Four in ten (39%) of those who reported having trouble paying medical bills said that denied claims contributed to their problem.

As a part of the annual QHP certification process, issuers (referred to as insurers in this brief) must report certain denied claims information to CMS for plans that were offered in the previous year that they want to offer in the upcoming year. Data does not include information about denied requests for prior authorization (a claim decision made before a service is provided). The dataset only includes information about claims for benefits (medical and prescription drugs combined) made after a service was provided (post-service claims).

Insurers participating in the Marketplace in 2025 reported aggregated data on all HealthCare.gov QHPs they offered in 2023. Additionally, plan-level data from 2023 are reported for plans returning in 2025, including the number of in- and out-of-network claims submitted and denied, and reasons for claims denials. Among insurers

participating in HealthCare.gov states in 2023, 43 are not participating in 2025 so they did not provide claims denial information. Among returning insurers, such denial information was only reported for 69% of their claims (the share of claims attributable to returning plans), as not all plans offered in 2025 were also offered in 2023. Additionally, only 40% of plans in the dataset were offered in 2023 and are included in the plan-level reporting for denial reasons. See the Methods and Data Limitations section for more details.

Claims Denials and Appeals in 2023

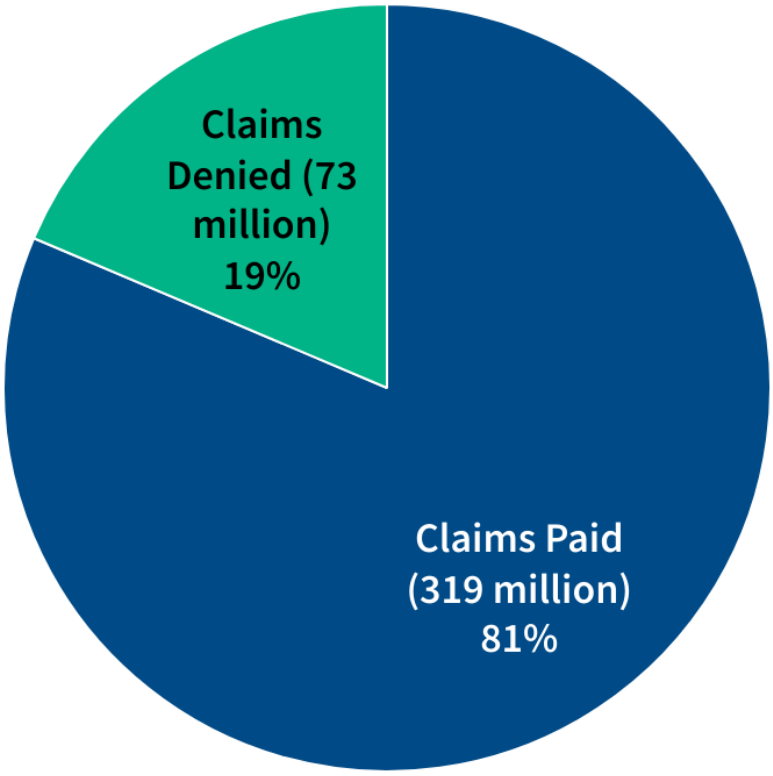
Insurer-level Claims Denials Data

Insurers reported receiving 425 million claims in 2023, with 92% (392 million claims) filed for in-network services. Of these in-network claims, 73 million were ultimately denied, resulting in an average in-network denial rate of 19% (Figure 1). Out-of-network claims totaled 33 million, with an overall higher denial rate of 37%. Claims that were initially denied then subsequently resubmitted and paid are not included as denied claims in the denial rate.

Figure 1

HealthCare.gov Issuers Denied 19% Of In-Network Claims In 2023

Among the 392 million in-network claims received, shares paid and denied



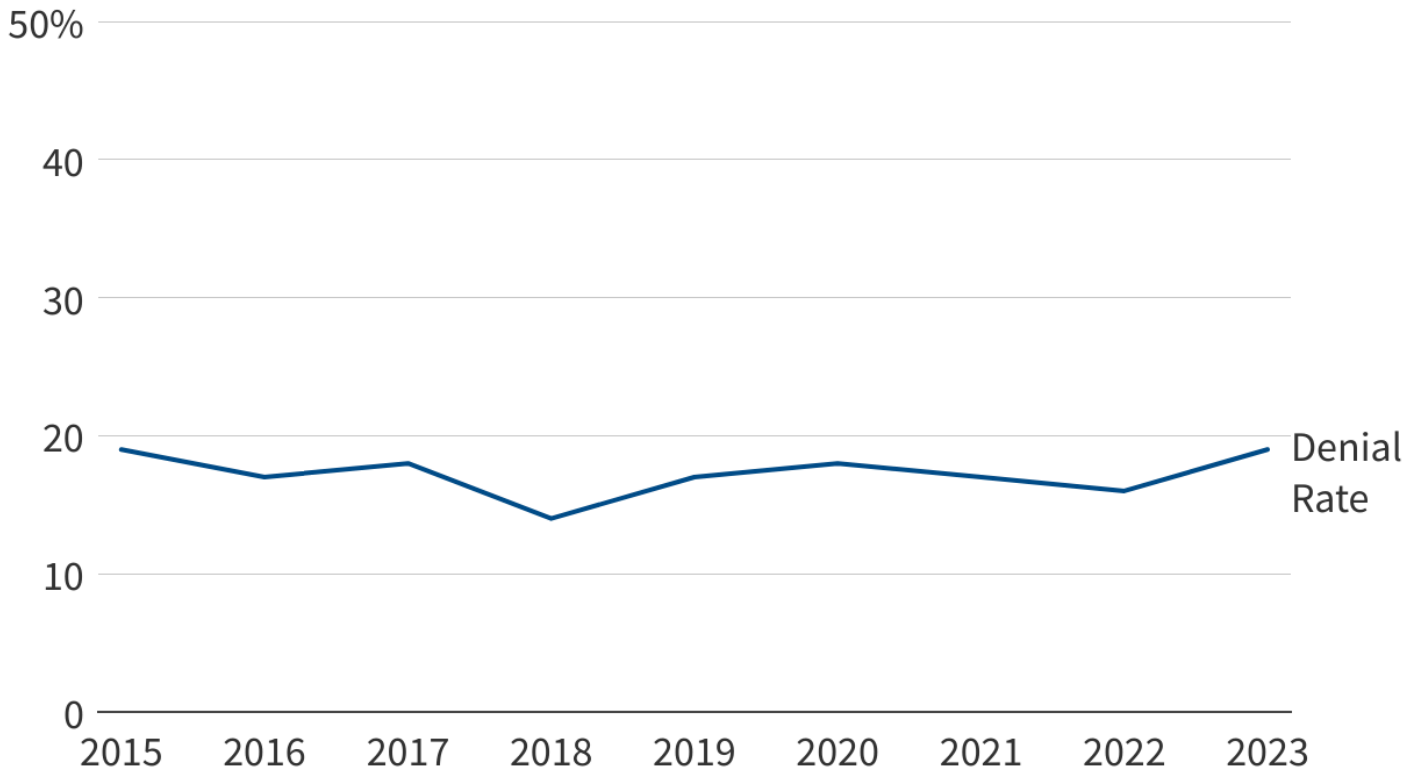
Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

KFF

Although the composition of HealthCare.gov states has continued to change since the inception of transparency reporting, the overall in-network denial rate in 2023 is similar to those from other analyses conducted by KFF (Figure 2).

Figure 2

Denial Rates For In-Network Claims By HealthCare.gov Issuers, 2015-2023



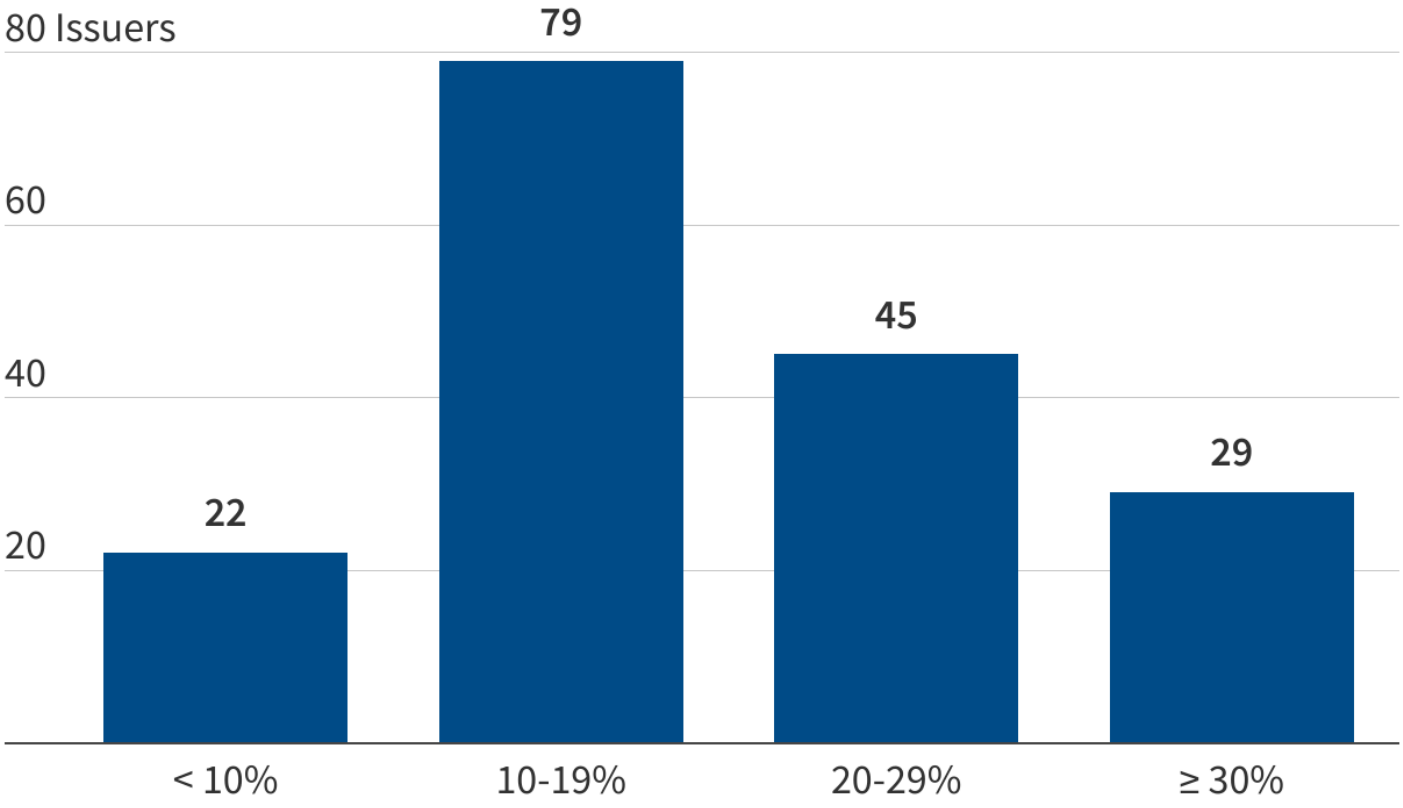
Note: States included in analysis vary by year due to establishment of state-based exchanges.
Source: KFF analysis of CMS Transparency in Coverage data for 2015-2023 plan years

KFF

Insurer denial rates for in-network claims received in 2023 varied widely, ranging from 1% to 54%. Twenty-two of the 175 reporting insurers had an in-network denial rate of less than 10% while twenty-nine insurers had a denial rate of 30% or more (Figure 3).

Figure 3

Denial Rates For In-Network Claims By HealthCare.gov Issuers, 2023



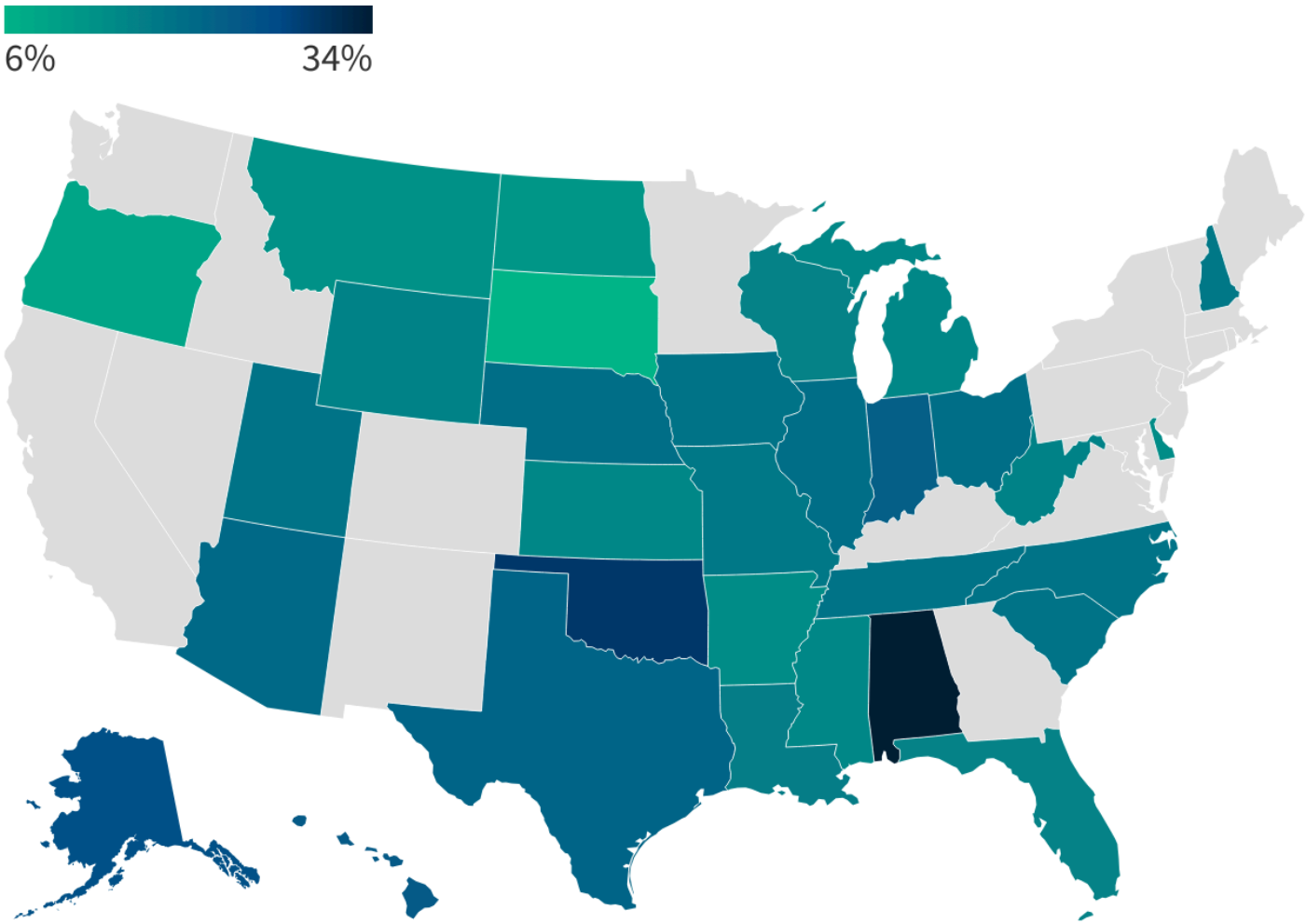
Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

KFF

Denial rates also varied geographically, as shown in Figure 4. The state with the highest average in-network denial rate for HealthCare.gov insurers was 34%, in Alabama, and the lowest was 6%, in South Dakota. Average denial rates have the potential to obscure variation. For example, while the average denial rate for insurers in Florida (16%) was slightly below the national average (19%), denial rates for insurers in Florida had more variability than another other state included in this analysis, ranging from 8% to 54% (the highest single insurer-level denial rate in the country).

Figure 4

Average Denial Rates For In-Network Claims By HealthCare.gov Issuers, By State, 2023



Note: States in gray do not use HealthCare.gov so are not included this analysis.
Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

KFF

Limited ACA transparency data collected by the federal government continue to show wide disparities in the rate at which Marketplace plans pay claims. While HealthCare.gov insurers denied an average of 19% of in-network claims in 2023, some insurers reported denying a much higher share. Table 1 shows denial rates for claims filed by parent companies that received more than 5 million claims within HealthCare.gov states in 2023. For in-network claims processed by these parent companies, the average in-network denial rate was 19%, ranging from 13% to 35% by

parent company. (Blue Cross and Blue Shield parent companies from different states are separated in this table because they operate independently.)

Table 1

Denial Rates For HealthCare.gov Parent Companies That Received More Than 5 Million Claims, 2023

Parent Company	Number of HealthCare.gov States	Total In-network Claims Received	Total In-network Claims Denied	In-network Denial Rate
Blue Cross Blue Shield of Alabama	1	13,033,751	4,533,017	35%
UnitedHealth Group	20	14,022,287	4,670,649	33%
Health Care Service Corporation	4	25,094,529	7,328,909	29%
Molina Healthcare	9	5,339,437	1,407,854	26%
Elevance Health	7	10,574,417	2,457,359	23%
CVS	11	31,419,396	6,796,838	22%
BlueCross BlueShield of Tennessee	1	4,493,833	939,798	21%
Cigna Health	8	18,151,575	3,777,467	21%
CareSource	5	5,495,489	1,129,642	21%
Scott & White	1	5,211,245	993,379	1…
BlueCross BlueShield of South Carolina	1	11,459,827	2,183,048	1…

Blue Cross and Blue Shield of North Carolina	1	18,257,563	3,451,238	1…
IHC Group	1	7,757,055	1,444,289	1…
Harris Health	1	6,915,555	1,238,096	18%
Oscar Health	13	19,655,916	3,362,228	17%
Arkansas Blue Cross Blue Shield	1	7,267,045	1,198,923	16%
Louisiana Health Service	2	5,237,979	852,031	16%
Centene Corporation	21	83,192,384	11,460,635	14%
GuideWell Mutual Holding	1	53,147,647	6,710,083	13%

Note: Number of HealthCare.gov states reflect Marketplace offerings in 2025.
Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

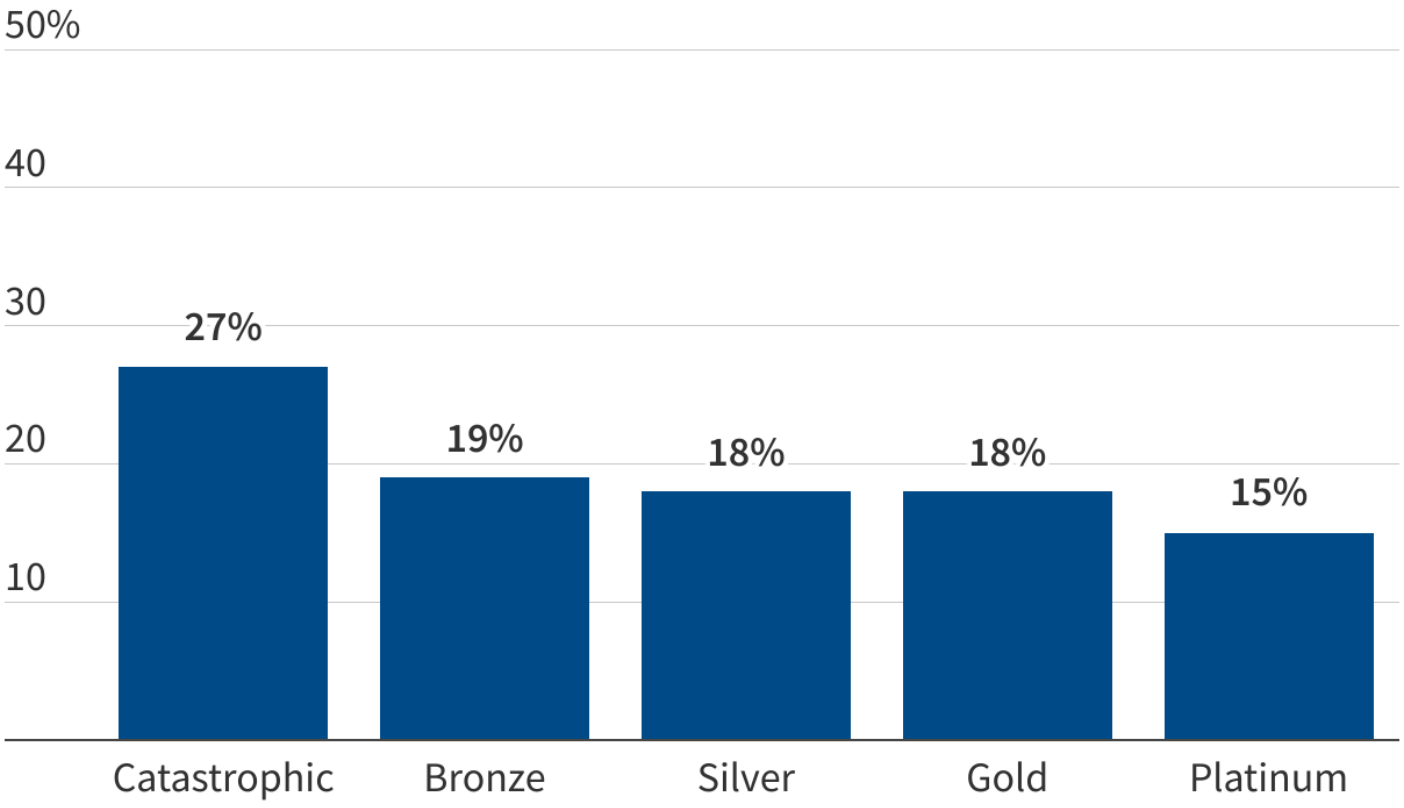
KFF

Plan-level Claims Denial Data

In all, insurers reported on 49 million denied in-network claims at the plan level for the 2023 coverage year. Denial rates varied only slightly between most plan metal levels. On average, in 2023, HealthCare.gov insurers denied 19% of in-network claims in their bronze plans, 18% in silver plans, 18% in gold plans, 15% in platinum plans, and 27% in catastrophic plans (Figure 5).

Figure 5

Plan-Level Denial Rates For In-Network Claims By HealthCare.gov Issuers, By Metal Level, 2023



Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

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CMS requires HealthCare.gov insurers to report the reasons for in-network claims denials at the plan level. Specified denial reason categories include:

- Denials due to lack of prior authorization or referral
- Denials due to an out-of-network provider
- Denials due to an exclusion of a service
- Denials based on medical necessity (reported separately for behavioral health and other services)
- Denials due to enrollee benefit reached
- Denials due to a member not being covered

Denials due to investigational, experimental, or cosmetic procedure

Denials for administrative reasons (which include claims that were duplicate, missing information, untimely, for an unapproved provider, or that met other criteria)

Denials for all other reasons not specified above.

Denials due to enrollee benefit reached (such as a limit on the number of physical therapy visits allowed per year); member not being covered at the time of service; investigational, experimental, or cosmetic procedure; and administrative reasons were reported on for the first time for 2022 data (in filings for application for the 2024 plan year).

A claim might be denied for more than one reason and on more than one submission. For example, if the initial submission of a claim misspelled a patient's name and was denied because the patient could not be identified, the claim may be denied again after being corrected and resubmitted if the claim were for a service that was not covered. Additionally, denial reasons are also reported for claims that are ultimately paid if they are resubmitted to correct the deficit or are successfully appealed. Insurers reported about 71 million denial reasons for in-network claims that were denied at some point in the adjudication process. The adjudication process employed by the insurer may affect how denial reasons are reported. Although publicly reported data allow for multiple reasons throughout the life of a claim, in practice, insurers may file denial reasons sequentially and not capture all applicable reasons for denying claims, such as denying claims from an unidentifiable enrollee before determining whether the claim was for a medically necessary procedure.

The distribution of in-network denials by reason is shown in Table 2. Of in-network claims, about 16% of denials were because the claim was for an excluded service, 9% due to lack of prior authorization or referral, and only about 6% based on medical necessity. The share of denial reasons related to administrative reasons is 18%, the most common reason aside from "other" (34%). The share of denial reasons attributed to "other" reasons in 2023 is significantly smaller compared to the 2021

data due to the reporting of new specific denial reasons, notably administrative reasons. Among all in-network claims filed, 6% required a resubmission (not necessarily for administrative reasons though). A resubmission may occur when the original claim was incomplete, contained errors, or was rejected for non-compliance with billing guidelines.

Table 2

Reasons For In-Network Claims Denials Among HealthCare.gov Plans, 2023

Denial reason	Total	Share
Other reason not listed	24,274,807	34%
Administrative reason	12,591,104	18%
Service excluded	10,988,868	16%
Enrollee benefit limit reached	8,444,754	12%
Lack of referral or prior authorization	6,460,181	9%
Not medically necessary *(excluding behavioral health)*	3,878,165	5%
Member not covered	3,723,250	5%
Not medically necessary *(behavioral health only)*	467,516	1%
Investigational experimental cosmetic procedure	123,173	0%

Source: KFF analysis of CMS Transparency in Coverage data for 2023 plan year

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Insurers also had wide variability in their use of denial reasons. While about 6% of all in-network claims denials by HealthCare.gov plans were based on medical necessity, several plans reported much higher shares for medical necessity reasons. For example, 30% of denial reasons for Cigna HealthCare of North Carolina were due to medical necessity. Similarly, while about 9% of all in-network denials by

HealthCare.gov plans were based on lack of prior authorization or referral, some plans reported a much larger share. For example, 97% of denial reasons for Blue Cross Blue Shield of Arizona were for lack of prior authorization or referral.

Plans may apply utilization review techniques differently. For example, individual insurer policies and practices may affect the balance between denials for failure to obtain referral/prior authorization and medical necessity denials, as greater use of prior authorization would shift utilization review to before a service is provided and possibly decrease the number of denials due to medical necessity. However, without more detail on the types of claims subject to these denials, it is not possible to discern the possible implications for patients. Recent federal regulations may provide further insight into the prior authorization process and what services typically require prior authorization for Healthcare.gov plans. Furthermore, denials captured in this data do not reflect the share or types of services covered by insurers.

Appeals Data

CMS requires insurers to report the total number of denied and internally appealed claims at the insurer level. Internal appeal is a process that allows a consumer to challenge a denied claim made by their health insurer. As in KFF's previous analysis of federal claims denial data, we find that consumers rarely appeal denied claims and when they do, insurers usually uphold their original decision.

Appeal to Insurer (Internal Appeal). Of the 73 million in-network denied claims in 2023, HealthCare.gov consumers appealed 376,527 – an appeal rate of less than 1%. Insurers upheld 211,393 (56%) denials on appeal. Relatedly, the 2023 KFF Survey of Consumer Experiences with Health Insurance found that only one in ten insured adults who reported experiencing a problem with their insurance in the past year had filed a formal appeal.

Appeal to Third Party (External Appeal). Consumers whose denial is upheld at internal appeal may have the right to an independent external appeal (also called external

review) for certain types of claims. Among insurers that reported at least 10 external appeals in 2023, Marketplace enrollees externally appealed at least 5,000 claims in 2023 (CMS suppresses reporting of observations lower than 10 so the number of externally appealed claims could be higher). Among insurers that reported at least 10 external appeals in 2023, 3% of upheld appeals were externally appealed. Due to the suppression of small values, the rate at which external appeals were upheld could not be calculated.

It is not well known that consumers can appeal claims denials through an external appeal process. KFF's 2023 consumer survey found that just 40% of consumers believed they have a legal right to appeal to a government agency or independent medical expert, while 51% said they were unsure if they had appeal rights, and 9% did not believe they had this right. Furthermore, Marketplace enrollees (34%) were less likely to know they had external appeal rights compared to those with Medicare (58%) and Medicaid (45%).

Other Data Sources

Absent data on how often insurers in other markets deny claims, it is difficult to put ACA transparency data in context. Below are other sources of claims denial data.

Covered California

California requires insurers to report data on claims received and denied each year for both in- and out-of-network services, in a manner similar to HealthCare.gov insurers. Among insurers submitting complete 2023 claims data to Covered California, the in-network denial rate was 21%, similar to HealthCare.gov insurers. One insurer had a denial rate of 87%. When excluding this insurer from the analysis, the overall claims denial rate among Covered CA insurers was 19%.

Specified denial reason categories are the same for both Marketplaces. At the plan-level, about 14% of in-network denials were due to lack of prior authorization or a referral, followed by about 6% due to administrative reasons, and about 1% for lacking medical necessity.

The appeal rate for Covered CA insurers (1%) was similar to HealthCare.gov insurers. Among all Covered CA insurers with complete data, about 40% of internal appeals and 47% of external appeals filed were upheld, substantially lower than HealthCare.gov insurers. Like denials, one insurer also represented a large share of the appeals data reported. When excluding that insurer, the rate of internal appeals upheld by Covered CA insurers was 61%.

Connecticut Health Insurance Report Card

Connecticut law requires private health insurers in all market segments with at least 1,000 enrollees to report annual data on claims payment practices, prior authorization requests and denials, claims denial reasons, and several other metrics (Table 3). The state insurance department publishes the aggregated data at the insurer level in its annual Consumer Report Card, which includes data from the largest insurer and is intended to inform consumer decision-making. Claims denial data include the total number of claims received and the total number of claims denied by reason.

Insurers in Connecticut reported receiving more than 11.8 million claims and denying more than 2.7 million claims in 2023, for an overall denial rate of 23%. In 2023, the largest shares of claims denials were for reasons related to the benefit not being covered (11.4% of denials) and for other reasons not specified (62.4%).

Connecticut's claims denial data are not directly comparable to those reported by Covered CA or HealthCare.gov insurers for several reasons, including that Connecticut's data includes group health plans, denial reasons are reported at the

insurer level rather than the plan level, and claims data in Connecticut are not separated by network status.

Table 3

Connecticut Health Insurer Claims Denials And Reasons, 2023

Among all state-regulated markets and including both in- and out-of-network claims

	Claim Denials	Received Claims
Total	2,756,560	11,875,304
Not a Covered Benefit	11.4%	2.7%
Not Medically Necessary	0.8%	0.2%
Not Eligible Enrollee/Dependent	9.4%	2.2%
Incomplete Submission	7.8%	1.8%
Duplicate Submission	8.2%	1.9%
All Other Miscellaneous	62.4%	14.5%

Note: CMS Transparency in Coverage data does not include the small group and large group markets and separates denials by network claims.

Source: KFF analysis of Consumer Report Card on Health Insurance Carriers in Connecticut, 2024

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National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC), via the Market Conduct Annual Statement (MCAS), collects uniform data annually on claims denials, prior authorization requests, appeals, and more from many insurers in the individual and group markets in nearly every U.S. state. MCAS data are intended to help state

insurance regulators monitor the market conduct of insurance companies, and insurers can use this information to identify areas to improve performance. However, full MCAS health insurance data are shared with state regulators only, not the general public or CMS. A limited national summary published by the NAIC shows that the average claims denial rate for both in- and out-of-network claims (excluding pharmacy) in 2023 was about 16%.

Medicare Advantage and Medicaid Managed Care

Medicare Advantage plans have come under scrutiny in recent years over concerns about policies and processes related to claims and prior authorization denials. According to a 2024 KFF analysis of federal data, Medicare Advantage plans denied (fully or partially) 3.4 million prior authorization requests for health care services in 2022, for an overall denial rate of about 7%, a share that has increased over the past few years. (Prior authorization is a process used by health insurers that requires providers to obtain approval before a service or other benefit is covered.) Additionally, a 2018 federal report found that 8% of claims and prior authorization requests (combined) submitted to Medicare Advantage plans between 2014 and 2016 were denied by insurers, which was less than half the denial rate reported, on average, by HealthCare.gov insurers during that period.

Medicaid managed care organizations (MCOs) also may require prior authorization. A 2023 federal report found that Medicaid MCOs denied more than 2 million prior authorization requests in 2019 for an overall prior authorization denial rate of nearly 13%–more than 2 times higher than the Medicare Advantage rate. However, these data are not directly comparable to the HealthCare.gov data being analyzed for this report, as the former pertains specifically to prior authorization denials while the latter covers post-service claims denials.

Looking Forward

Although research and investigations into health insurer practices have garnered attention from lawmakers and patient advocates over the past several years, the December 2024 killing of UnitedHealthcare's CEO ignited broad public outrage over insurer claims denials. According to a January 2025 KFF public opinion poll asking about certain health care priorities for Congress and the Trump administration, most people (55%) say more closely regulating insurers' decisions to approve or deny claims for health services or prescription drugs should be a "top priority." While prospects for significant changes in response to the public outrage may be limited, interest in providing the public with more transparency about how insurer claims review and appeals operate could, in the same way as providing more accurate price transparency information, better enable consumers and employers to make more informed choices when purchasing private coverage. Efforts might include:

Including more specific information in existing datasets.

Using the current data, the proportion of claims denied for a given reason cannot be calculated. For example, it is not possible to know the share of services that were denied due to a lack of medical necessity. Federal reporting on denials could be more useful when presented as claims ever denied for a given reason, instead of tallying the total reasons. Also, reporting that includes denial information about all claims from all insurers in the previous year, and not just those attributable to plans that are returning to the Marketplace next year, could be useful. Additionally, information about the types of services approved and denied (e.g., specialty of service and type of prescription drug) would give a more comprehensive picture of insurer practices and what type of care was actually covered by an insurer or employer. Information about appeals, especially external appeals, could provide insight into how this consumer protection mechanism is working for patients. Information about what services required prior authorization and how often the prior authorization itself is approved and denied is another data element not included in the CMS Marketplace public use file but is included in NAIC MCAS data not available to the public.

Providing claims denial information about employer coverage.

Employer-sponsored insurance covered 154 million people under 65 in 2023. Since most Americans have employer-sponsored coverage, efforts to provide more information to this group may be a way to begin to address concerns about insurer denials. A proposed regulation from 2016 that was never finalized would have added a claims denial metric to reporting required under the Employee Retirement Income Security Act of 1974 (ERISA). Also, in 2024, some members of Congress, urged the Department of Labor (DOL) to collect information on claims and claims denial, citing reports of "widespread denials of health benefits." An outside advisory panel to DOL also recently issued recommendations for increased data collection, among other claims and appeal reforms in this area. Also, federal mental health parity regulations updated in 2024 will require employer plans (and non-group plans) to collect and evaluate certain data, including the number and percentage of certain claims denials.

State-level initiatives.

There has been some activity at the state level to provide more transparency into claims denials and prior authorization requests. For example, in addition to California's and Connecticut's requirements for reporting claims denial data, Vermont requires insurers of state-regulated plans to report certain pre- and post-service claims denial data to the state, including breakdowns by mental health, substance use disorder services, and prescription drugs. Insurers in Oregon are required to report to the state claims denial and appeals data for behavioral health services compared to certain medical and surgical services. Additionally, Washington state requires insurers to report certain data related to prior authorization requests to the state, issue prior authorization determinations within certain timeframes, and use a standardized and streamlined prior authorization process. All of these states make at least some of this information available to the public annually. Going forward, more states may act to enact similar initiatives at the state level. These state laws, however, do not apply to self-insured health plans sponsored by private employers, which cover most insured Americans under age 65. Absent more uniform and complete data at a national level, efforts to fully understand and address issues related to health insurance claims denials will remain limited.

Methods and Data Limitations

Our analysis of the CMS Transparency in Coverage Public Use File includes insurers with more than 1,000 claims submitted and excludes stand-alone dental plans and small group (SHOP) plans. Of the 206 major medical insurers offering plans in 2025 in HealthCare.gov states, 175 reported receiving more than 1,000 claims and show data on claims received and denied. Among insurers participating in HealthCare.gov states in 2023, 43 are not participating in 2025 so they did not provide claims denial information. Calculation of claims denial rates includes information provided by insurers on plans offered in 2023 but not in 2025. A claim may be initially denied, then resubmitted and approved; claims that are paid even after initial denial do not count as denied in the claims denial rate calculation.

Twenty-nine insurers offering plans in 2025 did not offer plans in 2023. Just under half (45%) of plans available in 2025 were not available in 2023 among states that offered plans on HealthCare.gov in both years; of the 6,126 plans offered in 2023, only 2,481 (40%) were offered in 2025 and are included in the plan-level reporting providing information on denial reasons. Half of returning insurers did not provide statistics on denial reasons for more than 21% of claims filed in 2023, as they were associated with plans not being offered in 2025.

Calculation of denial reasons excluded claims that were denied as out-of-network in all totals. Since out-of-network denials may depend more on plan type than insurer processes, the analysis focused on in-network claims. Claims that are denied do not necessarily indicate that services are not ultimately paid by the insurer, such as when a new claim is filed instead of resubmitted.

The external appeal rate assumes that all external appeals went through an internal appeal first and was calculated as the number of external appeals filed over the number of internal appeals upheld. CMS suppresses reporting of values under 10. When calculating statistics with suppressed values, they were assumed to be zero. Additional considerations for using CMS transparency public files can be found here. To obtain the parent company name, the 2025 Qualified Health Plan landscape file was merged with the Medical Loss Ratio Submission Template header using HIOS plan identification numbers to find NAIC company codes. The NAIC identifier was then mapped to a parent

company name using the Enrollment by Segment Exhibit data from Mark Farrah associates. A small number of insurers could not be mapped by this method and parent company names were entered manually. Statistics calculated at the parent company level do not include plans offered in segments other than on-exchange ACA plans offered in HealthCare.gov states.

Data from Covered California was compiled from reporting by insurer. Of the 11 insurers submitting data for the 2023 plan year, 8 submitted complete information and are included in our analysis. One insurer reported its plan-level claims data by benefit category (medical, pediatric vision and dental, and pharmacy) instead of by plan; from this data we calculated plan-level totals. We assume that other Covered CA insurers also included these four benefit categories when reporting their plan-level data as all four are considered Essential Health Benefits. Our analysis excludes stand-alone dental plans and small-group plans.

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Congress Must Preserve Access to Affordable Marketplace Coverage

By Lindsey Copeland | September 11, 2025 | 2 Comments

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Congress acts soon, critical tax credits that help over 22 million people buy able Care Act (ACA) Marketplace plans will expire at the end of this year, causing

premiums and coverage losses to skyrocket.

The Role of Premium Tax Credits

Since 2012, ACA premium tax credits (PTCs) have helped people with low and middle incomes pay their Marketplace premiums. In 2021, The American Rescue Plan Act (ARPA) increased the amount and availability of the credits and the Inflation Reduction Act (IRA) in 2022 delayed their expiration, but only until the end of 2025. Notably, while the July 2025 reconciliation bill continued many other tax policies sunsetting this year, it excluded these enhancements.

While the July 2025 reconciliation bill continued many other tax policies sunsetting this year, it excluded PTC enhancements.

The PTCs, including the enhancements, are effective and widely used. They help nearly 93% of Marketplace enrollees afford insurance, reducing enrollee premiums from $619 to $113 per month, on average.

The PTC Enhancements Have Improved Access, Affordability

The PTC enhancements currently in place—and at risk—have had a significant impact. Thanks to these improvements, an estimated seven million more people will be able to afford a Marketplace plan this year and four million fewer people will be uninsured. Overall, they helped Marketplace enrollment grow from 12 million in 2021 to a record 24.2 million in 2025.

The enhanced subsidies have especially benefited low-income people.

As the Commonwealth Fund notes, the enhanced subsidies have especially benefited some people, increasing enrollment among those with incomes below 250% of poverty from 8.2 million in 2021 to 15.9 million in 2024.

Similarly, the Urban Institute predicted they would help the lowest income groups see a 50 to 100% reduction in their premium amounts this year, while people at the higher end of income eligibility would see a 25% reduction. These projections align with documented successes: In 2023 and 2024, 80% of Marketplace enrollees could find a plan for $10 or less per month. In 2020, before the tax credits were increased, only 36% of PTC-eligible enrollees could find such a plan.

Enhanced Credits Critical for Older Adults

A new report from AARP explains how many older adults who are not yet eligible for Medicare rely on Marketplace coverage and premium tax credits, and that the enhanced subsidies have been vital to improving enrollment and coverage among this population. In part, the PTCs have helped millions of adults aged 50 to 64 buy coverage through the Marketplace—spurring a 50% reduction in the uninsured rate among this cohort.

> The PTCs have helped millions of adults aged 50 to 64 buy coverage through the Marketplace.

In 2024, nearly five million of the 5.2 million Marketplace enrollees aged 50 to 64 received PTCs. A previous Avalere analysis estimated the credits saved these enrollees at least $600 a year, while some saw savings of nearly $5,000. Heightened affordability is especially important to this population, since ACA premiums for older adults can be up to three times higher than those for younger adults.

What Is At Risk

If the enhancements expire at the end of the year, analysts agree that rising costs will push many people, including older adults, out of their health insurance coverage. KFF projects enrollee premium payments would increase by over 75% on average, while people in rural areas could see a 90% increase and some enrollees could end up paying more than double.

Of the 5.2 million adults ages 50 to 64 with Marketplace coverage, AARP expects most or 4.8 million of them—will see higher premiums in 2026. Middle-income midlife

enrollees could see hikes of over $4,000, likely causing many to drop their coverage and become uninsured.

> Middle-income midlife enrollees could see hikes of over $4,000, likely causing many to drop their coverage and become uninsured.

The Congressional Budget Office (CBO) reached similar conclusions, estimating that unless the credits are extended, ACA enrollment will drop from nearly 23 million in 2025 to 15 million in 2030. Other analysis is even more stark. KFF notes actuaries at Wakely have warned of a 50% decline in Marketplace enrollment, when combined with the other changes to the ACA made in the reconciliation bill.

Some who lose subsidized Marketplace plans may be able to find other insurance, but others—at least 4.2 million people, according to CBO—will become uninsured. These coverage losses will not only mean reduced access to care and worse individual health outcomes, but also higher Medicare costs, because more people will enter the program in poorer health and needing more expensive interventions than they would have otherwise.

Congress Must Act Quickly

At Medicare Rights, we will continue to work to protect the ACA's coverage gains. People must have access to high-quality, affordable health care and coverage. Allowing the enhanced PTCs to expire would have the opposite effect. It would effectively raise taxes on low- and middle-income Americans, pricing millions out of health coverage.

> Medicare Rights urges lawmakers to extend the enhanced PTCs without delay.

t end, we urge lawmakers to extend the enhanced PTCs without delay. Although dits do not expire until the end of December, their availability must be guaranteed

before open enrollment begins on November 1. Otherwise, people may have no choice but to drop coverage this fall in the face of sky-high premiums, setting in motion harmful coverage losses that undermine individual health and economic security as well as Medicare sustainability.

Read the AARP fact sheet, Premium Tax Credits Protect Affordability of Marketplace Health Coverage for Adults Ages 50 to 64.

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Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays

CHIR Faculty | 2025-10-15
Jason Levitis, Sabrina Corlette, and Claire O'Brien

As the nation winds through its second week of government shutdown, Affordable Care Act (ACA) policy has again taken center stage. A key sticking point in funding negotiations is upcoming reductions in the premium tax credit (PTC). Democrats say they cannot vote for a bill that allows the reductions to proceed. Republicans have expressed openness to considering some form of extension but have insisted that negotiations can wait until later, since the reductions don't take effect until 2026.

So what's the truth of the matter? In this case, the facts are clear. As we explained here last year, the timeline of health insurance rate setting and Marketplace enrollment means that the harms from a reduction are locked in well before the new plan year.

Indeed, Congress has already waited too long. Even if the enhancements were to be extended tomorrow, millions of people now inevitably face higher premiums for the year, because insurance companies have finalized their rates assuming that smaller PTCs will push healthy people out. According to Congressional Budget Office (CBO) estimates, even if Congress had extended the enhancements on September 30, gross premiums would have been 5 percent higher compared to earlier enactment. And while it will never be "too late" for action to support future coverage, the immediate harms will grow quickly in the weeks ahead. By mid-October, millions of people will learn that they face drastically higher out-of-pocket premiums, leading to cancellations and decisions to stay uninsured that will be impossible to fully reverse. If an extension passes at year's end, coverage losses will be 1.5 million due to the delays alone, according to published reports citing CBO estimates.

These delays also impose financial costs on insurance companies, Marketplaces, and state regulators that are ultimately borne by consumers and taxpayers. When and if the enhancements are extended, Marketplaces have options to mitigate (but not eliminate) coverage losses. But executing these maneuvers is costly and grows more so the longer Congress waits.

Background

The PTC enhancements were first enacted in 2021 under the American Rescue Plan Act and extended in 2022 under the Inflation Reduction Act. The

enhancements increase affordability and expand coverage in several ways. First, they reduce net premiums for virtually all PTC recipients relative to the original, smaller PTC. Second, they eliminate the eligibility cliff at 400 percent of the federal poverty line (about $60,000 for a single individual in 2025). This is especially important for older people and others facing higher premiums. For example, in 2025 a 60-year-old with income at $65,000 (which is 432 percent of the federal poverty line) would pay $12,653 annually for a benchmark silver on average without the enhancements in place, or $5,525 with the enhancements in place. Finally, the enhancements reduce gross premiums by pulling healthier people into the risk pool, which helps people ineligible for PTC. Eliminating these savings would increase health care costs for consumers and employers and, in doing so, reduce coverage.

In our piece last year, we noted the perhaps-unintuitive timeline for effects of the PTC's expiration to be felt. Tax cuts are commonly enacted or extended during or even shortly after the tax year without substantial drawbacks, given the retrospective nature of tax filing. But the unique structure of the PTC means that the enhancements' expiration is felt much sooner. Specifically, the rate filing process for a year plays out in the spring and summer of the prior year. And the enrollment process locks in place consumer responses to expected net premium changes before the coverage year has even begun. Despite this dynamic, Congress acted in the reconciliation bill to extend other tax cuts that expire at year's end, while taking no action on the PTC.

The time for acting to completely avoid higher costs and coverage losses has now passed, and certain harms are now locked in place. However, swift passage of the PTC enhancements would stop additional harms that will otherwise spread in the coming weeks.

Harms Already Locked In Place

October 1: Higher Insurance Premiums Finalized

In a normal year, health insurers participating in the ACA marketplaces finalize their premiums in mid-August and sign Marketplace contracts by the end of September. This year, the Centers for Medicare & Medicaid Services (CMS) and many states extended those deadlines to account for the uncertainty over Congressional action on the extension of enhanced premium tax credits and other federal policy changes. On September 23, CMS announced that insurers would have until October 1 to make any changes to premium rates, and until October 2 to sign their contracts with the federal Marketplace. They have now reached a "pencils down" moment.

CBO has previously estimated that extending the enhancements would reduce premiums by 7.6 percent annually on average (though as explained in this article achieving that level of reduction for 2026 would have required acting earlier). This projection is supported by a recent analysis of health insurers' individual market proposed premium rates for 178 Marketplace plans across 28 states, which found that insurers are attributing between 1 and 14 percentage points of their proposed rate increases to the expiration of the enhanced premium tax credits. This is generally because insurers assume that most of the people who drop their coverage due to a loss of enhanced premium tax credits will be young and healthy, leaving them with a smaller and sicker risk pool and higher costs.

These higher premiums mean higher costs for consumers not eligible for premium tax credits, since these individuals, unlike those who do receive premium tax credits, are not insulated from list premiums. The higher

premiums also increase costs for employers who provide coverage for employees using individual coverage health reimbursement arrangements (ICHRAs) and similar vehicles.

If Congress passes an extension in the next few weeks, some state regulators and state-based Marketplaces could, in theory, require or allow for re-submission of plans and rates even at this late date. But this scenario is unlikely due to the operational difficulties and costs associated with re-loading plans and rates into Marketplace websites and revising consumer notices and marketing materials. Indeed, CBO estimated that, even if Congress had been able to enact an extension of the enhanced tax credits by September 30, 2025, insurers were only 50 percent likely to make rate adjustments after meeting state and federal deadlines for finalizing 2026 premium rates. And the value of such adjustments is quickly declining, since insurers would know that many of the healthier people already knocked out of the market won't return. For these reasons, CBO's forecast for a September enactment is that premiums for 2026 would have fallen by just 2.4 percent had Congress extended the enhanced PTC last month, compared to the 7.6 percent reduction CBO estimated with more of a runway. ***In other words, CBO believes that a premium increase of about 5 percent is already locked in.***

Any such late rate revisions would also impose costs on issuers, Marketplaces, and state regulators that would be passed along to consumers and taxpayers.

Harms That Will Be Locked In Place In The Weeks

Ahead

While the increases in gross premiums are substantial, the much larger impact will be on PTC recipients. KFF estimates that net premiums will more than double on average if the enhanced PTC are allowed to expire. And PTC recipients generally have lower incomes and so are less able to and less likely to have other good coverage options, meaning that higher net premiums will translate into substantial uninsurance for this population.

Over the course of October, most consumers will be informed of these higher net premiums through the various avenues described below. Many considering new enrollment will choose not to enroll. Current enrollees will have premium shock and may decide not to re-enroll, including cancelling auto-reenrollment.

Congress could still restore the higher PTCs by passing an extension later, and this would restore affordability for eligible consumers and mitigate coverage losses. But some consumers won't come back, since they will lose the benefit of auto-reenrollment, lose trust in the marketplace, change their budget planning, and/or tune out.

Throughout October: Window Shopping Shows Lower PTC

Before the open enrollment period, most Marketplaces offer tools that permit "window shopping": browsing plan options and receiving an estimate of financial help. Window shopping started at the beginning of October in six states (Georgia, Idaho, Maryland, Nevada, New York, and Virginia), opens by mid-October in most other State Marketplaces, and by late October in the Federal Marketplace. Window shoppers are already seeing much higher premiums. And because window shopping tools don't

generally collect contact information, Marketplaces will have no way to contact these potential enrollees if the enhancements are later restored.

Middle To Late October: Re-Enrollment Notices Showing Higher Net Premiums

By the end of October, virtually all State Marketplaces will send current enrollees re-enrollment notices showing higher net premiums and lower financial assistance. (The federal marketplace's notices do not include 2026 premiums). The National Association of Insurance Commissioners expressed concern about the resulting premium shock in its August 21 letter, noting, "Without an extension of the enhanced credits in September, insurers and marketplaces will begin to notify over 20 million consumers in all 50 states of major premium increases in a matter of weeks."

Even if Congress passes an extension soon, revising these letters is not instantaneous. Letters already in the mail may be impossible to stop. And sending revised letters will require states to re-run their "batch" redetermination on all current enrollees and then re-print and send large numbers of new letters—a process that will vary depending on each state's IT systems and operational capacity. Any such revisions will impose additional costs on Marketplaces.

By Late October: Marketplaces Lock Down IT And other Systems

Best practices for websites and other systems serving millions of people require extensive preparation, testing, and a "code freeze" well before the go-live date. When and if an extension passes, Marketplaces may be unable to immediately change course. Timelines will depend on the agility of each Marketplace's IT systems, customer support staff, and communications apparatus. Any such changes will impose additional costs for re-

programming systems, revising communications materials, retraining customer support staff and navigators, and booking additional advertising. Last-minute changes also create more demand for call centers and other assistance.

November 1: Open Enrollment Begins Nationwide

On November 1, the open enrollment period opens nationwide (and October 15 in Idaho). At that point, both new applicants trying to enroll and current enrollees updating their applications and shopping will see the higher net premiums, deterring many from enrolling.

December: Enrollees Receive Bills Showing Higher Net Premiums

In December, all enrollees–including those auto-reenrolled–will receive their January 2026 bills showing their net premium for 2026. For auto-reenrollees in the federal Marketplace who don't go in to shop, this will generally be the first time they see the higher premium, resulting in an additional round of disenrollment. If Congress later restores the enhancements, Marketplaces could contact these individuals to invite them back, but evidence suggests that direct-to-consumer notifications to uninsured people leads to only a small fraction of them enrolling.

In addition, December 15 is the last day to enroll for January 1 coverage in the federal Marketplace.

January: Open Enrollment Ends

The open enrollment period ends on January 15 in the federal Marketplace and most state Marketplaces. This will lock in consumers' coverage decisions and plan choices. They will not be able to enroll in coverage without a

special enrollment period. Some consumers will still enroll but will be more likely to disenroll later due to higher out-of-pocket costs. If Congress later restores the enhancements, Marketplaces could reach out to consumers who are not enrolled and ask them to come back, but again such marketing is typically not very effective. Marketplaces could also seek to increase the ongoing monthly PTC payments for remaining enrollees, as many of them did when the enhancements were first enacted in March of 2021. But this is an imperfect process, so some consumers would likely continue to pay the higher premiums throughout the year, leading to even more disenrollment.

Conclusion

While the substance of health policy is extremely important, sometimes timing matters, too. With 2026 rates already set and consumers starting to learn of premium increases, delays in extending the PTC enhancements beyond 2025 have already led to cost increases and coverage losses that cannot be reversed.

It will never be "too late" to extend the PTC enhancements—extending them will always save consumers money and help them get covered. But the next few weeks are crucial. Every passing day will lock in additional irreversible harms.

Jason Levitis, Sabrina Corlette, and Claire O'Brien "Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays" October 8, 2025, https://www.healthaffairs.org/content/forefront/damage-inaction-aca-tax-credits-has-begun-and-grow-further-delays. Copyright © 2025

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Eligibility Cliff on ACA Tax Credits Would Make Health Care Unaffordable for Middle-Class Families

Most Americans Receive Federal Help for Health Insurance, Tax Credits Fill the Gap for Those Left Out

Jason Levitis, Claire O'Brien, and Caitlin Rowley Gallamore

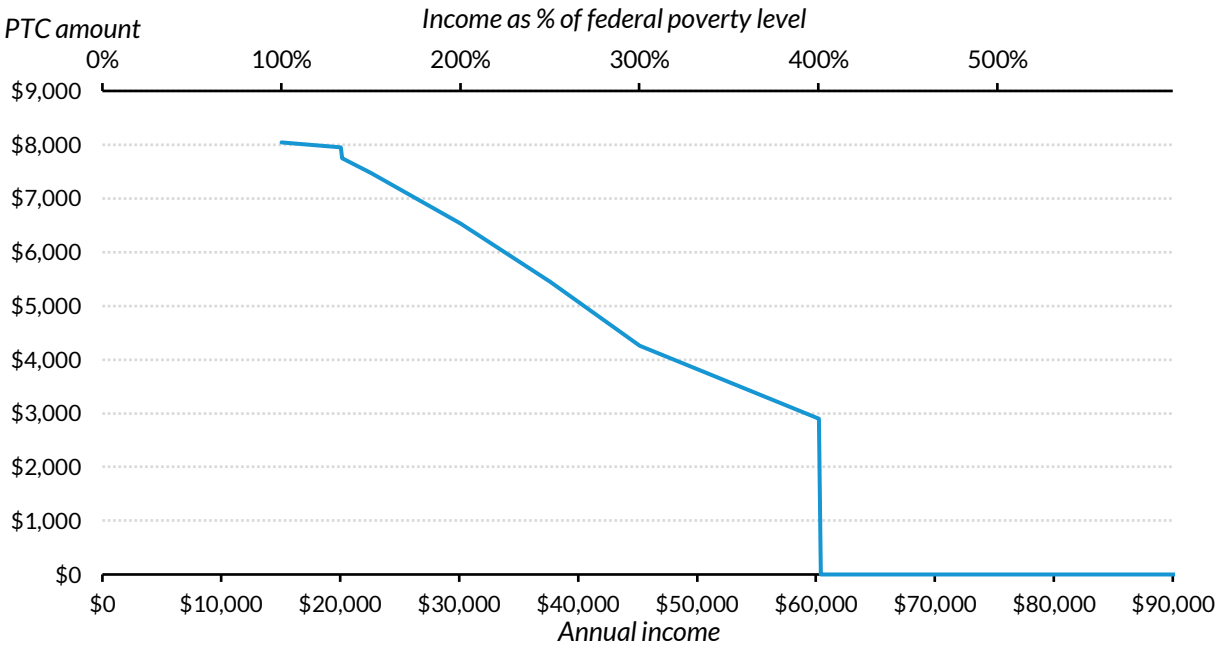
October 2025

A key sticking point in the government shutdown debate is the upcoming reductions in the premium tax credit (PTC; Buettgens et al. 2025),[1] particularly how the credit declines as income increases.[2] The reductions expected in 2026 (but already being felt; Levitis, Corlette, and O'Brien 2025) include reimposing an eligibility cliff at 400 percent of the federal poverty level (FPL)—a bit over $60,000 for a single person. With the cliff in place, the tax credit falls suddenly to zero when income crosses this line (figure 1).[3]

FIGURE 1

Without Enhancements, the PTC Cuts off in a Cliff

PTC amount without enhancements for a 50-year-old in an average premium benchmark plan, 2025



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Source: Authors ca cu ations using "Rev. Proc. 2024-35, IRS, 2024; and premiums from "Hea th Insurance Marketp ace Ca cu ator, *KFF*, October 29, 2024, https://www.kff.org/interactive/subsidy-ca cu ator/.

Notes: PTC = premium tax credit. Income is for an individua tax-fi er. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bi y Dering, JoAnn Vo k, and Kevin Lucia, "Ear y 2026 Rate Fi ings Show Marketp ace Po icy Changes Contribute to Eye-Popping Rate Increases, CHIR, June 26, 2025, https://chir.georgetown.edu/ear y-2026-rate-fi ings-show-marketp ace-po icy-changes-contribute-to-eye-popping-rate-increases-2/.

The cliff was originally included in the PTC as a means of reducing the Affordable Care Act's (ACA) cost.[4] It was then eliminated as part of PTC enhancements that were enacted in the American Rescue Plan Act of 2021 and extended in the Inflation Reduction Act of 2022. Without action by Congress, the enhancements will expire at the end of 2025, and the cliff will reappear. Some argue that providing the PTC past the cliff is an unnecessary giveaway to the rich. In a recent op-ed, a senior fellow at Americans for Prosperity claims that, without the "income cap,… sliding-scale subsidies are available to everyone… even millionaires."[5]

But this is not the case. In fact, the PTC without the cliff is income-limited—it just phases out gradually rather than dropping off suddenly. There are other reasons not to reimpose the cliff. Given the high cost of health coverage, virtually all Americans receive some kind of federal assistance to pay for it, whether from Medicare, Medicaid, or the tax exclusion for employer coverage. For those beyond the cliff, the enhanced PTC is already smaller on average than the tax benefit from the tax exclusion for employer-sponsored coverage. Reimposing the cliff would worsen this disparity. The cliff—and therefore this disparate treatment—falls disproportionately on older people, those in high-premium areas (which are heavily rural areas), and small business owners. More generally, cliffs are widely considered bad policy because they are inequitable and create perverse incentives. Finally, the PTC is especially ill-suited to a cliff, as it is advanceable, which creates the risk that a small income change triggers a large tax liability.

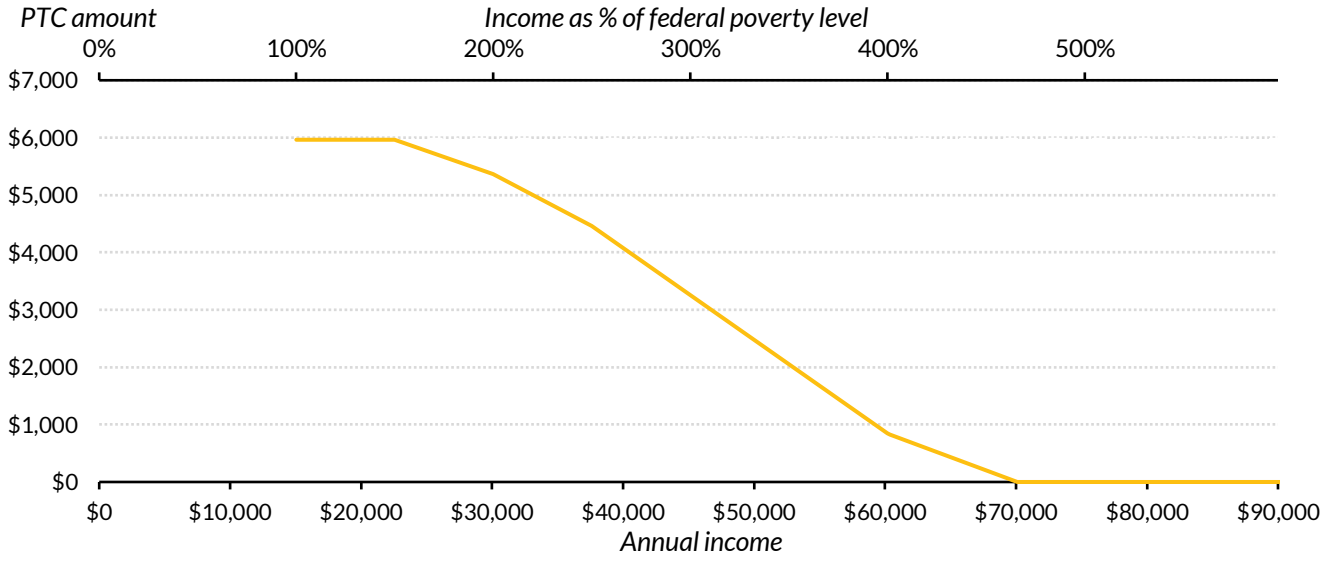
The Enhanced PTC Is Still Capped—Just without a Cliff

Even without the cliff, the PTC is income-limited, since it phases out as income increases. For example, for a 40-year-old with an average premium ($5,964 annually), the PTC hits zero at an income of $70,165, or 466 percent of FPL (figure 2). The PTC is very small at incomes just below that. For example, if the 40-year-old had an income of $68,000, their credit would be $184.

FIGURE 2

The Enhanced PTC Falls to Zero as Income Rises

PTC amount with enhancements in place for a 40-year-old in an average-premium benchmark plan, 2025



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Source: Authors ca cu ations using "Rev. Proc. 2024-35, IRS, 2024; and premiums from "Hea th Insurance Marketp ace Ca cu ator, *KFF*, October 29, 2024, https://www.kff.org/interactive/subsidy-ca cu ator/.

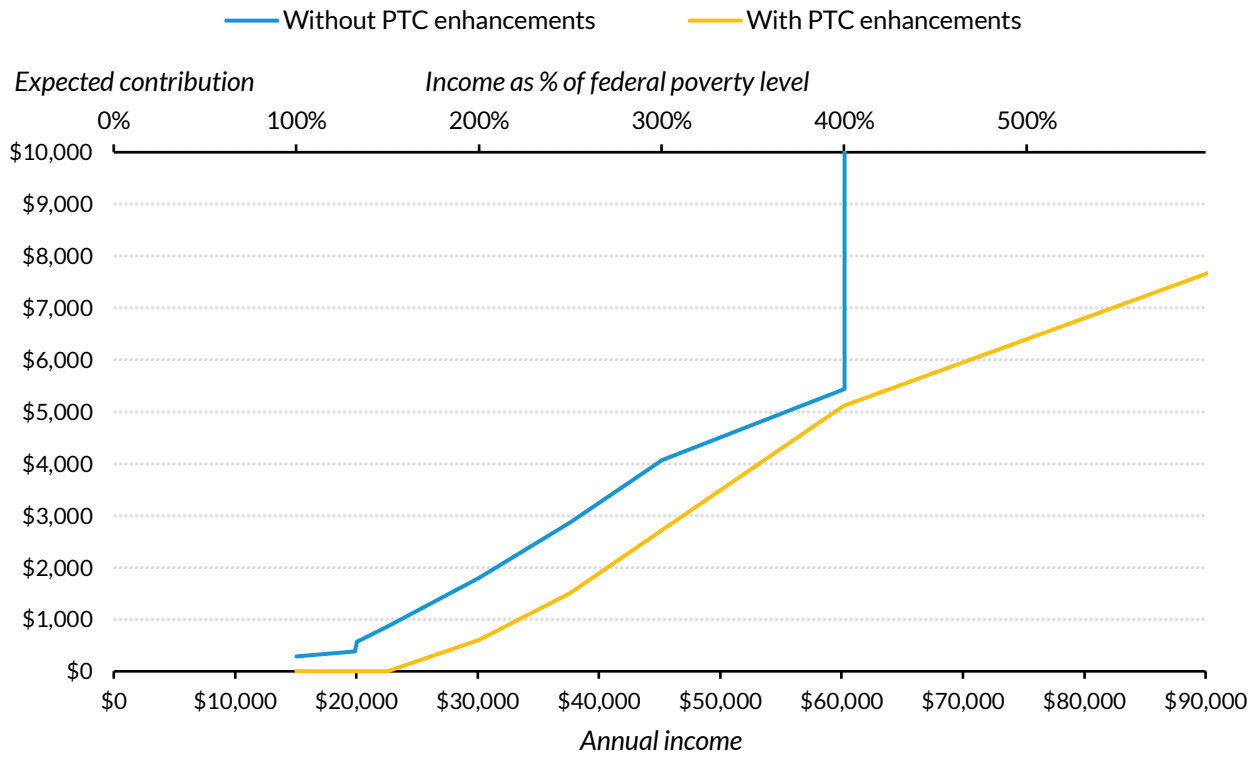
Notes: PTC = premium tax credit. Income is for an individua tax-fi er. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bi y Dering, JoAnn Vo k, and Kevin Lucia, "Ear y 2026 Rate Fi ings Show Marketp ace Po icy Changes Contribute to Eye-Popping Rate Increases, CHIR, June 26, 2025, https://chir.georgetown.edu/ear y-2026-rate-fi ings-show-marketp ace-po icy-changes-contribute-to-eye-popping-rate-increases-2/.

The PTC phases down to zero because it is calculated to cap the individual contribution toward a benchmark plan at a certain percentage of income. (The benchmark premium is the second-lowest cost "silver" tier plan. If a consumer buys a more expensive plan, they pay the difference). Under the enhancements, this individual contribution percentage is 8.5 percent at incomes above 400 percent of FPL ($60,240 for a single person). For example, a person with income of $65,000 (432 percent of FPL) has to pay $5,525 (8.5 percent of $65,000) for a benchmark plan, and the PTC covers the rest (figure 3). When income grows large enough that the expected individual contribution exceeds the benchmark premium, the tax credit zeros out. Without the enhancements, an individual with an income of $65,000 gets no assistance regardless of the premium they face.

FIGURE 3

The Cliff Exposes Middle-Income Consumers to Unlimited Premiums

Expected contribution with PTC to purchase individual benchmark coverage, with and without the PTC enhancements, 2025



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Source: Authors ca cu ations using "Rev. Proc. 2024-35, IRS, 2024; and "Federa Poverty Leve , Hea thcare.gov, accessed October 14, 2025. https://www.hea thcare.gov/g ossary/federa -poverty- eve -fp /.
Notes: PTC = premium tax credit. Income is for an individua tax-fi er.

Because of this structure, people with relatively higher incomes qualify for the enhanced PTC only if they face high gross premiums. For example, a person earning $200,000 has an expected contribution of $17,000 (8.5 percent of $200,000). So they qualify for PTC only if their benchmark premium exceeds $17,000. The credit at higher incomes is generally small. For example, if a person earning $200,000 faces a gross premium of $20,000, their expected contribution is $17,000, and the credit covers $3,000—15 percent of the total premium.

The Cliff Denies Some People the Federal Help for Health Insurance That's Available to Virtually All Other Americans—and Even the Enhanced PTC Is Smaller than the Tax Benefit for Employer Coverage at Incomes Beyond the Cliff

Almost all Americans receive some kind of federal assistance in paying for health insurance: more than half benefit from the tax exclusion for employer coverage—the largest tax expenditure in the tax code—and another hundred million or more have Medicare or Medicaid.[6] The PTC is designed to help people ineligible for these other benefits. With or without the enhancements, it is available only to people without other affordable coverage options.[7] The cliff denies this group any such benefit, disadvantaging them relative to other Americans.

Eliminating the cliff mitigates but doesn't remove this disparity. Treasury data shows that, for people with incomes past the cliff, the enhanced PTC is smaller on average than the tax benefit from employer-sponsored coverage.[8] This disparity is especially harmful to those who rely disproportionately on Marketplace coverage, including older people, rural Americans, and small businesses, as explained below.

The Cliff Is Especially Harmful for Older People and People in High-Premium Areas

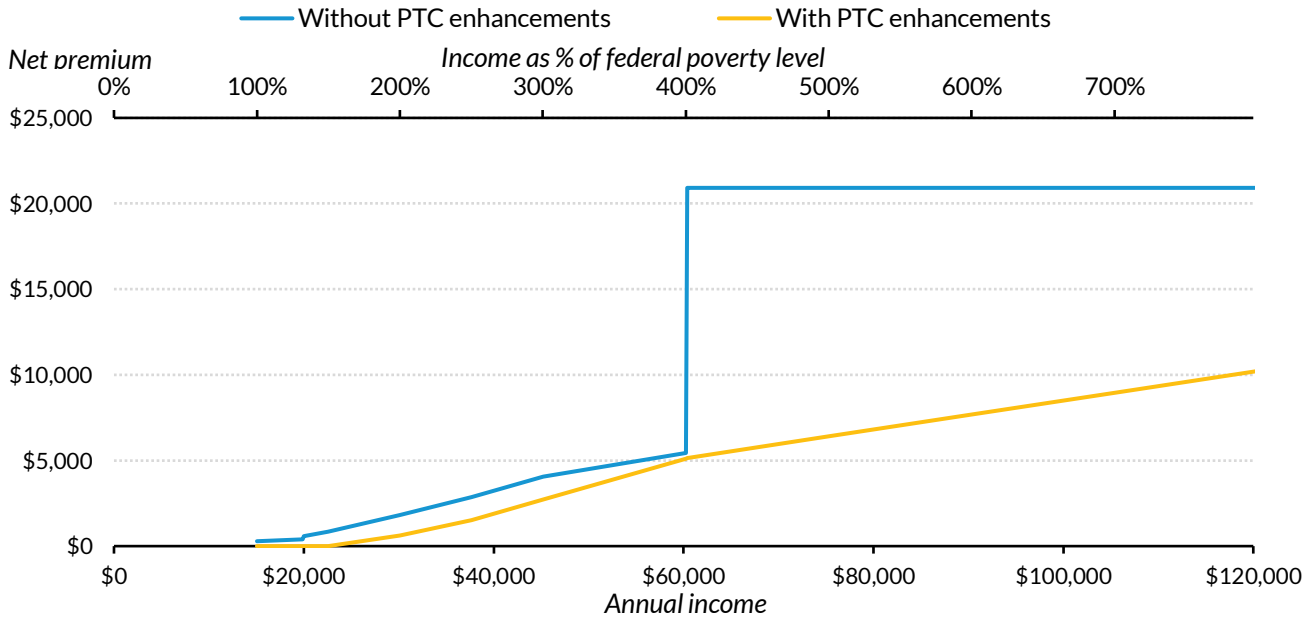
Extending the credit beyond the cliff is essential to making coverage affordable for people facing higher premiums—generally older people and people in high-premium areas (Banthin, Skopec, and Simpson 2024). With the cliff in place, those beyond it receive no assistance, even if the premium is very high.

For example, the benchmark premium for a 60-year-old in Cheyenne, Wyoming, is $20,916 annually.[9] With the cliff in place, a person with an income of $65,000 (432 percent of FPL) pays the full amount out of pocket, amounting to 32 percent of income (figure 4). They would likely also face a deductible of thousands of dollars (Holahan, Simpson, and Wengle 2025).

FIGURE 4

The Cliff Is Larger for Those Charged Higher Premiums

Net premium for a 60-year-old in a benchmark plan in Cheyenne, Wyoming, with and without PTC enhancements, 2025



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Notes: PTC = premium tax credit. Income is for an individual tax-filer. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bill Dering, JoAnn Volk, and Kevin Lucia, "Early 2026 Rate Filings Show Marketplace Policy Changes Contribute to Eye-Popping Rate Increases, CHIR, June 26, 2025, https://chir.georgetown.edu/early-2026-rate-filings-show-marketplace-policy-changes-contribute-to-eye-popping-rate-increases-2/.

Older adults not yet eligible for Medicare are especially harmed because the ACA permits higher gross premiums based on age.[10] Under age-rating rules, premiums are generally almost twice as expensive for a 50-year-old and three times as expensive for a 64-year-old compared with a 24-year-old.[11] This group includes people who have left the workforce and no longer have employer-sponsored insurance. The cliff affects this group disproportionately: of PTC recipients with incomes above 400 percent of FPL, 42 percent are 55 or older (USDT 2025). Of the small number of enrollees with income over 800 percent of FPL, about half are 55 or older (USDT 2025).

Premiums also tend to be high in rural areas, and they vary widely across states (Banthin, Skopec, and Simpson 2024; Holahan, Wengle, and O'Brien 2022). Enrollees in Alaska, West Virginia, and Wyoming pay significantly higher premiums relative to other states. This again translates to more harm from the cliff. For example, 21 percent of PTC recipients in Wyoming have income past the cliff, compared to 14 percent nationwide (USDT 2025).

With the enhancements in effect, the 60-year-old in Cheyenne earning $65,000 would have their contribution capped at 8.5 percent of income, or $5,525. This is the central logic of the no-cliff PTC—higher-income people pay more, but the amount is limited relative to income.

The Cliff Is Harmful for Small Businesses

The Marketplace is a crucial source of insurance outside of employer-sponsored coverage for the self-employed and small business owners, especially among those with incomes above the cliff. KFF estimates that 38 percent of adults younger than age 65 with incomes above 400 percent of FPL are self-employed, compared with 7 percent of adults under age 65 overall.[12] Treasury data shows that 3.3 million self-employed workers and small business owners ages 21 to 64 enrolled in Marketplace coverage in 2022, including 285,000 with incomes above 400 percent of FPL (USDT 2024). This represents 28 percent of total Marketplace enrollment for consumers ages 21 to 64 and 18 percent of all self-employed workers and small business owners; by comparison, the Marketplace covered just 6 percent of the rest of the population. This share is even higher in some states: in Florida, North Carolina, and Wyoming, at least a quarter of self-employed workers and small business owners enrolled in the Marketplace (USDT 2024). With Marketplace enrollment growth since 2022, the Center on Budget and Policy Priorities estimates that the number of self-employed workers and small business owners enrolled in the Marketplace has increased from 3.3 million to 5 million.[13]

Cliffs Are Widely Considered Bad Tax Policy

There is broad agreement among tax policy experts that eligibility cliffs in the tax system trigger negative behavioral effects and economic distortions (Maag et al. 2012; Viswanathan 2016).[14] Cliffs create perverse incentives to work less or otherwise make suboptimal decisions to retain benefits or reduce tax liability (Roll, Despard, and Miller 2025; Viswanathan 2016).[15] They also diminish horizontal equity —the principle that similarly situated taxpayers should be treated similarly (Viswanathan 2016).

Because of this, many tax provisions include gradual phaseouts, such as the Earned Income Tax Credit, the Child Tax Credit, and the recently created additional senior deduction.[16] Other notable examples include the American Opportunity Tax Credit, the Lifetime Learning Credit, and the Saver's Credit.[17] The income bracket system has the same effect by operating on a marginal basis.[18] The cliff in the unenhanced PTC defies this principle.

The PTC Reconciliation Requirement Makes the Cliff Especially Harmful

Even more than other tax benefits, the PTC is ill-suited to a cliff because it is typically paid in advance based on projected income and then "reconciled" with the actual PTC on the tax return.[19] Advance payment is essential, since most consumers cannot pay the full premium out of pocket. For consumers within the income eligibility range, the amount that must be paid back is never more than a small fraction of the income change. But consumers who cross the income cliff may owe back thousands of dollars after only a very small change in income. The surprise tax bills that result are especially large for those charged higher gross premiums, meaning older people and those in high-premium (often rural) areas.

Such increases in income can be impossible to predict—they could result from an end-of-year bonus, for example. KFF estimates that 9 percent of households with income between 100 and 400 percent of FPL in the first three months of the year end the year with income above 400 percent of FPL, and that 15 percent of adults ages 19 to 64 with incomes near the cliff have high income volatility.[20] This risk of large paybacks may deter people from enrolling. In 2019, taxpayers who ended the year with incomes between $100,000 and $200,000 and owed back PTC faced an average repayment of about $6,400.[21]

Conclusion

There are good reasons to focus public benefits on lower-income people who most need them. However, health coverage is so expensive that even middle-income earners need help affording it. The federal government provides this help to almost every American, whether via public insurance programs or tax benefits for employer-sponsored coverage. The PTC cliff would deny similar assistance to those who rely on the Marketplace, leaving middle-income Americans with health insurance premiums in the tens of thousands of dollars.

The enhanced PTC includes a phase-out that targets the credit to those who need it, taking into account both income and the premiums people face. A cliff on top of that phase-out is both redundant and, as the analysis presented here demonstrates, harmful to many who need help.

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Advancing Health in America

Fact Sheet: Enhanced Premium Tax Credits

The Issue

The federal government offers enhanced premium tax credits (EPTCs or tax credits) to help some individuals and families purchase insurance on the health insurance marketplaces. Eligibility and tax credit amounts are based on the individual or family's income level, as well as their access to other forms of comprehensive coverage, e.g., through their employer.

In 2021, Congress increased and expanded eligibility for the tax credits; however, those policies are scheduled to expire at the end of 2025. These 2021 tax credits have resulted in an additional 10 million people gaining coverage through the health insurance marketplaces while others receiving assistance paying their health insurance costs.[1] This has increased access to health care coverage and high quality care for patients and communities served by hospitals, health systems and other providers.

AHA Take

In support of the health of our patients and communities, as well as the stability of the entire health care system, the AHA urges Congress to extend the enhanced premium tax credits.

Why?

- The tax credits helped millions of Americans purchase affordable commercial health care coverage. **The expiration of this policy would effectively be a tax increase of $700 on average for millions of people across the nation.**
- The expiration of the enhanced tax credits will result in 4.2 million people becoming uninsured by 2034.[2] There would be a disproportionate impact to those in rural states and those with lower incomes.
- Some states would see higher rates of disruption in coverage and loss of federal tax funds, particularly those that have not expanded Medicaid. Several of these states, such as Texas and Florida, experienced some of the highest enrollment growth in the health insurance marketplaces due to the enhanced tax credits.
- The loss of coverage would put considerable financial stress on hospitals, health systems and other providers, which will face more uncompensated care and bad debt. This, in turn, would make it difficult for them to maintain services in their communities KNG Health Consulting found that **allowing the EPTCs to expire would result in a $28 billion reduction in hospital spending over 10 years.**

American Hospital Association™
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Background

Certain individuals and families are eligible for prospective, monthly tax credits that lower the cost of health insurance marketplace premiums. To be eligible, these individuals or families must:

- Meet certain income thresholds, based on the federal poverty level (FPL).[3]
- Not be eligible for other comprehensive coverage, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage (defined as costing less than 8.5% of household income).[4]
- Be a U.S. citizen or have proof of legal residency or, as of Jan. 1, 2025, be eligible for Deferred Action for Childhood Arrivals.
- If married, file taxes jointly.

The amount of tax credit that an individual or family is eligible for is based on household income, as well as the cost of the second-lowest silver plan in the individual's market. Once an individual or family has been determined eligible and selected their preferred health plan, the tax credit is immediately applied directly to the premium; thus, the enrollee only needs to pay the remaining amount.

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1 kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes

2 cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

3 The income used to calculate the EPTCs is an estimate by the applicant based on what they expect their household income to be in the coming year. When filing taxes at the end of the year, they may receive additional tax credits if their income was lower than expected. Alternatively, they may have to repay some of their tax credit if their income was higher than expected.

4 For employer-sponsored coverage to be considered affordable, it must meet a minimum value requirement, and the annual premium must be equal to or less than 9.02% of the individual's household income.

01.08.2026 / Statement

Families USA Applauds House Passage Of Three-Year Extension Of ACA Tax Credits After Forced Vote

WASHINGTON, D.C. — Anthony Wright, executive director of Families USA, issued the following statement after the House of Representatives voted 230-196 to pass a three-year extension of the enhanced premium tax credits under the Affordable Care Act, after a successful discharge petition late last year required the House to bring a vote to the floor:

"We now have a majority of both the House and the Senate in support of stopping the spikes in health premiums that happened on January 1. This discharge petition and vote put pressure on the President and the Republican Congressional leadership to stop with the poison pills and procedural barriers and extend the enhanced tax credits so Americans can afford coverage. Millions of Americans began the new year facing staggering increases in their monthly health insurance premiums – in many cases seeing health costs double overnight. This sudden spike, of more than one thousand dollars on average, is not just a shock – it's a breaking point. Without action, an estimated four million marketplace enrollees are expected to go uninsured, and many millions more will become underinsured, paying more and getting less.

"Today's vote represents a glimmer of hope for the 22 million Americans desperately trying to hold onto affordable health coverage for themselves and their families. Congress should not have needed a discharge petition to force a vote on something so **overwhelmingly supported** by the public and so essential to the health and financial security of American families. Every day we delay does further damage, so it's urgent for the Senate to stand with the **77%** of voters who want to see a clean extension passed.

"With open enrollment ending in most states in just six days, families are being forced to make impossible choices in real time. Doing nothing is a choice to price out and push millions to lose coverage, rack up debt and go without care. The Senate must now do its job and deliver the relief American families urgently need."

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Updated: November 3, 2025 | Gideon Lukens and Elizabeth Zhang

Health Insurance Premium Spikes Imminent as Tax Credit Enhancements Set to Expire

Enhancements to premium tax credits, enacted in the American Rescue Plan and extended by the Inflation Reduction Act, are helping more than 20 million people afford health coverage in the Affordable Care Act (ACA) marketplaces. The enhancements helped spur a doubling of enrollment in the ACA marketplaces and contributed to record-low uninsured rates but are set to expire at the end of 2025. And marketplace enrollees are already starting to see the impact: insurers have finalized their 2026 premium rates, enrollees can see their 2026 premiums on marketplace websites, and open enrollment will be underway November 1. If Congress waits until the end of the year to extend the enhancements, 1.5 million more people will be uninsured in 2026 compared to an earlier extension, the Congressional Budget Office (CBO) estimates.[1]

Congress can still protect people from cost increases due to the end of the enhancements — which will exceed $1,000 annually for the average enrollee receiving premium tax credits, and many times that for some people — and minimize the number who are left uninsured by extending the enhancements as soon as possible. Since Congress has not acted sooner and many enrollees likely have already experienced sticker shock and decided not to enroll, it should also extend the open enrollment period (scheduled to end January 15 in most states) to give people more time to sign up. Appendix 2 provides state-by-state data on the premium increases if the enhancements expire.

The megabill Republicans enacted in July and a marketplace regulation the Trump Administration finalized in June will already create new barriers to marketplace enrollment and raise people's out-of-pocket costs.[2] If Congress allows the premium tax credit enhancements to expire, nearly all marketplace enrollees will face significantly higher premium costs, which will more than double on average, and 3.8 million more people will be uninsured in 2035.[3] Congress should make the enhancements permanent so that families have stability and predictability when it comes to their access to affordable health insurance.

Premium Costs Will More Than Double on Average if Enhancements Expire

A record 93 percent of marketplace enrollees, or over 20 million people, receive premium tax credits (PTCs).[4] These tax credits provide upfront financial assistance to help people afford the individual or family health insurance plans offered in their state through the ACA marketplaces.[5]

The PTC enhancements help these enrollees by:

- lowering the caps on the share of income that people at all income levels pay in premiums;

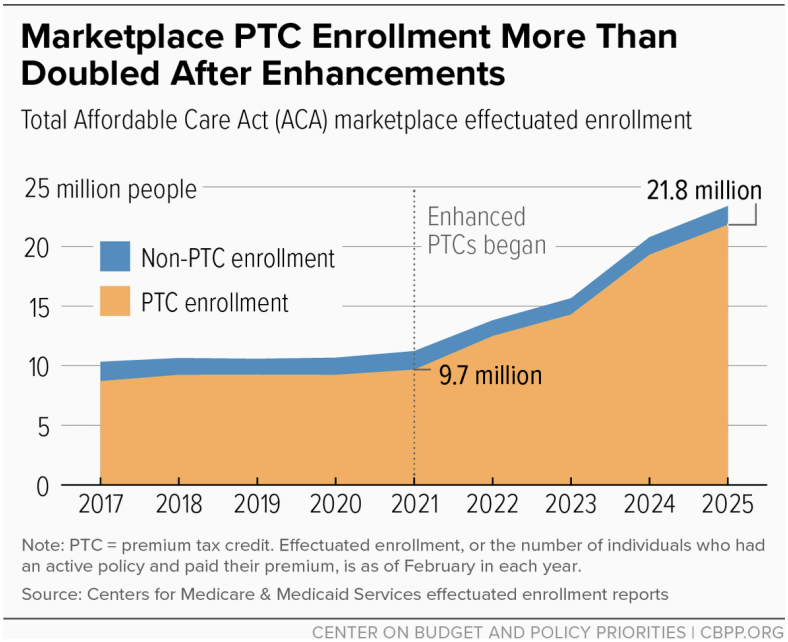
- allowing people with incomes between 100 and 150 percent of the poverty level (roughly $16,000 to $23,000 for an individual) to pay $0 in premiums for "benchmark" silver-level plans; and
- extending eligibility for PTCs to people with incomes above 400 percent of poverty (roughly $63,000 for an individual) if their benchmark premiums would exceed 8.5 percent of household income.

Without the PTC enhancements, the amount the average enrollee receiving PTCs pays in premiums out of pocket will more than double, rising by more than $1,000 a year.[6]

Enhancements Spurred Record Coverage, Especially Among Black and Latino People and Families With Lower Incomes

By making health insurance more affordable, the PTC enhancements have helped more people afford marketplace coverage: 23.4 million were enrolled as of February 2025, up from 11.2 million in February 2021, prior to the enhancements. Some 21.8 million of them receive tax credits to help pay for their coverage, more than double the 9.7 million who received tax credits in February 2021.[7] (See Figure 1.) Thanks in large part to the PTC enhancements, gains in marketplace enrollment offset much of the 2024 decline in Medicaid enrollment due to the unwinding of the pandemic-related provision that temporarily kept Medicaid enrollees covered.[8]

FIGURE 1

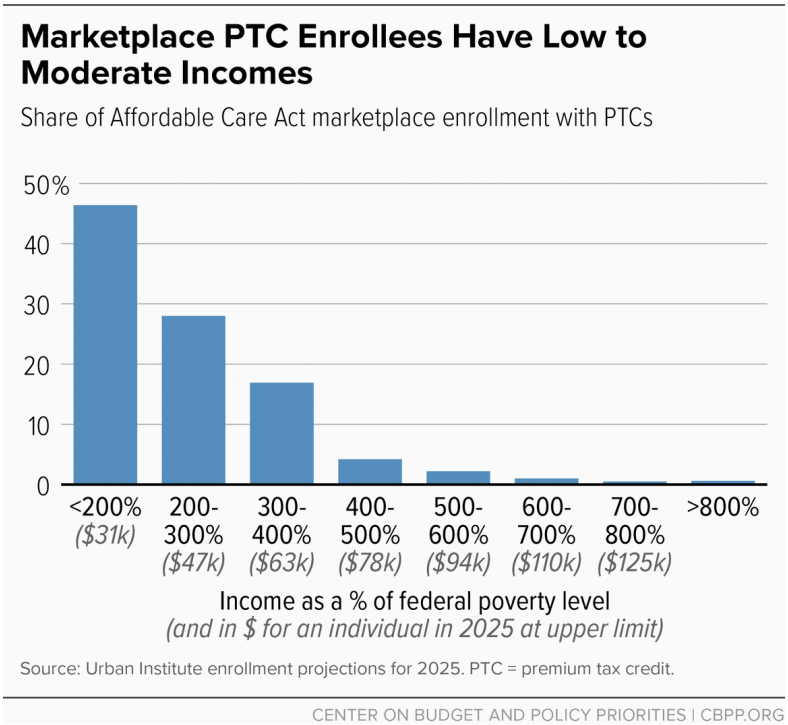


The PTC enhancements have been especially critical for increasing enrollment among Black and Latino people. People of color made up 54 percent of marketplace enrollees in 2024, up from 46 percent in 2021. Between 2021 and 2024, marketplace enrollment among Black and Latino people grew by 186 percent and

158 percent, respectively, compared to 63 percent for other racial and ethnic groups.[9] Marketplace enrollment rates of Asian American people have long been higher than other racial and ethnic groups, potentially due to robust and language-specific enrollment assistance among nonprofits and insurance brokers.[10]

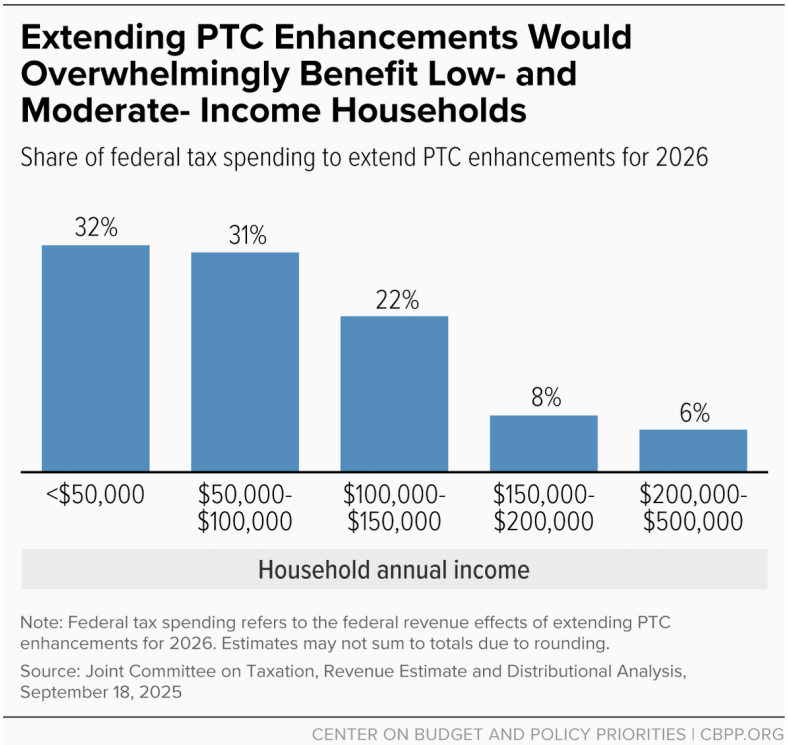
The PTC enhancements also helped spur enrollment among people with lower incomes — those just above the minimum income level for PTC eligibility. Between 2021 and 2025, marketplace enrollment among people with incomes between 100 and 200 percent of the federal poverty level grew by 143 percent, more than twice the 59 percent growth rate among those with other incomes.[11] Marketplace PTCs overwhelmingly benefit people with low to moderate incomes. More than 9 in 10 enrollees have incomes below 400 percent of the federal poverty level, or about $63,000 for an individual in 2025.[12] (See Figure 2.)

FIGURE 2



The total dollar value of the PTC enhancements is also overwhelmingly concentrated among people with low and moderate incomes. According to the Joint Committee on Taxation (JCT), if the enhancements are extended, the majority of the benefits would go to households making less than $80,000, and 94 percent would go to households with incomes under $200,000.[13] No benefits would go to households with incomes above $500,000, according to JCT. (See Figure 3.)

FIGURE 3



Finally, the PTC enhancements have been crucial for self-employed workers and small business owners who, prior to the ACA, had limited options for affordable coverage and who disproportionately benefit from the ACA marketplaces.[14] Self-employed workers and small business owners generally make up about 1 in 4 marketplace enrollees, the Treasury Department estimates; based on this figure, CBPP estimates that more than 5 million self-employed workers and small business owners are enrolled in ACA marketplaces.[15]

Many of these coverage gains will be lost if the PTC enhancements are allowed to lapse. Without the enhancements, CBO projects that 3.8 million more people will be uninsured in 2035.[16] According to the Urban Institute, the number of Black people who are uninsured in 2026 will increase by 30 percent or 925,000, the largest rate of increase among racial/ethnic groups.[17] Marketplace enrollment would decline in every state and congressional district, with the number of enrollees receiving PTCs declining by 38 percent overall.[18]

> “[M]aybe I have to hold back … eat less … take less insulin” if the PTC enhancements expire
>
> *– M. M., 45-year-old IT consultant in Illinois*

Recent focus groups convened by CBPP show the real-world impacts that the PTC enhancements have had on people’s lives — and the repercussions if they expire.[19] For Tracy, a 57-year-old customer service

representative from Georgia whose plan's out-of-pocket premiums are set to rise by $350 per month, the rise in marketplace premiums would "most likely mean sacrificing essentials: groceries, gas, basic necessities that I rely on." Losing the PTC enhancements would force tough decisions, including for people with chronic conditions. M. M., a 45-year-old IT consultant from Illinois, might "hold back on some of those medications, eat less … take less insulin to treat my diabetes."

Premiums Would Rise in Every State, for All Ages and Income Levels

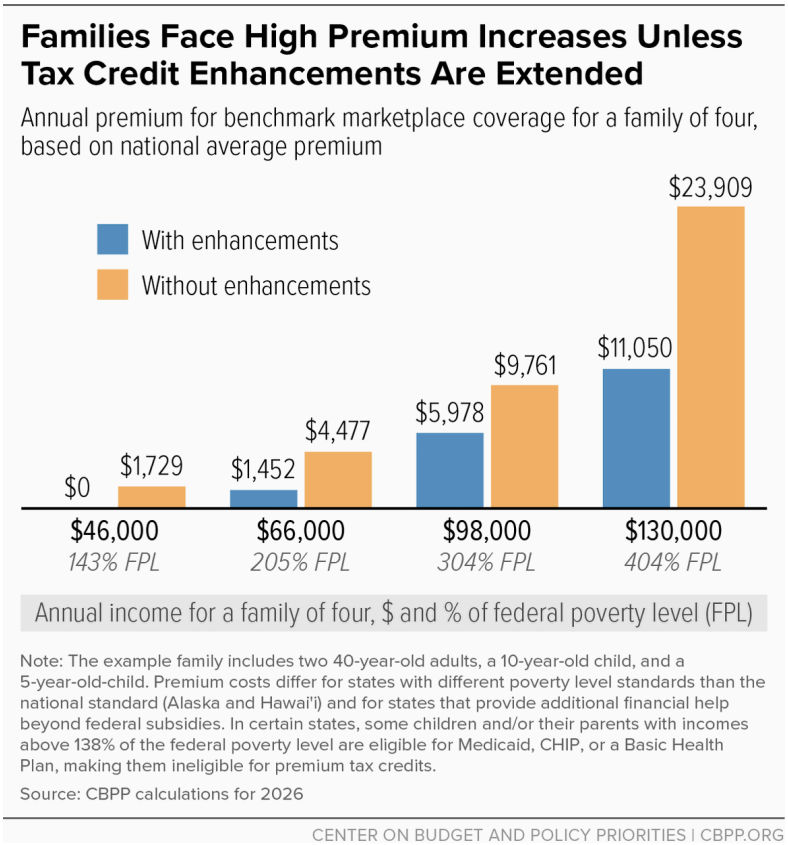
If the PTC enhancements expire, premium costs will soon increase for people across states, ages, and income levels. Many have already experienced "rate shock" and more will continue to do so, as insurers in some states have sent renewal notices showing spiking 2026 premiums and premiums are already viewable on many marketplace websites. And the premium increases would come on top of premium and other out-of-pocket cost increases already set to begin in 2026 due to a recent Trump Administration rule.[20]

People with lower incomes will tend to face the largest percentage increases in premium costs if the PTC enhancements expire. For example:

- A single individual making $22,000 (140 percent of the poverty level) will no longer be eligible for a zero-premium silver plan with cost-sharing reductions and will see their monthly marketplace premium rise from $0 to $66 — an annual increase of $786.
- A single individual making $32,000 (204 percent of the poverty level) will see their monthly marketplace premium rise from $58 to $180 — an annual increase of $1,468.
- A couple making $44,000 (208 percent of the poverty level) will see their monthly marketplace premium rise from $85 to $253 — an annual increase of $2,013.
- A family of four making $66,000 (205 percent of the poverty level) will see their monthly marketplace premium rise from $121 to $373 — an annual increase of about $3,025.

See Figure 4 for a family of four at different income levels; Appendix Table 1 for premium increases among people of various family sizes, ages, and incomes; and Appendix Table 2 for premium increases at the state level. State-by-state graphics of sample households are also available.[21]

FIGURE 4



As a result of the enhancements, people with incomes above 400 percent of the poverty level became newly eligible for PTCs if their marketplace premiums would exceed 8.5 percent of household income. This was especially beneficial for some people earning just over 400 percent of poverty, whose premiums would otherwise have taken up a large share of their income.[22] If the PTC enhancements are not extended, people in this group will face dramatic premium increases:

- A typical 60-year-old couple making $85,000 (401 percent of the poverty level) will see monthly marketplace premiums jump from $602 to $2,647 — an annual increase of roughly $24,500.
- A typical family of four making $130,000 (404 percent of the poverty level) will see their monthly marketplace premium go from $921 to $1,992 — an annual increase of about $12,900.

Dramatic premium spikes are most likely to occur:

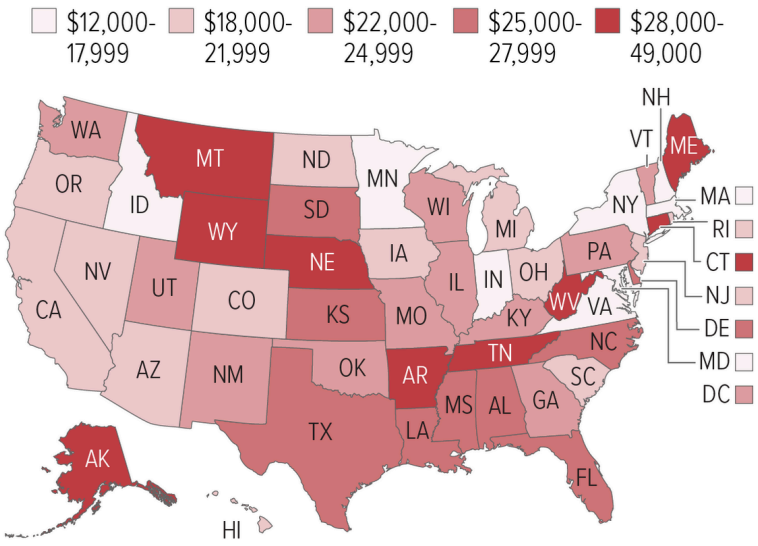
- in states with high underlying marketplace premiums, such as West Virginia and Wyoming;
- for older enrollees, who pay higher premiums under ACA rules than younger people; and
- for people with incomes above 400 percent of the poverty level (roughly $63,000 for an individual), who would lose subsidies entirely if the enhancements expired.

For example, a 60-year-old West Virginia couple making $85,000 will see annual premiums for a benchmark silver plan skyrocket from $7,225 to over $54,000. (See Figure 5 and Appendix Table 2).

FIGURE 5

Premiums Set to Rise Dramatically Without Extension of Tax Credit Enhancements

Annual premium increase, 60-year-old couple with income of $85,000 (401% FPL)



Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 state average benchmark (second-lowest-cost silver plan) premiums. Calculations for Alaska and Hawai'i are for incomes of 401% of state poverty levels, which differ from the FPL. Calculations do not account for state subsidized marketplace premiums in Massachusetts, New Jersey, and New Mexico.

Source: CBPP calculations

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Appendix

APPENDIX TABLE 1

National Average Premium Increases if Enhancements Expire, by Income Level

	Annual marketplace premiums			
	With enhancements (current)	Without enhancements	Premium increase without enhancements	Percentage premium increase
		45-year-old individual		
$22,000 (140% FPL)	$0	$786	$786	N/A
$32,000 (204% FPL)	$691	$2,159	$1,468	212%
$48,000 (306% FPL)	$2,952	$4,781	$1,829	62%
$64,000 (408% FPL)	$5,440	$8,450	$3,010	55%
		60-year-old couple		
$30,000 (141% FPL)	$0	$1,090	$1,090	N/A
$44,000 (208% FPL)	$1,021	$3,034	$2,013	197%
$64,000 (306% FPL)	$3,872	$6,374	$2,502	65%
$85,000 (401% FPL)	$7,225	$31,762	$24,537	340%
		Family of four		
$46,000 (143% FPL)	$0	$1,729	$1,729	N/A
$66,000 (205% FPL)	$1,452	$4,477	$3,025	208%
$98,000 (304% FPL)	$5,978	$9,761	$3,783	63%
$130,000 (404% FPL)	$11,050	$23,909	$12,859	116%

Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 national average benchmark (second-lowest-cost silver plan) premiums for essential health benefits with age adjustments. The example family includes two 40-year-old parents, a 10-year-old, and a 5-year-old. Estimates are applicable in all states except for those with different poverty level standards than the national standard and/or those that subsidize marketplace premiums beyond the federal subsidy. See Appendix Table 2 for state-specific estimates.

Source: CBPP calculations

APPENDIX TABLE 2

State-by-State Premium Increases if Enhancements Expire

	45-year-old individual; $64,000 (408% FPL)			60-year-old couple; $85,000 (401% I		
State	With enhancements (current)	Without enhancements	Premium increase without enhancements	With enhancements (current)	Without enhancements	Prem incre with enhanc
U.S. average	$5,440	$8,450	$3,010	$7,225	$31,762	$24,
Alabama	5,440	8,745	3,305	7,225	32,874	25,6
Alaska[a]	6,780	13,993	7,213	9,009	52,598	43,5
Arizona	5,440	7,213	1,773	7,225	27,115	19,8
Arkansas	5,440	10,494	5,054	7,225	39,449	32,2
California	5,440	7,756	2,316	7,225	29,153	21,9
Colorado	5,440	7,539	2,099	7,225	28,338	21,1
Connecticut	5,440	11,796	6,356	7,225	44,341	37,1
Delaware	5,440	9,369	3,929	7,225	35,218	27,9
District of Columbia	5,440	8,823	3,383	7,225	31,362	24,1
Florida	5,440	9,261	3,821	7,225	34,811	27,5
Georgia	5,440	8,556	3,116	7,225	32,160	24,9
Hawai'i [a]	6,239	7,335	1,096	8,289	27,573	19,2
Idaho	5,440	6,671	1,231	7,225	25,076	17,8
Illinois	5,440	8,217	2,777	7,225	30,886	23,6
Indiana	5,440	6,427	987	7,225	24,158	16,9
Iowa	5,440	6,793	1,353	7,225	25,535	18,3
Kansas	5,440	9,084	3,644	7,225	34,148	26,9
Kentucky	5,440	8,217	2,777	7,225	30,886	23,6
Louisiana	5,440	8,759	3,319	7,225	32,925	25,7
Maine	5,440	9,600	4,160	7,225	36,085	28,8
Maryland	5,440	5,573	133	7,225	20,947	13,7
Massachusetts [b]	5,440	6,534	1,094	7,225	20,455	13,2
Michigan	5,440	7,118	1,678	7,225	26,758	19,5
Minnesota	5,440	6,034	594	7,225	22,680	15,4
Mississippi	5,440	8,976	3,536	7,225	33,740	26,5
Missouri	5,440	8,203	2,763	7,225	30,835	23,6
Montana	5,440	9,383	3,943	7,225	35,269	28,0
Nebraska	5,440	9,627	4,187	7,225	36,187	28,9
Nevada	5,440	6,739	1,299	7,225	25,331	18,1
New Hampshire	5,437	5,437	0 [c]	7,225	20,438	13,2

APPENDIX TABLE 2

State-by-State Premium Increases if Enhancements Expire

	45-year-old individual; $64,000 (408% FPL)			60-year-old couple; $85,000 (401% I		
State	With enhancements (current)	Without enhancements	Premium increase without enhancements	With enhancements (current)	Without enhancements	Prem incre with enhanc
New Jersey [b]	5,440	7,389	1,949	7,225	27,777	20,5
New Mexico [b]	5,440	8,461	3,021	7,225	31,803	24,5
New York	5,440	9,948	4,508	7,225	19,896	12,6
North Carolina	5,440	8,650	3,210	7,225	32,517	25,2
North Dakota	5,440	7,728	2,288	7,225	29,051	21,8
Ohio	5,440	6,956	1,516	7,225	26,146	18,9
Oklahoma	5,440	8,189	2,749	7,225	30,784	23,5
Oregon	5,440	7,444	2,004	7,225	27,981	20,7
Pennsylvania	5,440	7,891	2,451	7,225	29,663	22,4
Rhode Island	5,440	6,874	1,434	7,225	25,840	18,6
South Carolina	5,440	7,688	2,248	7,225	28,898	21,6
South Dakota	5,440	8,881	3,441	7,225	33,383	26,1
Tennessee	5,440	9,640	4,200	7,225	36,238	29,0
Texas	5,440	8,962	3,522	7,225	33,689	26,4
Utah	5,440	9,077	3,637	7,225	31,156	23,9
Vermont	5,440	15,540	10,100	7,225	31,080	23,8
Virginia	5,440	6,223	783	7,225	23,394	16,1
Washington	5,440	8,284	2,844	7,225	31,141	23,9
West Virginia	5,440	14,548	9,108	7,225	54,688	47,4
Wisconsin	5,440	8,284	2,844	7,225	31,141	23,9
Wyoming	5,440	14,779	9,339	7,225	55,554	48,3

Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 state average benchmark (second-lowest-cost silver plan) premiums for essential health benefits with age adjustments. The example family includes two 40-year-old parents, a 10-year-old, and a 5-year-old.

[a] Incomes in dollars for Alaska and Hawai'i differ from those shown here because these states' poverty levels differ from the federal poverty level.

[b] Massachusetts estimates do not account for extra state subsidies available through ConnectorCare Plan Type 3D, which will only be continued in 2026 if tax credit enhancements are extended. New Jersey estimates do not account for extra state subsidies of $50 per member per month for enrollees with income between 400 and 600 percent FPL. New Mexico estimates do not account for extra state subsidies that will cover the impact of the expiring enhancements in 2026 for enrollees with income over 400 percent FPL through June 2026.

[c] Premium payments without the enhancements do not exceed the income cap of 8.5 percent and are therefore equal with or without enhancements.

[d] Estimates for a family of four in New York are for an income level of $132,000 (410 percent FPL), as the CHIP income eligibility threshold for children is 405 percent FPL.

Source: CBPP calculations

END NOTES

[1] By the end of the year, open enrollment will be almost over in most states, and many peop will have decided to drop coverage after seeing large premium increases for their plans. Alsc insurers have already finalized rates assuming that the expiration of the premium tax credit enhancements will push out some healthier enrollees, driving up underlying premiums. Congressional Budget Office estimates provided to House leadership. Laura Weiss and Samantha Handler, "Johnson's To-do List of Tuesday," Punchbowl News, September 16, 202 ttps://punchbowl.news/archive/91625-am/#__thevaultwhydemswantobamacaredealnow.

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Center on Budget and Policy Priorities

Off the Charts
POLICY INSIGHT
BEYOND THE NUMBERS

December 4, 2025, 9:00 am

How to Evaluate Proposals to Address Expiring Premium Tax Credit Enhancements

By Jennifer Sullivan

With just weeks to go until the premium tax credit (PTC) enhancements expire — which would increase Affordable Care Act (ACA) marketplace enrollees' annual premiums by more than $1,000 on average[1] — members of Congress have floated proposals ranging from cleanly extending the enhancements[2] to making major structural changes[3] that would raise people's costs and leave many uninsured. As proposals claiming to address expiring PTC enhancements continue to surface, they should be evaluated based on the extent to which they:

1. preserve existing coverage levels and avoid leaving more people uninsured;
2. ensure people keep access to affordable, comprehensive coverage; and
3. can take effect quickly.

Preserve existing coverage levels and avoid leaving more people uninsured: Proposals that increase marketplace enrollees' premiums (after taking into account premium credits) will result in more people becoming uninsured. If the enhancements expire completely, the Congressional Budget Office estimates that 3.8 million people[4] will lose marketplace coverage and become uninsured. This is against the backdrop of the harmful megabill that Republicans enacted earlier this year, which cuts Medicaid, Medicare, and marketplace coverage and is projected to leave an additional 10 million people[5] uninsured in 2034.

Proposals that would eliminate $0 premium plans — which have been instrumental[6] in providing a pathway to affordable coverage for people with very low incomes who are ineligible for Medicaid — would increase financial and administrative burdens and make it more likely that people with low incomes lose coverage or are covered for fewer days per year. Nearly 1 million[7] marketplace enrollees would lose coverage if they were required to pay even a few dollars a month, according to an estimate from the Brookings Institution.

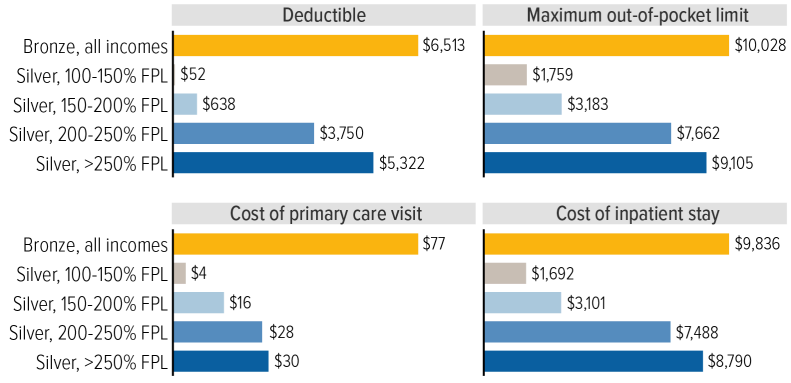
Ensure people keep access to affordable, comprehensive coverage: Although their designs vary widely, all ACA marketplace plans currently provide financial protections in the form of limited deductibles and annual out-of-pocket spending limits. People with income at 250 percent of the federal poverty level

($37,650 for an individual) and below qualify for cost-sharing reductions (CSRs) that provide even stronger protections against large health care bills and medical debt.

Proposals to replace these protections with cash or health savings account (HSA) deposits[8] or to use federal dollars to drive people into less-comprehensive coverage (e.g., bronze plans, see graphic) would leave people vulnerable to high out-of-pocket costs[9]. They'd also take federal resources[10] away from people with more health care needs to give cash or HSA deposits to people with fewer needs.

Silver Marketplace Plans Provide More Protection From High Health Care Costs Than Bronze Plans

Average plan features and example costs of care for individuals in Affordable Care Act marketplace plans, by metal level and income eligibility for silver plans with CSRs



Note: CSR = cost-sharing reduction; FPL = federal poverty level.

Source: CBPP analysis of the Centers for Medicare & Medicaid Services landscape files for healthcare.gov states. Costs of care are based on the latest national averages from the Agency for Healthcare Research and Quality adjusted for health care inflation and assume enrollees have not applied other expenses toward their deductibles.

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Can take effect quickly: The 2026 coverage year begins on January 1, 2026, and the ability for millions of enrollees to maintain coverage hangs in the balance. Each day that passes without an extension to the PTC enhancements drives more people away[11] from marketplace coverage, and it will be hard to get them back.

> "Each day that passes without an extension to the PTC enhancements drives more people away from marketplace coverage, and it will be hard to get them back." [12]

Proposed changes to marketplace policy — including to the PTCs and premium payment requirements, CSRs, benefits, and HSAs — vary in complexity, but nearly all would be structural and impossible to implement quickly. Significant changes would take time and resources[13] for marketplaces to develop policies and operationalize, and would require yet more time to explain to enrollees (which would be especially difficult in HealthCare.gov states, where the Administration slashed federal funding[14] for enrollment assistance by 90 percent).

Extending the PTC enhancements, in contrast, would be far simpler because they are in place until the end of 2025 and could be restored quickly[15] for people purchasing 2026 coverage. If legislation also grants people more time to enroll for 2026, they will be able to return to the marketplace, assess their new options, and secure coverage.

A clean extension would be the best outcome for the more than 20 million people whose coverage and costs are hanging in the balance, and there is still time for Congress and President Trump to act.

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ADVOCACY

Older Adults Face Spike in Health Insurance Costs as ACA Tax Credits Expire

AARP is fighting for a permanent extension of savings that lower the price of Affordable Care Act coverage

By 71

Published September 19, 2025 / Updated December 12, 2025

AARP (GETTY IMAGES, 2)

Charlene Sterlace is feeling the pinch of higher health insurance premiums already.

The 61-year-old New York state resident has purchased insurance since 2019 through the state's Affordable Care Act Marketplace. She remembers her rates plunging during the pandemic when Congress enacted new tax credits. "I was so grateful," she says.

Since then, she and millions of other older adults who rely on health

those enhanced premium tax credits. Those credits, a form of savings that emerged in 2021 and expanded upon federal tax credits already available to low-income enrollees, lowered the cost of marketplace plans across the board.

But the enhanced premium tax credits are set to expire at the end of this year, and open enrollment ends Dec. 15 for coverage that starts on Jan. 1. Two proposals to address this problem — one by Democrats to extend the tax credits for three years and one by Republicans to soften the blow of higher premiums with health savings accounts — were blocked in the Senate on Thursday. That means the cost of ACA health insurance will skyrocket for many people in January.

The change will hit especially hard for nearly 5 million adults between the ages of 50 and 64 who rely on this coverage. They already pay up to three times more for private insurance than younger adults on the same plan.

Join Our Fight to Protect Older Americans

Here's what you can do to help:

- Sign up to become an AARP activist for the latest news and alerts on issues you care about.
- Find out more about how we're fighting for you every day in Congress and across the country.
- AARP is your fierce defender on the issues that matter to people 50-plus. Become a member or renew your membership today.

When the enhanced premium tax credits lapse, people with incomes above 400 percent poverty will lose their cushion entirely. Adults between the ages of 50 to 64 who have high premiums will see their average annual

enrollees will continue to receive premium reductions but will see higher premiums because of the loss of enhanced premium tax credits. Older adults with incomes at 100 to 400 percent of poverty will face average premium increases in 2026 of $600 to $1,400 per year.

In August, Sterlace estimated that the current tax credits are saving her $35 to $40 per month on her premiums.

“When you take away this extra help, even if it’s $5 a month, that’s still $5 a month, because your electric bill goes up $14 a month,” she says. “People can’t afford it.”

The importance of ACA tax credits

Health insurance rarely feels like a bargain. But enhanced premium tax credits have been a lifeline for those who otherwise felt priced out of their insurance.

Before the pandemic, people whose incomes fell between 100 percent and 400 percent of the federal poverty level and did not have access to affordable coverage through an employer could receive financial help for their ACA plans. But those limits froze out anyone above that 400 percent threshold.

“That was really hard for our folks, the 50 to 64, many of whom are right above that,” says Brendan Rose, a government affairs director at AARP. According to KFF, a nonprofit focused on health policy research and polling, 51 percent of ACA enrollees with incomes over four times poverty ($62,600 for an individual in 2025) fall in that age range.

2022, Congress extended these benefits through the end of 2025 as part of the Inflation Reduction Act.

AARP has been pushing Congress to make the enhanced premium tax credits permanent rather than letting them expire. In 2023, AARP joined Keep Americans Covered, a coalition of health care organizations and advocacy groups fighting for lower-cost premiums and a permanent extension of ACA credits.

Throughout 2025, AARP also engaged with members of the Senate, House and their staff members hundreds of times to emphasize the damage the loss of these tax credits will have in a specific state or congressional district.

"We urge Congress to act swiftly and extend the enhanced premium tax credits that help make health care more affordable and accessible for millions of Americans before they expire at the end of this month," AARP wrote in a December statement to the U.S. Senate Committee on Health, Education, Labor and Pensions. "Nowhere is that pressure heavier than on Americans ages 50 to 64, who do not yet qualify for Medicare coverage and who are more likely to need health care services than other age groups."

Without the enhanced premium tax credits, a couple with a household

year-old couple earning $85,600, just above 400 percent of poverty, could see annual premium increases of 399 percent in Texas, 384 percent in South Dakota, and 421 percent in Florida.

Health insurance sticker shock

Just over 40 percent of those enrolled in ACA marketplace health insurance are between the ages of 45 and 64, [according to a fact sheet](#) published by AARP's Public Policy Institute in September. Some retired before they were eligible for Medicare. Others work for companies

"A lot of folks are starting businesses, taking on new challenges or facing adverse circumstances where they were let go from their jobs and face a loss of coverage for the first time in decades," Rose says.

The enhanced premium tax credits meant that people with annual incomes below 150 percent of poverty may pay nothing at all for their premiums, depending on which plan they select. People with incomes above four times poverty got a break for the first time in 2021.

For example, AARP's Public Policy Institute found that a 60-year-old marketplace enrollee earning 450 percent of poverty, or $70,425, would pay an average annual premium of $5,760 for silver plan coverage in 2025. Without the 8.5 percent cap, that person would have paid $12,653 for the year.

These credits reduced the number of uninsured people and helped drive ACA marketplace enrollment to a record high of 24.3 million people in 2025, according to KFF.

"It shows that this just wasn't a pandemic crisis," says Sara Collins, senior scholar at the Commonwealth Fund, a foundation that supports health care research. "It was an affordability issue in the law itself that needed to be fixed by Congress."

KFF estimates that the premiums enrollees pay out of pocket will increase by an average of 114 percent next year for those receiving tax credits across all age groups — but the increase will likely be higher for older adults. This spike is not just about pending expiration of the enhanced premium tax credits, though. Insurers are also concerned about rising health care and labor costs, inflation and tariffs.

If ACA enrollees feel they cannot afford their new rates as premiums rise and enhanced tax credits disappear, the trade-offs they face are tough. Open enrollment ends on Dec. 15 for coverage that starts on Jan. 1, leaving little time to decide.

People may choose to downgrade to a cheaper plan, such as from a silver to a bronze plan, but that will come with more out-of-pocket costs when seeking medical care. Those who are self-employed may decide to reenter the corporate world to access group health insurance, at the cost of job flexibility or a solo business they enjoy. Others may need to cut back on other expenses to afford medical care.

“Some individuals will be left with no good option,” says Matt McGough, a policy analyst in KFF’s program on the Affordable Care Act.

Christine Meehan, who is 51 and lives in Upper Chichester, Pennsylvania, has faced the dilemma of whether or not to maintain insurance. Meehan has been a hairstylist for 32 years. At one point, she worked for a chain that offered health insurance. Otherwise, she sometimes purchased private insurance and other times risked going without before the ACA.

The cost of coverage through Pennie, Pennsylvania’s marketplace, “is not bad,” Meehan says. She pays $160 per month thanks to her premium tax credits; otherwise, her monthly rate would be $583. Meehan and her fiancé explored the cost of adding her to his group health insurance, but he

Meehan will pay $264 out of pocket for the same plan in 2026. "It's a $100 increase a month, but it's still doable," she says. "I am just going to have to watch other things."

Still, she notes that the increase in her monthly premiums between 2025 and 2026 will be 65 percent.

"That's a lot," she says.

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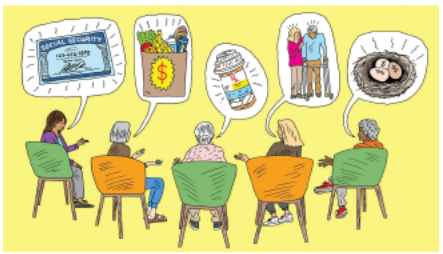

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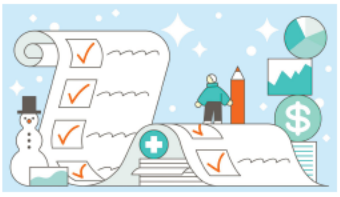

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Moe's Southwest

September 15, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Chuck Schumer
Senate Minority Leader
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable John Thune
Senate Majority Leader
U.S. Senate
S-230, the Capitol
Washington, DC 20510

The Honorable Hakeem Jeffries
House Democratic Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson, Majority Leader Thune, Minority Leader Schumer, and Leader Jeffries:

The undersigned physician organizations representing national medical societies and state medical associations write to urge Congress to enact legislation to extend the enhanced advance premium tax credits (APTCs) established under section 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986.

These enhanced credits have made health coverage more affordable for the more than 24 million Americans who purchased coverage through the Health Insurance Marketplaces in 2025, including many who are older, live in rural areas, or operate small businesses. For these individuals, the credits are a key means of securing comprehensive coverage, as the credits are only available to individuals who do not have access to such coverage outside of the Health Insurance Marketplaces.

Without congressional action, millions of Americans will face significant increases in their annual premiums, and the Congressional Budget Office projects that 4.2 million people will lose coverage entirely. The financial consequences are substantial:

- A family of four earning $64,000 annually would see the amount they pay for insurance coverage rise by approximately $2,600 in 2026.
- A 60-year-old couple with an income of $80,000 would see an increase of about $17,500 annually.

Even individuals who are not eligible for APTCs will be affected by their expiration, as the enhanced APTC drew healthier people into the insurance marketplaces, improving the risk pool and lowering premiums overall.

These increases will be evident to consumers as soon as marketplace “window shopping” begins in the fall of 2025, well ahead of the 2026 open enrollment period. Many current enrollees are already receiving insurer notices that project steep premium increases if the credits are not extended.

Extending the enhanced APTCs will continue to lower premiums across income levels, mitigate financial barriers to care, and sustain enrollment in the marketplaces. Allowing them to expire would reverse these gains, increase the uninsured rate, and raise uncompensated care costs for hospitals and physician practices nationwide.

We respectfully urge Congress to act in a timely manner so that marketplaces, insurers, and consumers have certainty well in advance of the 2026 coverage year.

Thank you for your attention to this important matter and for your continued commitment to ensuring access to affordable health coverage.

Sincerely,

American Medical Association
Academy of Physicians in Clinical Research
American Academy of Allergy, Asthma & Immunology
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
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American College of Lifestyle Medicine
American College of Medical Genetics and Genomics
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Epilepsy Society
American Geriatrics Society
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Surgery of the Hand Professional Organization
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Hematology
American Society of Neuroradiology
American Society of Plastic Surgeons
American Urological Association
American Medical Group Association
Association for Clinical Oncology
Association of American Medical Colleges
Medical Group Management Association
National Association of Medical Examiners
National Association of Spine Specialists
Renal Physicians Association
Society for Maternal-Fetal Medicine
The National Association of Medical Examiners

Medical Association of the State of Alabama

Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Vermont Medical Society
The Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

Keep Americans Covered

KAC APPLAUDS HOUSE PASSAGE, URGES SENATE TO EXTEND HEALTH CARE TAX CREDIT

Keep Americans Covered

Washington, DC – Today, the House of Representatives passed a three-year extension of the health care tax credit, continuing a trend of growing bipartisan support for the policy. In response, Keep Americans Covered, a coalition of the health care community fighting for an extension of the health care tax credit, released the following statement:

"Today a bipartisan majority of the House took an extraordinary action to force a vote and demonstrate that there is clear support for extending the health care tax credit in Congress. We appreciate all those members who voted to avoid a cost crisis for millions of families. Right now, Americans everywhere are suffering from skyrocketing health premiums because lawmakers have not gotten the job done. That is unacceptable, and now it is critical that the Senate make solving this affordability challenge its top priority. We know that the only path to protecting American families through bipartisan cooperation, and time is running short. Open enrollment closes in just one we

Keep Americans Covered

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Keep Americans Covered is a coalition of the health care community representing patients, consumers, doctors, hospitals, health insurers, and employers, all working together to keep health care affordable for millions of Americans.

SCIENCE & MEDICINE

A proposed law could force California health insurers to explain claim denials

Amid growing anger over rising health insurance costs and uncovered care, a California lawmaker has introduced a measure that would force insurers to disclose their denial rates and provide reasons for denying coverage. (Jenny Kane / Associated Press)

By Christine Mai-Duc
KFF Health News reporter

Feb. 18, 2025 3:13 PM PT

When Colleen Henderson's 3-year-old daughter complained of pain while using the bathroom, doctors brushed it off as a urinary tract infection or constipation, common maladies in the potty-training years.

Henderson, however, suspected it could be something worse, and asked for an ultrasound. The doctor and ultrasound technician told her that her insurance provider, UnitedHealthcare, would not cover it, but Henderson decided to do it anyway, charging the $6,000 procedure to her credit card. Then came the news: There was a grapefruit-sized tumor in her toddler's bladder.

That was in 2008. The next five years, Henderson said, became a protracted battle with UnitedHealthcare over paying for the specialists who finally diagnosed and treated her daughter's rare condition, inflammatory pseudotumor. She appealed denial of coverage for hospital stays, surgeries and medication to the insurer and state regulators, to no avail. The Sacramento-area family racked up more than $1 million in medical debt, she said, because UnitedHealthcare had decided that treatments recommended by doctors were unnecessary. The family declared bankruptcy.

"If I had not fought tooth and nail every step of the way, my daughter would be dead," said Henderson, whose daughter eventually recovered and is now a thriving 20-year-old junior at Oregon State University. "You pay a lot of money to have health insurance, and you hope that your health insurance has your well-being at the forefront, but that's not happening at all."

While insurance denials are on the rise, surveys show few Americans appeal them. Various analyses have found that many of those who escalate complaints to government regulators successfully get denials overturned (unlike the Hendersons). Consumer advocates and policymakers say that's a clear sign insurance companies routinely deny care they shouldn't. Now a proposal in the California legislature seeks to penalize insurers who repeatedly make the wrong call.

While the measure, Senate Bill 363, would cover only about a third of insured Californians whose health plans are regulated by the state, experts say it could be one of the boldest attempts in the nation to rein in health insurer denials — before and after care is given. And California could become one of only a handful of states that require

insurers to disclose denial rates and reasoning, data the industry often considers proprietary information.

The measure also seeks to force insurers to be more judicious with denials, by fining them up to $1 million per case if more than half of appeals filed with regulators are overturned in a year.

In 2023, state data show, about 72% of appeals made to the Department of Managed Health Care, which regulates the vast majority of health plans, resulted in an insurer's initial denial being reversed.

"When you have health insurance, you should have confidence that it's going to cover your healthcare needs," said Sen. Scott Wiener, the San Francisco Democrat who introduced the bill. "They can just delay, deny, obstruct, and, in many cases, avoid having to cover medically necessary care, and it's unacceptable."

A spokesperson for the California Assn. of Health Plans declined to comment, saying the group was still reviewing the bill's language. Gov. Gavin Newsom's spokesperson Elana Ross said his office generally does not comment on pending legislation.

Concerned about spiraling consumer health costs, lawmakers in states across the nation have increasingly looked for ways to verify that insurers are paying claims fairly.

In 2024, 17 states enacted legislation dealing with prior authorization of care by private insurers, according to the National Conference of State Legislatures. For example, Connecticut, which has one of the most robust denial rate disclosure laws, publishes an annual report card detailing the number and percentage of claims each insurer has denied, as well as the share that ends up getting reversed. Oregon published similar information until recently, when state disclosure requirements lapsed.

In California, there's no way to know how often insurers deny care, which health experts say is especially troubling as mental health needs are reaching crisis levels among children and young adults. According to Keith Humphreys, a health policy professor at Stanford University, it's easier to deny mental health care because a diagnosis of, say, depression can be more subjective than that of a broken limb or cancer.

"We think it's unacceptable that the state has absolutely no idea how big of a problem this is," said Lishaun Francis, senior director of behavioral health for the advocacy group Children Now, a sponsor of the bill.

Under Wiener's proposal, private insurers regulated by the state's Department of Managed Health Care or Department of Insurance, or both, would be required to submit detailed data about denials and appeals. They would also need to explain those denials and report the outcomes of the appeals.

For appeals that make it to the state's independent medical review process, or IMR, insurers whose denials are overturned more than half of the time would face staggering penalties. The first case that brings a company above the 50% threshold would trigger a fine of $50,000, with a penalty ranging from $100,000 to $400,000 for a second. Each one after that would cost the company $1 million.

If passed, the measure would apply to roughly 12.8 million Californians on private insurance. It would not apply to patients on Medi-Cal, the state's Medicaid program, or Medicare, and it would exclude self-insured plans offered by large employers, which are regulated by the U.S. Department of Labor and cover roughly 5.6 million Californians.

The phrase "deny and delay" continues to reverberate across the healthcare industry after the killing of UnitedHealthcare Chief Executive Brian Thompson in December. In a survey by the research organization NORC at the University of Chicago, conducted shortly after the attack, 7 in 10 respondents said they believed denials for health

coverage and profits by health insurance companies bore a great deal or a moderate amount of responsibility for Thompson's death.

Following Thompson's death, UnitedHealthcare said in statements that "highly inaccurate and grossly misleading information" had been circulated about the way the company treats claims, and that insurers, which are highly regulated, "typically have low- to mid-single digit margins."

Wiener called Thompson's killing a "cold-blooded assassination," and said his measure had grown out of a narrower proposal that failed last year aimed at improving mental health coverage for children and adults under age 26. But he acknowledged that the public's reaction to the killing underscored the long-simmering anger many Americans feel about health insurers' practices and the urgent need for reform.

Humphreys, the Stanford professor, said the U.S. health system creates strong financial incentives for insurers to deny care. And, he added, state and federal penalties are paltry enough to be written off as a cost of doing business.

"The more care they deny, the more money they make," he said.

Increasingly, large employers are starting to include language in contracts with claim administrators that would penalize insurance providers for approving too many or too few claims, said Shawn Gremminger, president of the National Alliance of Healthcare Purchaser Coalitions.

Gremminger represents mostly large employers that fund their own insurance, are federally regulated, and would be excluded from Wiener's bill. But even for the so-called self-funded plans, it can be nearly impossible to determine denial rates for the insurance companies hired simply to administer claims, he said.

While the bill may be too late for many families, Sandra Maturino of Rialto said she hopes lawmakers tackle insurance denials so other Californians can avoid the saga she endured to get her niece treatment.

She adopted the girl, now 13, after her sister died. Her niece had long struggled with self-harm and violent behavior, but when therapists recommended inpatient psychiatric care, her insurer, Anthem Blue Cross, would cover it for only 30 days.

For more than a year, Maturino said, her niece cycled in and out of facilities and counseling because her insurance wouldn't cover a long-term stay. Doctors tested a laundry list of prescription drugs and doses. None of them worked.

Anthem declined to comment for this story.

Unlike so many others in similar situations, Maturino was eventually able to get outside assistance to remedy the situation. She asked her adoption agency for help, and it ended up covering the cost of her niece's stay in a residential program in Utah, where she was diagnosed with bipolar disorder and has been undergoing treatment for a year.

Maturino said she didn't have the energy to appeal to Anthem.

"I wasn't going to wait around for the insurance to kill her, or for her to hurt somebody," Maturino said.

KFF Health News is a national newsroom that produces in-depth journalism about health issues and is one of the core operating programs at KFF — the independent source for health policy research, polling, and journalism.

More to Read

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Oct. 13, 2025

Center on Budget and Policy Priorities

Off the Charts
POLICY INSIGHT
BEYOND THE NUMBERS

July 29, 2025, 4:00 pm

Marketplace Enrollees Tell Congress: Extend the Enhanced Premium Tax Credits

By Claire Heyison

No one should be forced to choose between taking care of their health or paying for other basic needs, like food or utilities. But if enhancements to the premium tax credits (PTCs) expire at the end of this year, that will be the case for millions of people who buy their insurance through the Affordable Care Act (ACA) marketplaces.

The enhanced PTCs have made marketplace coverage more affordable, resulting in a record number[1] of people gaining insurance through the marketplace. Growth has been concentrated among Black and Latino people[2], people with low incomes, and people living in states that haven't expanded Medicaid[3]. The marketplace is also an important source of coverage for small businesses and self-employed individuals[4].

But unless Congress acts, the enhanced PTCs will expire at the end of 2025, causing premiums to spike for both subsidized and unsubsidized enrollees. As a result, an estimated 4.2 million people[5] are expected to drop their marketplace coverage and become uninsured in 2034.

"Dropping the enhancement now is going to put the hurt on a lot of people who aren't going to be able to absorb those costs since everything else is going up," said Carrie, a 49-year-old Iowan who is the primary caretaker for her mother and gets her insurance through the marketplace. "This is something that is a pretty easy way to continue helping the American people who need it."

Already, insurer rate filings for 2026 are showing double-digit rate increases[6] in marketplace premiums. These rate increases reflect federal policy changes, like the impending expiration of the enhanced PTCs and a new Trump Administration rule[7] that makes it harder for people to get and keep their marketplace coverage. Insurers expect that these changes will lead people with fewer health needs to drop their marketplace coverage, meaning the marketplace risk pool will have more people with greater health needs, who are more expensive to insure.

Extending the enhanced PTCs would reduce the premiums most people pay, greatly reducing premium shocks. But Congress must act soon, as enrollees will start getting their renewal notices[8] — which include information about the next year's premiums — in late summer and early fall.

“Sacrificing Essentials”

In March, April, and May 2025, CBPP convened 21 marketplace enrollees across ten states for a series of focus groups to better understand how the imminent expiration of the enhanced PTCs would impact their lives. Most participants were surprised and alarmed to learn that the premium tax credit would drop substantially at the end of 2025 if Congress does not act, dramatically increasing their costs for coverage in 2026.

As part of the focus groups, enrollees were asked to use a KFF calculator[9] to determine how much their premiums would increase if the enhanced PTCs aren’t extended. Many enrollees said that higher premiums, combined with increasing costs in other areas of their household budgets, would strain their finances and force them to either drop their health insurance or compromise on other basic needs.

“If my marketplace plan were to increase by $103 a month, I honestly don't know what I would do,” said Tracy W., a 57-year-old customer service representative from Georgia. “That amount may not seem like much to the government or to the insurance companies, but for me it would most likely mean sacrificing essentials: groceries, gas, basic necessities that I rely on.”

Some enrollees said that losing the enhanced PTC would force them to drop their coverage, even though they fear for their health. “The increased cost wouldn't be affordable for me right now,” said B.A.P., 35, a restaurant manager from North Carolina. “I would consider dropping insurance if the cost goes up too much. I would avoid medical attention until it's an emergency. And I also think there may be a greater risk of complications from illnesses because they weren't prevented.”i If the enhanced PTCs expire, B.A.P.’s premiums are estimated to increase by 185 percent in 2026, from $25 to $135 a month.

Hear more from Tracy and B.A.P.:

“Maybe I Have to Hold Back … Eat Less … Take Less Insulin”

But for some people, especially those with chronic illnesses, going uninsured is not an option. If the enhanced PTCs expire, M.M., a 45-year-old IT consultant from Illinois with Type 1 diabetes, said he “would just have to make sacrifices in other aspects of my life so I could afford the increased cost of that insurance.” His premiums are estimated to increase by $95 a month in 2026 if the enhanced PTCs end, which he says would cause him to ration care.

“I would have to consider switching to a cheaper plan which has a higher deductible, which means that at the beginning of the year I'd have to pay for my medications out of pocket,” he said. “And maybe I have to hold back on some of those medications, eat less, so take less insulin to treat my diabetes.”

Hear more from M.M.:

Workers who are self-employed as freelancers, gig workers, part-time workers, or a combination of these, don’t have employer-sponsored insurance. The enhanced PTCs have been a lifeline so these workers can affordable health insurance.

“It’s impactful for many people who might also be invisible like I am as a freelancer,” said Kat M., a 64-year-old in California who faces a possible $70 per month premium increase. “Here we are trying to make a living any way we can. There are a lot of us who don't have the access that others have with group insurance through their work.”

Hear more from Kat M.:

Overwhelmingly, the marketplace enrollees we spoke with want Congress to extend the enhanced PTCs. "This is a program that is used by millions of people around the country," said M.M., the IT consultant from Illinois. "The subsidies and the enhanced subsidies really make life easier. And I think it would greatly benefit [people] if they were extended indefinitely."

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[1] https://www.cms.gov/files/document/effectuated-enrollment-early-snapshot-2025-and-full-year-2024-average.pdf

[2] https://aspe.hhs.gov/reports/healthcaregov-plan-selections-race-ethnicity-2015-2024

[3] https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf

[4] /research/health/5-million-small-business-owners-and-self-employed-workers-likely-enrolled-in-aca

[5] /research/health/by-the-numbers-republican-reconciliation-law-will-take-health-coverage-away-from

[6] https://www.healthsystemtracker.org/brief/individual-market-insurers-requesting-largest-premium-increases-in-more-than-5-years/#Distribution%20of%20proposed%202026%20rate%20changes%20among%20105%20ACA%20Marketplace%20insurers%20in%2019%20states%20and%20The%20District%20of%20Columbia

[7] /research/federal-budget/executive-action-watch?item=30165

[8] https://chirblog.org/delays-in-extending-enhanced-marketplace-subsidies-would-raise-premiums-and-reduce-coverage/

[9] https://www.kff.org/interactive/how-much-more-would-people-pay-in-premiums-if-the-acas-enhanced-subsidies-expired/

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

November 18, 2025

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Mike Johnson
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Leader Thune, Leader Schumer, Speaker Johnson, and Leader Jeffries:

We write once again on behalf of state insurance regulators to support immediate Congressional action to extend enhanced premium tax credits for health insurance. Residents of every state and DC will be adversely affected if the enhanced credits are allowed to expire, but it is not too late to provide an extension for 2026.

NAIC has advocated for continuation of the enhanced premium tax credits for Marketplace coverage for over a year. We know the enhanced credits have delivered crucial stability and affordability to individual health insurance markets in our states. The anticipated end of the enhanced credits, however, is disrupting those markets with higher premiums, insurer exits, and steep expected declines in enrollment – in particular, we expect reduced enrollment of young and healthy consumers.

While Open Enrollment for 2026 coverage is underway, Congress still has time to act to extend the enhanced subsidies, maintaining affordability for consumers and restoring stability to individual markets. We urge Congress to approve an extension before December 15 and to look to state regulators to allow any adjustments to underlying health insurance rates.

While extension of the credits would be impactful at any time, December 15 marks the next key date in the enrollment process for 2026 Marketplace coverage. It is the last date for most consumers to actively select a plan that will go into effect on January 1, 2026. After December 15, Marketplaces will reenroll 2025 enrollees who have not selected a 2026 plan into coverage for next year. New and continuing enrollees will receive a bill in December for their January coverage. Without an extension of the credits, the average consumer will see out-of-pocket premiums more than double what they paid in 2025, with many seeing even larger increases.

These high premium bills will result in many consumers choosing not to pay them, particularly younger and healthier enrollees. Without the first payment, coverage will lapse. We expect it will be very difficult to bring these consumers back into coverage, even if Congress approves an extension of the enhanced tax credits in late December or early 2026. With a disproportionately younger and healthier cohort absent from the risk pool, the individual markets in each state will suffer, leading to higher costs for those

who keep coverage and more insurers considering market exits. While markets would still welcome an extension of the enhanced tax credits after December 15, they may suffer significant deterioration if action is delayed past that date.

We also urge Congress to include in legislation to extend the credits a clarification on CMS authority to work with states in making updates to health insurance rates in the individual market so that the benefit of the credits can be realized by consumers as soon as possible. The rates now in place for 2026 reflect insurer assumptions about changes to the risk pool due to the end of the enhanced tax credits. Should the enhanced tax credits be extended AND younger/healthier consumers choose to remain in the pool, then the rates that states approved for 2026 would not reflect the latest Congressional action. States will review the rates and some may want to require insurers to make adjustments. There is currently uncertainty about whether CMS has the authority to allow mid-year rate adjustments for Marketplace coverage. Specifying this authority and the need to work in coordination with states in making mid-year adjustments would avoid uncertainties that could keep rates too high longer than necessary.

Any rate adjustments must be thoroughly considered, based on good data, and made under existing state authorities on a state-by-state basis. Despite the need for immediate action to extend the enhanced tax credits, there remains time for deliberations on the underlying rates.

State insurance regulators welcome further discussion with you, your staff, or other members of Congress on the consumer impact and market effects of changes to the tax credits for Marketplace health insurance. We agree that more must be done to address underlying healthcare costs that ultimately drive rising premiums, and we would be pleased to work with Congress on that after markets are stabilized.

Thank you for your efforts on these important issues.

Sincerely,

Jon Godfread
NAIC President
Commissioner
North Dakota Insurance Department

Scott White
NAIC President-Elect
Commissioner
Virginia Bureau of Insurance

Elizabeth Kelleher Dwyer
NAIC Vice President
Director
Rhode Island Department of Business Regulation

Jon Pike
NAIC Secretary-Treasurer
Commissioner
Utah Insurance Department

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

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1/22/2026

Chairman Griffith, Ranking Member DeGette, and Members of the Health Subcommittee,

The National Alliance of Healthcare Purchaser Coalitions appreciates the subcommittees attention to the pressing need to make healthcare more affordable, and we thank you for holding the hearing *"Lowering Health Care Costs For All Americans: An Examination of Health Insurance Affordability."*

The National Alliance is the only nonprofit, purchaser-led organization with both national and regional reach. Through more than 40 employer coalitions, our members represent public and private employers, nonprofits, and labor unions that provide health benefits to over 90 million Americans, spending more than $850 billion every year on healthcare. Employers play a vital role in maintaining access to affordable, high-quality coverage for working families and the policies you consider here have a direct impact on those costs.

Our coalitions and their employer members work every day to design high-value, affordable benefits for their employees, but entrenched market failures and misaligned incentives in today's healthcare system often limit what employers can achieve on their own. Meaningful federal policy reform is essential to drive real change. At the National Alliance, we are encouraged to see lawmakers engaging seriously on the question employers, working families, and plan sponsors ask every day: *why does health care keep getting more expensive and what can we do about it?*

As the Subcommittee works to address these questions, the National Alliance urges a focus on real, attainable, policy solutions. **Passing PBM reform and addressing rising hospital prices are among the most impactful actions Congress can take to improve healthcare affordability for employers and working families**. Together, these reforms would tackle two of the largest and fastest-growing drivers of healthcare spending and restore accountability and value across the system.

PBM Reform

Employers and working families strongly **support the PBM reforms included in Sections 6701 and 6702 of the draft January 30 Continuing Resolution (CR) released earlier this week**. We have long called for these reforms, and without these policies in the final CR, employers will not see meaningful relief from rising healthcare costs.

We support policies that increase transparency and require the pass-through of rebates because employers and other plan fiduciaries must be able to see where healthcare dollars are going to manage costs responsibly. When rebates and fees are retained by intermediaries rather than passed back to plans, incentives become misaligned, driving higher list prices, increasing overall spending, and undermining affordability for workers and their families.

Transparency and rebate pass-through are not abstract policy concepts for employers. They are foundational tools that allow purchasers to evaluate value, negotiate fairly, and fulfill their fiduciary

responsibilities. Employers are doing everything within their control to manage costs while preserving access and quality for employees, but they cannot overcome opaque pricing structures and distorted incentives on their own. Lasting healthcare affordability will require federal policy solutions that restore accountability and ensure savings flow to the people paying for and relying on coverage. **It is past time for Congress to pass meaningful PBM reform.**

Hospital Pricing and Transparency

Hospital prices are a major and growing driver of healthcare costs for employers and working families, accounting for 50 cents of every dollar spent. Prices for the same hospital services can vary dramatically, often without any relationship to quality, and are frequently unknown until after care is delivered. This lack of transparency limits competition and makes it difficult for employers to manage costs or help employees make informed decisions.

The National Alliance supports policies that meaningfully strengthen hospital price transparency, including the bipartisan *Patients Deserve Price Tags Act*. Employers need access to clear, usable price information before care is delivered to negotiate fair contracts, design benefits that promote value, and meet their fiduciary responsibilities to protect plan assets.

We also urge Congress to **pass site-neutral payment policies** that address incentives encouraging care to shift into higher-cost hospital settings when lower-cost, clinically appropriate options are available. Paying the same amount for the same service, regardless of setting, would help curb unnecessary spending without sacrificing access or quality. The National Alliance also urges Congress to **pass fair billing requirements, requiring hospitals to to use unique billing identification numbers at each of their off-campus locations**. These requirements provide greater transparency and ensure that patients and purchasers are paying appropriately for the site where the care was delivered. These provisions can be found in the *Fair Billing Act* intruded by Sens. Hassan and Marshall, and in Sec. 228 of the *Lower Costs for Everyday Americans Act*, introduced by Rep. Pallone. Together, these policies represent practical steps Congress can take to slow hospital cost growth and improve affordability for employers and their employees.

We appreciate the attention this issue is receiving and look forward to continuing to work with policymakers to advance common sense, bipartisan reforms that put affordability first.

Sincerely,

Shawn Gremminger
President and CEO
National Alliance of Healthcare Purchaser Coalitions

cc: Brett Guthrie, Chair, Committee on Energy and Commerce
Frank Pallone, Ranking Member, Committee on Energy and Commerce
Jake Auchincloss, Member, Committee on Energy and Commerce
Buddy Carter, Member, Committee on Energy and Commerce

National
Multiple Sclerosis
Society

January 22, 2026

The Honorable Brett Guthrie
Chair
Committee on Energy & Commerce
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce
U.S. House of Representatives
2107 Rayburn House Office Building
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The Honorable Morgan Griffith
Chair, Health Subcommittee
Committee on Energy & Commerce
U.S. House of Representatives
2110 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
Committee on Energy & Commerce
U.S. House of Representatives
2111 Rayburn House Office Building
Washington, DC 20515

Statement for the Record

"Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

On behalf of the nearly one million people living with multiple sclerosis (MS) in the United States, we thank you for holding a hearing on healthcare affordability for all Americans. We appreciate your efforts to reform the healthcare system by identifying insurance tactics that create significant financial and administrative barriers to care. We urge you to prioritize patient-centered solutions that protect access to affordable, comprehensive care for those living with MS and other chronic conditions.

MS is an unpredictable disease of the central nervous system. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. Access to affordable, high-quality healthcare is essential for people living with MS. Comprehensive health insurance coverage is a vital component to ensure that people can get the care and treatments they need. While significant progress is being made to achieve a world free of MS, there is still no cure. The National Multiple Sclerosis Society (Society) funds research, drives change through advocacy, and provides programs and support to help people affected by MS live their best lives.

The Society believes that enrollment should be easy to understand, and benefits within a health plan should be clearly defined. In partnership with the MS community, we developed a set of Principles to Access High Quality MS Healthcare. Key elements of these principles are that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments people need, including all the services in the essential health benefit package; (2) healthcare should be affordable, enabling people to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible,

meaning that coverage should be easy to understand and not pose a barrier to care.

As Congress continues its efforts to reform the healthcare system, we urge the Committee to consider these principles and work in a bipartisan manner to craft proposals that improve access to care for people and strengthen the nation's health system in the near and long-term.

Managing and receiving treatment for a disease such as MS means that every single aspect of healthcare coverage is meaningful—both in terms of access to care, and maintaining financial security. MS requires comprehensive care, including access to prescription medications such as the MS disease-modifying therapies (DMTs) which can help reduce disease activity and disease progression for many people living with MS. Delays or gaps in care can worsen the prognosis for an individual living with MS and may lead to serious, long-term consequences, including irreversible disease progression.

"I live independently, but I depend on many pieces falling into place to make that possible. My custom wheelchair is my lifeline and helps me navigate my home. The medications and splints I use to manage spasms are all essential to keeping me going, including the depression medication that helps me push through fatigue. I can still transfer myself in and out of my chair, but I know that if I lose that ability, I'll lose my independence." – Scott C., Mississippi

DMTs have transformed the treatment of MS over the last 20 years; however, many people living with MS face still significant financial and administrative barriers to getting the medications and care they need. High and rapidly escalating medication prices, confusing and inconsistent formularies, costs for necessary care increasingly shifting to patients, coupled with a complex approval process for both drugs and other components of care can prohibit people's access to treatment.

Without adequate medical and prescription drug coverage, managing this disease becomes financially impossible for many individuals.

- The average annual cost of living with MS is $88,487 per year.[1]
- As of July 2025, the median annual brand price of MS DMTs was over $113,000.

For individuals and families already struggling financially, these costs are insurmountable without access to affordable, comprehensive health coverage. Ensuring continuous and adequate coverage reduces the risk of disease progression, prevents costly hospitalizations, and can enable more people with MS to remain engaged in their communities and the workforce.

To this end, we believe that current law can be strengthened to protect access for people living with MS and other chronic conditions and offer the following recommendations to help guide the Committee's work.

1) Protect affordability by extending the enhanced advanced premium tax credits.

"When diagnosed with multiple sclerosis in 1999, I became a medical hostage. Since this was pre-Affordable Care Act, my same insurance company could refuse coverage, slot

[1] Bebo, B., Cintina, I., LaRocca, N., Ritter, L., Talente, B., Hartung, D., Ngorsuraches, S., Wallin, M., & Yang, G. (2022). The Economic Burden of Multiple Sclerosis in the United States. *Neurology*, *98*(18).

me into a high-risk pool, or keep me from receiving the "too new" disease stalling medications debuting at that time, which have since become the standard of care." – Vivian Leal, Nevada

Passage of the Affordable Care Act (ACA) resulted in drastic reductions of our nation's uninsured rate and expanded coverage to millions of people. This law has transformed health insurance for people living with chronic conditions like MS, who previously faced denials of coverage, exclusions of needed benefits, annual and lifetime limits, and unaffordable premiums based solely on their health status. It has also meant that people, regardless of health status, gained access to coverage that was more comprehensive than what they had been able to purchase previously, and many have been able to get coverage at a significantly lower cost. We have also heard from many people affected by MS that due to the coverage options established via the ACA, they were able to pursue opportunities previously unavailable to them, such as starting a small business, becoming an entrepreneur, or simply quitting a job that they had wanted to leave for years.

While we recognize that the ACA is not perfect, it has helped millions, including people living with a pre-existing condition like MS. This is why we have long been supportive of the enhanced Advance Premium Tax Credits (eAPTCs) and have advocated that they be extended into 2026 and beyond. For people affected by MS with incomes too high to qualify for Medicaid but who struggle to access coverage in the private market, these tax credits have been a vital tool for maintaining consistent coverage.

Now that these tax credits have lapsed, people living with MS are struggling to afford the treatments, prescriptions, and care they need to manage their health. Some have decided to forego coverage for the 2026 plan year entirely.

Jeanine P., who lives with MS in Rhode Island, is trying to figure out how to afford her deductible that increased over 17% for the 2026 plan year. As an early retiree with limited income, she is two years away from qualifying for Medicare. Until then she shared, "I will end up needing to borrow from friends [and] family to cover my living costs [and] food - there is absolutely no wiggle room…I'm still seriously looking at other alternatives, including rolling the dice and dropping my health insurance all together (which is more than my home mortgage)!"

In the near term, we urge this Committee to extend these enhanced tax credits that, simply put, make purchasing high-quality care possible for those living with MS. In the longer term, we caution against proposals that allow insurers to provide coverage that is neither comprehensive nor affordable for people with high medical expenses.

2) Advance proposals that ensure comprehensive coverage for people living with MS.

Affordability is a vital component of coverage for people living with MS; however, affordability absent comprehensive plan options poses significant barriers to access. For people living with MS, comprehensive coverage is not optional—it is a necessity. For example, people living with MS may require access to a wide range of healthcare providers. Since the symptoms of MS vary from person to person, in addition to a neurologist and a primary care provider, people often need a more comprehensive care team which may include urologists, mental health professionals, physical and occupational therapists, ophthalmologists, and/or other providers.

The Committee can strengthen access to comprehensive coverage by ensuring that all health plans:

- Maintain coverage for essential health benefits (EHBs),

- Ban lifetime and annual caps for all aspects of care,
- Expand out-of-pocket maximums to include cost-sharing for any medically-necessary service or treatment,
- Eliminate discriminatory plan decisions, and
- Increase transparency on plan design and consumer education.

While certain plans may appear cheaper, we know they risk leaving people with MS in the lurch with insufficient coverage, unpaid medical bills, and lifelong health implications – just as many of these plans did before the Affordable Care Act (ACA) was passed. Use of the arrangements covered below jeopardize access to comprehensive, affordable care.

Association Health Plans

Plans which offer less costly coverage, like association health plans (AHPs) and other multiple employer welfare arrangements (MEWAs), are not required to provide comprehensive coverage or cover Essential Health Benefits (EHBs). Many also have a long history of fraud and insolvency that has historically harmed small employers and individuals the most. Research and investigations have demonstrated that some plans collected premiums for health insurance coverage that did not exist and did not pay medical claims—leaving businesses, individuals, and providers with millions of dollars in unpaid bills. For people with chronic illnesses or disabilities such as MS, the results were disastrous. For these reasons, among others, the Society has cautioned against proposals that provide greater flexibilities for, or expanded enrollment in, AHPs as a solution.

Short-Term Limited Duration Plans

Similarly, Short-Term Limited Duration Plans (STLDPs) are not required to adhere to critical standards including coverage for pre-existing conditions, financial protections, or coverage for EHBs. They also do not provide critical patient protections such as caps on annual out-of-pocket costs for enrollees and they can institute lifetime limits on coverage. Between regular visits to various specialists, MRIs, prescription drugs, physical and occupational rehabilitation therapies, or other needs, a person living with MS could quickly hit their limit and be left without meaningful coverage. For a person with MS, having a short-term plan can truly mean having coverage in name only.

Kody, from Illinois, chose a STLDP believing it was the best option as a "healthy" and active young male in his twenties. Later that year, Kody experienced concerning symptoms and was diagnosed with MS. He then faced the difficult news that he would also need to pay for nearly all his diagnostic testing out-of-pocket before he reached his $7,500 deductible. After his diagnosis he received notice that his insurance would no longer cover his DMT. He shared, "[t]hey had classified my MS as a pre-existing condition, even though I did not know I had it when enrolling. My DMT, which costs $7,000 a month, would now need to be paid for completely out-of-pocket. I was sent into debt due to the predatory practices and false advertising of this 'insurance.' These plans are dangerous."

Short-term plans put enrollees at risk of incurring huge amounts of medical debt. Most people with MS are diagnosed between the ages of 20 and 50, meaning that people who were previously young and healthy can suddenly face a diagnosis that can be serious or even debilitating. Should an individual with a short-term plan be diagnosed with MS, not only would the policy not offer adequate coverage, it is possible that coverage could be retroactively canceled.

These plans can also impact non-enrollees by siphoning healthy individuals out of the overall risk pool into cheaper coverage, leading to higher premiums and fewer plan choices for those who depend on more comprehensive coverage.

Health Savings Accounts

We also urge the Committee to take a deeper look into the role of health savings accounts (HSAs), which are paired with high-deductible health plans (HDHPs) that typically leave consumers with a high cost burden and may pose a significant financial risk for people with health conditions such as MS.

HSAs are designed to help people to offset high out-of-pocket costs for their health care. For those who can maximize use of these accounts and contribute to the level needed to match the annual deductible of a high-deductible health plan, there are both financial and health access advantages. However, research has demonstrated that high numbers of consumers, including those who are older and/or living with a chronic condition, are not able to take full advantage of them. For individuals enrolled in HDHPs who do not have sufficient funds in their HSAs, it can be extremely challenging to afford medical care.

Some concerning findings from a relevant JAMA study include:[2]

- About 1 in 3 US adults enrolled in an HDHP do not have an HSA.
- Most individuals who reported having an HSA had not made any contributions in the previous 12 months. Individuals commonly report that they did not contribute because they were either unable to afford saving, had not considered saving, or were not aware of the option.

Other concerning data points:

- A large proportion of these accounts have low balances; around 51% of HSA accounts have balances of $500 or less.[3]
- Meanwhile, 82 percent of marketplace enrollees had incomes below 300% of the federal poverty level ($46,950 for an individual).
- In 2024, 36% of households in the U.S. had medical debt, 21% had a past-due medical bill, and 23% were paying a medical bill in installments over time.[4]

The Society has concerns about policy proposals intended to encourage uptake and use of HSAs for several reasons. Any policy effort linked to HSAs should focus on the particular needs of people with lower incomes, as well as people affected by chronic health conditions. These groups are among those who are least likely to be able to access or afford care when enrolled in an HDHP if they do not have enough in an HSA to lower their cost-related barriers, and potentially face a very high out-of-pocket burden.

3) Prioritize meaningful pharmacy benefit manager reform that protects consumers.

Pharmacy Benefit Managers (PBMs) manage prescription drug benefits for health insurers, Medicare Part D drug plans, large employers, and other payors. They play a powerful role in determining what access people with MS have to their DMTs and symptom management medications. PBMs can

[2] Kullgren, J. T., Cliff, E. Q., Krenz, C., West, B. T., Levy, H., Fendrick, M., & Fagerlin, A. (2020). Use of Health Savings Accounts Among US Adults Enrolled in High-Deductible Health Plans. *JAMA Network Open*, *3*(7).

[3] Mulholland, P. (2025, April 3). *HSA Account Balances Continue to Grow*. Psca.org.

[4] Fulford, S. L., & Wilson, E. (2025). Medical Debt and Collections in the U.S. *Health Affairs Scholar*, *3*(8).

determine which medications are covered by payors, which tier those medications are on, and where consumers must get certain prescriptions filled (e.g., a specialty or mail order pharmacy). In effect, PBM practices determine whether a person with MS can get the medication prescribed by their healthcare provider and if they can afford their out-of-pocket costs.

Despite a large number of PBMs existing in the market due to vertical integration in the healthcare system, just a few control the vast majority of prescriptions dispensed. The top three account for nearly 80% of prescriptions dispensed in the market and the top six account for 94%. This vertical integration can create both access and affordability issues and leaves the door open to perverse incentive structures.[5]

Our system is driven by rebates and other price concessions, which are negotiations between pharmaceutical manufacturers, insurance companies, and PBMs. This makes it difficult to understand the true cost to the system of any given medication. Pharmaceutical companies have a list price for their medications, but PBMs then negotiate drug prices, rebates, and price concessions with the pharmaceutical companies on behalf of insurers. Determining the role that PBMs play in prescription drug pricing, consumer access, and quality is currently difficult to assess given a lack of publicly available information. Insurers often lack clarity regarding the prices PBMs have negotiated. PBMs then contract with pharmacies and negotiate the reimbursement amount that the pharmacies will receive from the insurers. Rebate benefits may or may not be directly passed on to the person taking the medication or their insurer. Negotiated prices for medications, including rebates, should benefit the person using and paying out-of-pocket costs for the medication. Additionally, greater transparency is needed into additional fees that PBMs charge other stakeholders in the healthcare system, especially PBM subsidiaries, which can drive up prescription drug costs.

A newer trend is PBM Group Purchasing Organizations (GPOs), sometimes also referred to as rebate aggregators. GPOs appear to have taken on some of the original role of PBMs, processing data and negotiating rebates. As GPOs are subsidiaries of the three big PBMs, policy solutions related to sharing rebates with enrollees and transparency into additional fees must also apply to GPOs and all PBM subsidiaries. Transparency into subsidiaries and vertically integrated health conglomerates should also be required.

Although a stated purpose of PBMs is to lower prescription drug costs, PBMs frequently disincentivize lower priced generics and biosimilars. PBMs often place generic drugs and biosimilars in higher formulary tiers alongside brand medications, thus negating the cost savings to the health system and the consumer. We have seen this practice in the MS space as MS generics are often covered as specialty medications and as a result sit on a higher cost-sharing tier than most common generic medications. This results in higher out-of-pocket costs for people with MS. Likewise, a PBM may prefer a higher cost drug because it will increase their revenue, so despite lower cost alternatives being available, they give favorable formulary placement to a higher priced product. We believe that the choice of therapy for people with MS should be between the patient and their healthcare provider, with the enrollee's health being the top priority.

[5] U.S. Federal Trade Commission, Office of Policy Planning (2024). *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies.*

Reforms to the PBM system are necessary and comprehensive reform should include:

- Disclosure of specific costs, prices, rebates, additional fees, and mark-ups, to bring transparency to the PBM process.
- Prohibition of unfair and deceptive pricing models like spread pricing and claw backs on payments.
- Passing along PBMs' savings from rebates to the health plans and consumers.
- Banning PBMs from using discriminatory formularies.
- Allowing patient choice in pharmacies.
- Requiring oversight and reporting on PBM behavior.

We were pleased to see that provisions from the bipartisan PBM Reform Act of 2025 (H.R. 4317) were included in the pending minibus package. This is an important first step in patient-centered PBM reform that will have an immediate impact for people living with MS and we urge Congress to ensure its passage.

4) Establish stronger consumer protections and increase oversight of cost-containment tactics from insurers.

Although there are now more than 20 DMTs on the market (including generic copies of the same DMT), competition has not driven down their price, and the majority have increased in price several times each year. In an effort to contain these costs, insurers have increasingly implemented tactics that shift a higher cost burden onto enrollees.

Co-insurance for many MS treatments can be as high as 40% in some health plans. Nearly one out of every five (19%) U.S. adults living with MS or clinically isolated syndrome who participated in a 2023 survey reported that out-of-pocket costs had caused a delay, pause, or discontinuation of their DMT. Nearly two-thirds (64%) have received copayment assistance or other financial support for their DMT.[6]

It is therefore not surprising that a survey of over 12,000 survey respondents living with MS revealed as many as 70% relied on help from a Copay Assistance Program in order to maintain access to these treatments. Copay assistance refers to a range of discounts and other programs financed by drug manufacturers to enable third party contributions toward the cost-sharing requirements of high-cost treatments for those who meet income eligibility criteria.

The Society is concerned by the growth of efforts to identify and financially punish individuals who rely on copay assistance to access their medications. Often, these types of programs are not available to support people who take high-cost generic or biosimilar medications, even though generics and biosimilars are less costly than brand medications. When PBMs place generics and biosimilars on formulary tiers with high out-of-pocket costs and no copay assistance is available, there are generally three potential outcomes, all of which are damaging to the healthcare system. The first possibility is that a person stops taking the medication, which could lead to an MS relapse and/or worse health outcomes, which could lead to higher healthcare needs and costs. Second, a person may find themselves still paying for health coverage, which has been rendered useless, as they seek to purchase a generic outside of their health insurance. This leads to higher costs for the individual, as now what they're paying for

[6] Talente, B., Finseth, L. T., Blake, N., Costello, K., Schmidt, H., Vandigo, J., & Oehrlein, E. M. (2025). Patient Experiences with the Impacts of Multiple Sclerosis & Disease-Modifying Therapies. *ClinicoEconomics and Outcomes Research: CEOR*, *17*, 199–215.

their medication does not count towards their health insurance deductible or out-of-pocket cost cap. The third possibility is that the individual moves from taking the less expensive generic/biosimilar back to the higher priced brand medication because they can receive financial support for their out-of-pocket costs.

Copay Accumulators

Copay accumulator programs are practices that some health insurers and PBMs use to prohibit third-party copay assistance from counting toward a member's annual deductible or maximum out-of-pocket costs. Essentially, health plans with copay accumulators will only credit the amount the individual members themselves pay toward their annual deductible or maximum out-of-pocket amount. As a result of not counting outside assistance, patients may never reach their deductible and face higher out-of-pocket costs. This prevents or delays vulnerable individuals from reaching the financial relief of the deductible and annual out-of-pocket cap features of their health insurance plan. As an example, a person with MS may continually take their DMT to manage their MS, but because they do not reach their deductible, they never pursue an MRI which would help inform them if their DMT is working to prevent further MS lesions.

Historically, individuals affected by copay accumulator programs have generally not been notified of this program and do not realize they have not achieved their deductible until they are getting their medication from a pharmacy after the copay assistance has run out. Typically, there is no recourse such as the right to an appeal or exception request.

While copay assistance is not a perfect solution to the drug affordability problem, these programs effectively take away one of the only solutions patients have for bringing their costs down.

Copay Maximizers

Copay maximizer programs are also referred to as "manufacturer coupon optimization." The goal of these programs is to "maximize" the available manufacturer copay assistance. Insurance companies steer enrollees toward third-party companies to cover specific medications. These third-party companies will calculate what an enrollee could receive in financial copay assistance in a year and set that as the out-of-pocket maximum to ensure they are collecting as much as possible from the drug manufacturers. This also ensures that enrollees only ever meet their separate out-of-pocket maximum at the end of the plan year. The core issue is that while the manufacturer assistance pays the new, artificially high monthly copay, none of those payments count toward the patient's overall annual deductible or out-of-pocket maximum for all other medical services (like doctor visits, surgery, or hospital stays). This ensures the patient must still meet their separate annual out-of-pocket maximum with their own money before the plan pays 100% for *other* care.

As an example, an enrollee who can receive $24,000 in assistance in a year may be told that their non-essential health benefits (EHB) co-insurance would come out to $2,410 a month but if they enroll with the third-party company it will be $10 a month and the company will keep the $2,000 monthly from the drug manufacturer.

It is also important to note that copay maximizer programs are increasingly introduced in response to states' banning of copay accumulator programs. Insurers oppose utilizing manufacturer financial assistance in copay accumulators yet embrace the business practice under maximizers.

Alternative Funding Programs

Alternative funding programs (AFPs) are a more recent tactic being utilized to shift costs for specialty medications, like DMTs, away from insurers and employers in self-funded plans. Plans are able to do this when a patient appears to be underinsured after being denied a specialty medication that is not considered an EHB. After a denial, the enrollee can either pay for their medication entirely out of pocket or work with an AFP to help source their drug at low or no cost to the patient. The AFP then typically sources the drug through a manufacturer's patient assistance program or independent charitable organizations.

AFPs, like accumulator and maximizer programs, do not count toward an enrollee's deductible or out-of-pocket maximum. In addition to a potential increase in administrative burden for people living with MS, the time it takes an AFP to source a specialty medication may also lead to delays in treatment.

The Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to escalating price increases, barriers to care and a system too complex to navigate. It is reasonable to question the role of copay assistance programs and the potential role they inadvertently play in raising costs or impeding access—but this should not be the first change that happens. Until we find real solutions to the challenges in our healthcare system that prevent people from affordably accessing the care and treatments they need, we cannot rip away the band-aids people have come to rely on—like copay assistance programs. Mechanisms like copay accumulators, maximizers, and AFPs primarily impact people who are seeking whatever avenue they can find to be able to take their needed medications.

5) Limit administrative hurdles for consumers and providers that create barriers to accessing care.

As the prices of MS DMTs have increased, health plans and PBMs have employed increasingly strict utilization management practices (prior authorization, step therapy, and formulary restrictions) to minimize DMT use and cost liability. These practices present significant hurdles for prescribers and real barriers for people with MS. Utilization management practices can result in delays or disruptions in treatment as individuals wait for their health plan to determine whether they will cover care as prescribed. Delays in necessary diagnostic tests or treatments can worsen the prognosis for an individual living with MS and may lead to serious, long-term, and irreversible consequences and disease progression. If coverage is denied, additional delays may occur if the provider and patient go through an appeals process. In a 2023 survey of people with MS, about one-third (30%) indicated that an insurer rejected their provider's request for DMT coverage at some point[7].

Due to a lack of standardization in this process, providers report substantial administrative burden from having to navigate numerous forms, websites, and requirements. According to an AMA physician survey, physicians and their staff spend 13 hours each week completing prior authorization requests and appeals, pulling time away from direct patient care[8].

This administrative burden is compounded in underserved communities where providers have limited staff resources to dedicate to the time-consuming prior authorization (PA) process. The PA

[7] Talente, B., Finseth, L. T., Blake, N., Costello, K., Schmidt, H., Vandigo, J., & Oehrlein, E. M. (2025). Patient Experiences with the Impacts of Multiple Sclerosis & Disease-Modifying Therapies. *ClinicoEconomics and Outcomes Research: CEOR*, *17*, 199–215.

[8] 2024 AMA prior authorization physician survey. AMA. Accessed February 24, 2025. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

administrative burden does not just fall on providers but also on individuals seeking care. Americans from poorer communities are less likely than their wealthier peers to engage with the healthcare system in general and are more likely to characterize the completion of healthcare-related administrative tasks, including the provision of PA documentation, as burdensome.[9]

The Committee can address these access challenges by prioritizing policies that reform utilization management within coverage and address access barriers for people living with MS. Some examples we support include:

- Reforming step therapy protocols to ensure transparency by allowing providers to request an exception to the step therapy process for patients if it could be ineffectual or damaging for them and require that the exceptions process be transparent and accessible (SAFE Step Act, H.R. 5509).
- Reforming prior authorization processes by requiring an insurer to respond to a prior authorization request for medication within 72 hours; requiring that insurers use a standardized prior authorization form or allowing for electronic submission of requests.
- Banning non-medical switching practices and prohibiting insurers from making changes to prescription drug benefits and formularies after the plan year has begun. Such policies should also include provisions that prevent insurers from increasing out-of-pocket costs for prescription drugs or making mid-year changes to formularies that limit or restrict access to medications, except during open enrollment.

_____

The Society thanks the Committee for having these important conversations and we look forward to partnering with you to make healthcare more accessible, affordable, and adequate for people living with MS and their families.

Sincerely,

Bari Talente

Bari Talente, Esq.
Executive Vice President, Advocacy and Healthcare Access
National Multiple Sclerosis Society

[9] Kyle M.A., & Frakt A.B. (2021). Patient administrative burden in the US health care system. *Health Services Research*, *56*(5), 755–765.

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Medicare Watch

Older Adults at Risk if ACA Subsidies Expire

By Lindsey Copeland | October 30, 2025 | 7 Comments

From funding cuts to policy reforms, the Republican-passed reconciliation bill (HR 1) 'v harms older adults, including by making health care and coverage less available ɔre expensive. As the fate of expiring Affordable Care Act (ACA) tax credits

remains uncertain, we look to a recent KFF analysis for more on how HR 1's interactions with the ACA will impact adults ages 50 and over.

HR 1's Impact on ACA Marketplaces

HR 1 makes changes to the ACA Marketplaces that will increase the number of uninsured and premium costs.

Enrollment Changes

Combined with the Trump administration Marketplace integrity rules, the new law will make it harder to sign up for a Marketplace plan, in part by shortening enrollment timelines and creating burdensome administrative requirements. As many as three million people, including older adults, are expected to lose health coverage as a result.

Premium Tax Credits

The law also fails to renew the premium tax credits that are set to expire this year. Since 2012, ACA tax credits have helped people with low and middle incomes pay their Marketplace premiums. In 2021, the American Rescue Plan Act (ARPA) increased the amount and availability of the credits and the Inflation Reduction Act (IRA) in 2022 delayed their expiration, but only until the end of 2025.

This assistance has allowed millions of adults ages 50 to 64 buy coverage—spurring a 50% reduction in the uninsured rate among this cohort.

Today, the enhanced credits ease ACA Marketplace plan affordability for more than 22 million people, including many older adults who are not yet Medicare-eligible. The credits reduce enrollee premium payments by $705 a year, on average. This assistance has allowed millions of adults ages 50 to 64 buy coverage—spurring a 50% reduction in the uninsured rate among this cohort—while helping overall Marketplace enrollment grow from 12 million in 2021 to a record 24.2 million in 2025.

Adults at Significant Risk

If the enhanced tax credits lapse, Marketplace enrollees with incomes over 400% of poverty ($84,600 for a family of two in 2025) will lose all assistance, and people with incomes between 100% ($21,000 for a family of two) and 400% of poverty will receive less support.

Older adults would be hit especially hard. Over half of all enrollees who would be cut off from subsidies are between the ages of 50 and 64. They would they be on the hook for the full costs of their premiums, which are expected to increase by at least 18% in 2026, though some could see much higher jumps. And these enrollees are already at a cost disadvantage: under the ACA, insurers can charge people in their 50s and 60s higher premiums than they charge younger adults who purchase the same plan in the same area.

Under the ACA, insurers can charge people in their 50s and 60s higher premiums than they charge younger adults who purchase the same plan in the same area.

As a KFF example illustrates, the impacts would be severe: A 59-year-old single widow earning $63,000 (just above 400% of the poverty level, $62,600 for an individual) would pay $5,355 for her silver Marketplace plan in 2026 if Congress extends the enhanced premium tax credits before the end of this year. But if the credits expire, she could pay more than twice that—$14,213 in premiums, almost 23% of her income—for the exact same health insurance policy.

What's at Stake

If the enhancements expire, nearly all (92%) of the 5.2 million adults ages 50 to 64 with Marketplace coverage would experience higher costs next year. Analysis suggests enrollees could see premiums rise by 75% on average, while people in rural areas could see a 90% increase.

ome may be able to find other insurance, millions will not. The resulting coverage
s would mean reduced access to care and worse individual health outcomes as

well as higher Medicare costs, because more people would enter the program in poorer health and needing more expensive interventions than they would have otherwise.

> The coverage losses would mean higher Medicare costs, because more people would enter the program in poorer health and needing more expensive interventions.

Across all age groups, at least 4.2 million people are expected to become uninsured unless Congress acts.

Congress Must Act Quickly

At Medicare Rights, we will continue to work to protect the ACA's coverage gains. People must have access to high-quality, affordable health care and coverage. To that end, we urge lawmakers to extend the enhanced credits without delay. Otherwise, people may have no choice but to drop their Marketplace plans, setting in motion harmful coverage losses that could undermine individual health and economic security as well as Medicare sustainability.

Read the KFF report, What Could the Health-Related Provisions in the Reconciliation Law Mean for Older Adults?

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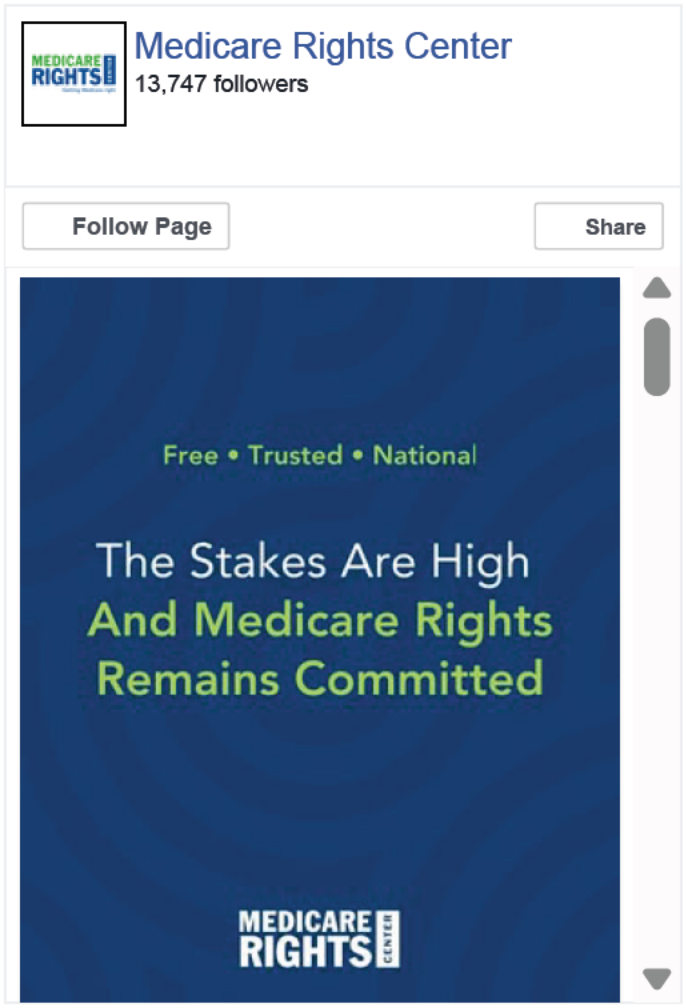

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PATIENTS FOR AFFORDABLE DRUGS NOW™

Statement of Merith Basey
Chief Executive Officer, Patients For Affordable Drugs NOW

before the

U.S. House Energy and Commerce Subcommittee on Health

for a hearing on

"Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability"

January 22, 2026

Patients For Affordable Drugs NOW is the only national patient advocacy organization focused exclusively on policies to lower prescription drug prices. We are independent, bipartisan, and we do not accept funding from any organization that profits from the development or distribution of prescription drugs.

Since our founding nine years ago, nearly 40,000 patients across all 50 states have shared stories with us about struggling to afford their medications. And we have built a nationwide community of more than three-quarters of a million patients and allies who support commonsense policies to lower drug prices.

Prescription drug prices must be part of any serious conversation about health care affordability because they drive up costs throughout the system – not just at the pharmacy counter. Americans pay far more for prescription drugs than people in other wealthy nations. On average, U.S. **list prices** for brand-name drugs are more than **four times higher** than those in comparable countries.[1] Even after accounting for rebates and discounts that lower **net prices**, Americans are still paying **more than three times as much** for the same brand-name drugs.[2] These high drug prices contribute to rising healthcare costs, including insurance premiums paid by families, employers, and taxpayers.[3,4] According to America's Health Insurance Plans (AHIP), prescription drugs account for roughly 24 cents of every dollar spent on health insurance

[1]Mulcahy, A., Schwam, D., and Lovejoy, S. (2024, February). International Prescription Drug Price Comparisons: Estimates Using 2022 Data. *RAND Corporation.* https://www.rand.org/pubs/research_reports/RRA788-3.html
[2] IBID
[3] (2025, December 8). Driven by GLP-1s, prescription drug spending explodes at major health insurers. STAT News. https://www.statnews.com/2025/12/08/health-insurers-spending-more-on-prescriptions-glp-1-drugs-cited/
[4] 2024, April 3. The impact of rising prescription drug costs on employers and employees. Marsh & McLennan Agency. https://www.marshmma.com/us/insights/details/health-care-economics.html

premiums.[5] While insurers have taken some voluntary steps to manage costs, those efforts have not delivered durable, system-wide savings or ensured affordable access for patients. Voluntary actions alone cannot counteract unchecked drug pricing driven by key actors, including the pharmaceutical industry, pharmacy benefit managers (PBMs), and insurers.

The reality is that people struggle to pay these high prices even with insurance. A 2024 report by The Assistant Secretary for Planning and Evaluation (ASPE) found that high list prices likely induced higher cost-sharing for patients, meaning that reductions in net prices do not automatically translate to out-of-pocket savings for Americans.[6] The existing system too often fails to ensure that patients can access the medications they need at prices they can afford.

Consequently, about three in 10 Americans report having difficulty affording their medications,[7] and 47 percent say they are concerned about affording basic healthcare services in 2026.[8] When drug prices are too high, patients are forced to make impossible tradeoffs between their medications and other essentials such as food and housing. One national survey found that more than 20 percent of people took on debt or declared bankruptcy because of their prescription drug costs.[9]

Congress has already demonstrated that policy can change this reality. Passed in 2022, the Inflation Reduction Act (IRA) included the most sweeping prescription drug reforms in decades. Today, the new law is lowering prescription drug prices and reducing out-of-pocket costs for millions of people in this country. The benefits include:

- Insulin costs in Medicare are capped at $35 monthly.[10]
- Recommended vaccines that would have cost $100-200 per vaccination are now free under Medicare Part D.[11]
- The law also requires that drug makers pay rebates to Medicare if the price of brand-name, single-source drugs increases at an annual rate greater than that of inflation.[12]
- As of January 1, 2026, negotiated prices took effect on 10 of the highest-cost drugs for Medicare, lowering prices and out-of-pocket costs for roughly 8.8 million individuals.

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[5] (2026, January) Health Care Costs 101: What's Driving Premiums Higher and How to Make Coverage More Affordable. *AHIP.* https://www.ahip.org/news/articles/health-care-costs-101-whats-driving-premiums-higher-and-how-to-make-coverage-more-affordable

[6] (2024, November) Prescription Drug Spending, Pricing Trends, and Premiums in Private Health Insurance Plans. *ASPE.* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/2024-report-to-congress-prescription-drug-spending.pdf

[7] Kirzinger, A., Montero, A., Sparks, G., Valdes, I., Hamel, L. (2023, August). Public Opinion on Prescription Drugs and Their Prices. *KFF.* https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

[8] (2025, November 18). How Do Americans Experience Healthcare in Their State? *Gallup.* https://news.gallup.com/poll/698042/americans-experience-healthcare-state.aspx

[9] Nguyen, A. (2021, March). Survey: Americans Struggle to Afford Medications as COVID-19 Hits Savings and Insurance Coverage. *GoodRx*. https://www.goodrx.com/blog/survey-covid-19-effects-on-medication-affordability/

[10] (2023, August 16). *The Inflation Reduction Act of 2022 One Year Anniversary Highlights from ASPE Drug Pricing Report.* ASPE. https://aspe.hhs.gov/reports/inflation-reduction-act-2022-one-year-anniversary-highlights-aspe-drug-pricing-reports

[11] IBID

[12] IBID

That number will rise to 60 drugs in the coming years, extending the benefits of negotiation to many more millions of people.[13]

- The law also includes an out-of-pocket cap for Medicare Part D set at $2,100 in 2026, which is estimated to reduce patient out-of-pocket spending by about $7.4 billion annually among more than 18.7 million people (36 percent of Part D enrollees).[14]

The law is already changing lives. Judy Aiken is a retired nurse living in Maine who takes Enbrel to manage her psoriatic arthritis. Before these reforms, the drug's $7,000 monthly price created serious financial strain and access challenges. Describing the uncertainty in her life before the IRA, Judy says, "*My husband and I delayed household repairs and stretched our grocery budget just to keep up. When too many expenses stacked up at once, I was sometimes forced to delay refilling my prescription…With Enbrel's price finally coming down and the out-of-pocket cost cap in place, my husband and I have been able to worry less from month to month about whether we can afford my medication. I no longer have to skip doses just to get by, and I can focus on what really matters: my health.*"[15]

While these reforms are making drugs more affordable for millions of patients across the country, especially those on Medicare, the work is not done. Most Americans receive their coverage through the private market, and too many still face unaffordable prescription drug costs despite being insured.[16] Congress should build on the success of the IRA by expanding the number of drugs eligible for negotiation under Medicare each year, and extending the benefits of negotiated prices and the out-of-pocket cap to people with commercial insurance. Patent reform and policies to rein in PBMs can deliver additional savings to both patients and taxpayers. These ideas enjoy broad popularity across party lines.[17,18,19]

As Congress considers building on these reforms, it is important to address claims from the pharmaceutical industry that lower drug prices threaten innovation. There is no evidence that the Inflation Reduction Act has hindered research and development (R&D). In fact, during the nine months following its passage, big drug companies continued to invest heavily in new medicines, even completing more mergers and acquisitions of small-molecule drugs than in the nine months

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[13] (2024, August 15) Medicare Drug Price Negotiation Program: Negotiated Prices for Initial Price Applicability Year 2026. *Centers for Medicare & Medicaid Services.*
https://www.cms.gov/newsroom/fact-sheets/medicare-drug-price-negotiation-program-negotiated-prices-initial-price-applicability-year-2026
[14] (2023, August 16). *The Inflation Reduction Act of 2022 One Year Anniversary Highlights from ASPE Drug Pricing Report.* ASPE.
https://aspe.hhs.gov/reports/inflation-reduction-act-2022-one-year-anniversary-highlights-aspe-drug-pricing-reports
[15] Aiken, J. (2026, January 16) Letter: Drug price negotiations changed my life. *Bangor Daily News.*
https://www.bangordailynews.com/2026/01/16/opinion/letters/letter-drug-price-negotiations-changed-my-life-joam40zk0w/
[16] (2024, November) Prescription Drug Spending, Pricing Trends, and Premiums in Private Health Insurance Plans. ASPE.
https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/2024-report-to-congress-prescription-drug-spending.pdf
[17] (2025, October) Understanding Americans' Top Concerns on Drug Pricing: Corporate Greed *I-MAK.*
https://reports.i-mak.org/drug-pricing-concerns
[18] (2025, April 22) NEW POLL: Majority of Americans Support Lower Drug Prices, Demand Congress Act. Arnold Ventures.
https://www.arnoldventures.org/newsroom/new-poll-majority-of-americans-support-lower-drug-prices-demand-congress-act
[19] (2023, August 27). Polling on Drug Prices, August 2023. GS Strategy Group & Hart Research Associates.
https://patientsforaffordabledrugsnow.org/wp-content/uploads/2023/09/P4AD-Poll-August-23.pdf

prior, demonstrating that R&D remains strong.[20] Affordability and innovation are not competing goals – it's about balance - and patients need both. Because, drugs don't work if people can't afford them.

High prescription drug prices are *not* an unavoidable feature of the U.S. healthcare system. They are the result of policy choices. The Inflation Reduction Act proved that Congress can lower drug prices, reduce patient costs, and preserve a strong pipeline of new medicines. The next step is to build on what works so that every American can get the prescription drugs they need at prices they can afford.

Thank you.

[20] Frank, R., Huang, R. (2023, August 23) Early claims and M&A behavior following enactment of the drug provisions in the IRA. Brookings. https://www.brookings.edu/articles/early-claims-and-ma-behavior-following-enactment-of-the-drug-provisions-in-the-ira/

KFF The independent source for health policy research, polling, and news.

News Release

Poll: 1 in 3 ACA Marketplace Enrollees Say They Would "Very Likely" Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They "Very Likely" Would Go Without Insurance

As Enhanced Credits Expire, Nearly All Enrollees Expect to Make Coverage Decisions This Year

Published: Dec 4, 2025

If the amount they pay in premiums doubled, about one in three enrollees in Affordable Care Act Marketplace health plans say they would be "very likely" to look for a lower-premium Marketplace plan (with higher deductibles and co-pays) and one in four would "very likely" go without insurance next year, finds a new survey of Marketplace enrollees fielded shortly after open enrollment began in the first weeks of November.

The survey captures the views and experiences of Marketplace enrollees as they weigh their coverage options for 2026, without the enhanced ACA credits or other policy changes that the Senate could debate this month. About 22 million of the 24 million Marketplace enrollees have benefited from the expiring tax credits, and without them, their premium payments are expected to rise an average of 114%, from $888 to $1,904 annually.

Nearly six in 10 enrollees (58%) say they would not be able to afford an increase of just $300 per year in the amount they pay for insurance without significantly disrupting their household finances. An additional one in five (20%) say they would not be able to afford a $1,000 per year increase in the amount they pay for health insurance without disrupting their finances.

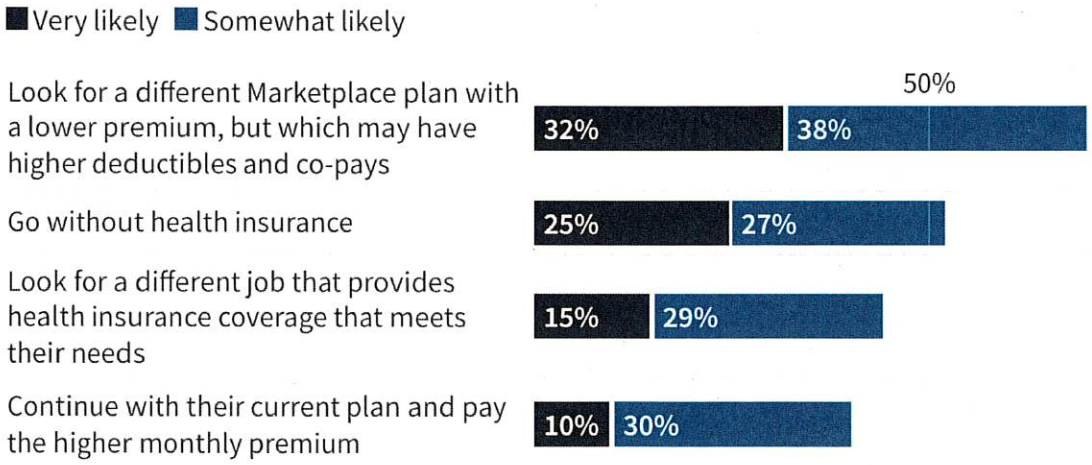
If their total health care costs, including premiums, deductibles and other cost-sharing, increased by $1,000 next year, most Marketplace enrollees (67%) say they would likely cut spending on daily household needs, about half (54%) say they would likely to try to find another job or work extra hours, and four in 10 (41%) say they would likely skip or delay paying other bills. A third (34%) say they would take out a loan or increase their credit card debt.

"The poll shows the range of problems Marketplace enrollees will face if the enhanced tax credits are not extended in some form, and those problems will be the poster child of the struggles Americans are having with health care costs in the midterms if Republicans and Democrats cannot resolve their differences," KFF President and CEO Drew Altman said.

It asked Marketplace enrollees to say how likely it was that they would take each of four different potential responses if the monthly premiums they pay doubled (or increased $50 a month for those who currently don't pay a premium).

Marketplace Enrollees May Consider Different Health Insurance Options if Premium Payments for Their Current Coverage Doubled

Percent who say that if the monthly amount they pay for their health insurance doubled [*For those who currently do not pay a premium:* increased by $50] they would be **very** or **somewhat likely** to:



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.
Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Open enrollment for Marketplace coverage began Nov. 1 and runs through Jan. 15 in most states, though consumers must enroll in a plan by Dec. 15 if they want their coverage to begin on Jan. 1. The vast majority of enrollees (89%) expect to make a decision by the end of this year, with many saying they have already made their decision about coverage for next year.

More than half of Marketplace enrollees (54%) say they expect that the cost of their health insurance coverage for next year will "increase a lot more than usual." An additional one in four (26%) expect it to increase a "little more than usual," while smaller shares expect their insurance costs to "increase about the same as usual" (12%) or "not increase at all" (8%).

If their overall health care expenses, including co-pays, deductibles, and premiums, increased by $1,000 next year, about half of Marketplace enrollees say it would have a "major impact" on their decision to vote in the 2026 midterm elections (54%) or on which party's candidate they will support (52%).

People with Marketplace insurance are more likely to say that either President Trump (37%) or Congressional Republicans (33%) would deserve most of the blame if their health care costs increased by $1,000 next year than they are to say Congressional Democrats (29%).

Democrats would overwhelmingly blame Republicans in Congress (46%) or President Trump (49%). Most Republicans (65%) would blame Congressional Democrats, though about a third say they would blame either Republicans in Congress (20%) or President Trump (14%). Among independents, more than four in 10 (44%) would blame the President, a third (32%) would blame Congressional Republicans, and about one in four (23%) would blame Congressional Democrats.

Other findings include:

- Overall, about four in 10 Marketplace enrollees (39%) are Republicans or Republican-leaning independents, including about one in four (24%) who identify with President Trump's Make America Great Again (MAGA) movement. Just over four in 10 enrollees (45%) identify as Democrats or Democratic-leaning independents, while 17% don't identify or lean toward either party.
- Even with the current levels of financial assistance, many Marketplace enrollees say it is already difficult to afford their deductibles and other out-of-pocket costs for medical care (61%) and to afford the cost of health insurance each month (51%). More enrollees say their out-of-pocket medical costs are difficult to afford than say the same about other household expenses, such as their rent or mortgage, food and groceries, utilities, and gasoline or transportation costs.
- Large majorities of Marketplace enrollees, regardless of partisanship, say that having health insurance is "very important" for their peace of mind (78%), their ability to get needed health care (77%), and their financial well-being (69%). Enrollees between the ages of 50 and 64 are more likely than younger enrollees to say health insurance is very important for each of these three reasons.
- A large majority (84%) of enrollees say that Congress should extend the enhanced tax credits, while one in six (16%) think they should let the tax credits expire. Of

them, nearly all Democrats (95%), about eight in 10 independents (84%), and about seven in 10 Republicans (72%) and MAGA supporters (72%) favor extending the expiring tax credits.

Designed and analyzed by public opinion researchers at KFF, the 2025 Marketplace Enrollees Survey was conducted November 7-15, 2025, online and by telephone, in English and in Spanish, among a nationally representative sample of 1,350 U.S. adults ages 18-64 who purchase coverage on the ACA Marketplaces. The margin of sampling error is plus or minus 3 percentage points for the full sample. For results based on other subgroups, the margin of sampling error may be higher.

August 21, 2024

Speaker of the House Mike Johnson
House of Representatives
Cannon House Office Building, CHOB – B68
Washington, DC 20515

Senate Majority Leader Chuck Schumer
United States Senate
Hart Senate Office Building, SH – 322
Washington, DC 20151

Senate Minority Leader Mitch McConnell
United States Senate
Russell Senate Office Building, SR – 317
Washington, DC 20510

House Minority Leader Hakeem Jeffries
House of Representatives
Rayburn House Office Building, RHOB - 2433
Washington, DC 20515

Re: The Need to Make Permanent the Enhanced Advanced Premium Tax Credits

Dear Speaker Johnson, Senate Majority Leader Schumer, Senate Minority Leader McConnell, House Minority Leader Jeffries:

The undersigned 40 Partnership to Protect Coverage (PPC) member organizations urge Congress to permanently extend the Affordable Care Act's (ACA) enhanced advance premium tax credits (APTCs) before they expire at

the end of 2025. Permanently extending these critical subsidies is essential to prevent a sudden increase in out-of-pocket costs and the loss of insurance coverage for millions of people.

Our organizations represent millions of patients and consumers who face serious, acute, and chronic health conditions. Together, we offer unique perspectives on what individuals and families need to prevent disease, cure illness, and manage their health. The diversity of our organizations and the populations we serve enable us to draw upon extensive knowledge and expertise that can be an invaluable resource as Congress considers any legislation that would reform our healthcare system.

In March of 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) health care should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) health care should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) health care must be adequate, meaning healthcare coverage should cover treatments patients need.

Overview & Impact of the Enhanced APTCs

The ACA established advance tax credits to help lower the cost of health insurance purchased in the Marketplaces. Under the ACA, individuals earning between 100% and 400% of the federal poverty level (FPL) are eligible for these tax credits on a sliding scale – the lower the income level, the higher the amount of tax credits.

In 2021, Congress made two temporary, but critically important changes to the tax credits: it increased the amount of the tax credits for those between 133% - 400% FPL; and capped premium costs at 8.5% of annual income for individuals and families earning more than 400% FPL.[1] These enhanced tax credits were in effect in 2021 and 2022. Then in response to their success, in 2022, Congress extended these enhanced tax credits again, this time through the end of 2025.

Since the enhanced APTCs were first enacted in 2021, they have helped 9.4 million Americans gain access to high-quality and affordable health coverage – reducing the number of uninsured to just 7.7 percent.[2] Today, enrollment in the ACA marketplaces is at an all-time high, with more than 21 million people now insured through the ACA.[3]

Enrollment in marketplace plans generated by enhanced APTCs have provided millions of Americans with affordable, comprehensive health coverage by allowing more people to purchase high-quality health insurance coverage that meets their health care needs. This includes services included in the Essential Health Benefits (EHB) package (such as doctor's visits, prescription drugs, hospitalizations, and preventive services), annual out-of-pocket cost caps, and prohibitions on discriminatory plan design and practices like denying coverage or charging more based on pre-existing conditions.

Congress Should Act Now to Permanently Extend the Enhanced APTCs

The enhanced APTCs are scheduled to expire by the end of 2025. If Congress fails to act by August of 2025, premiums for Marketplace enrollees will skyrocket, forcing some patients and consumers to abandon the high-quality coverage upon which they have come to rely. Action is urgent because the process for setting rates and developing plans is lengthy and complex.

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[1] Center for Budget and Policy Priorities, *Health Insurance Costs Will Rise Deeply If Premium Tax Credit Improvements Expire.* https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire

[2] Assistant Secretary for Planning and Evaluation, *National Uninsured Rate Reaches an All-Time Low in early 2023 after the Close of the ACA Open Enrollment Period* (August 3, 2023), https://aspe hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf

[3] Centers for Medicare and Medicaid Services, *Health Insurance Marketplaces 2024 Open Enrollment Report* (March 22, 2024), www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollmentreport-final.pdf

Issuers will begin finalizing rates for 2026 Marketplace plans early in 2025 - working throughout the year with state and federal regulators to ensure their products comply with state and federal standards. However, if the enhanced APTCs are not extended in time for issuers to develop rates in time for open enrollment, patients and consumers could see considerable price hikes when they begin shopping for 2026 coverage in the fall of 2025.

The drastic change in premium cost could be devastating for the patients and consumers we represent. For example, a family of four making $60,000 (200% of FPL) would see their monthly marketplace premium increase from $100 to $326—an annual increase of about $2,700. A 60-year-old couple making $45,000 (228% of FPL) would see monthly marketplace premiums increase from $117 to $283 — an annual increase of almost $2,000.[4]

Patients with serious and chronic conditions cannot afford to go without insurance that meets their healthcare needs. As such, we urge Congress to take immediate action to permanently extend the enhanced APTCs. Please contact Katie Berge (Katie.Berge@lls.org) and Jelani Murrain (Jelani.Murrain@cancer.org) if you have questions or feedback. We thank you for your attention to this issue and welcome the opportunity to discuss it further.

Sincerely,

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cancer*Care*
Child Neurology Foundation
Chronic Disease Coalition
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NMDP (formerly National Marrow Donor Program)
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.
WomenHeart

[4] Center for Budget and Policy Priorities, *Health Insurance Costs Will Rise Deeply If Premium Tax Credit Improvements Expire.* https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire

Senate Must Act Quickly on Expired ACA Premium Tax Credits to Stabilize Coverage and Protect Emergency Care

(/newsroom) **January 8, 2026**

WASHINGTON, D.C. – Following today's successful House passage of legislation restoring the Affordable Care Act's advanced premium tax credits, or APTCs, the American College of Emergency Physicians (ACEP) urges the U.S. Senate to immediately take up and pass legislation that provides stability for patients and for the nation's emergency care system.

The enhanced APTCs expired in December. The result is that many patients will now be responsible for paying the full premium for their healthcare insurance, many of whom will not be able to afford to do so. Estimates are that millions of Americans will lose healthcare coverage. Those coverage losses are expected to have a devastating impact on emergency care and its critical role as our nation's health care safety net.

ACEP projects the loss of the tax credits will result in more than one million additional uninsured emergency department visits each year, and as much as $322.35 million in estimated losses to emergency medicine.

"These are not abstract numbers," said ACEP President L. Anthony Cirillo, MD, FACEP. "They represent more families forced to choose between health insurance and rent, more patients arriving sicker and later, and more hospitals—especially those in rural or underserved communities—absorbing uncompensated care that could force them to close their doors."

ACEP also believes that there should be stronger oversight of healthcare insurers who are receiving full annual insurance premiums, mostly from the premium tax credit subsidies, even for patients who never receive any healthcare services.

"It is critical for all Americans to have access to both health care professionals and health care coverage, and these subsidies are vital to ensuring that access remains strong," Dr. Cirillo said.

The safety net is already under extraordinary financial pressure, with twenty percent of all care provided by emergency physicians left unpaid leading to $5.9 billion in **annual losses (/press-releases/2025/4-7-25-insurance-company-tactics-threaten-emergency-care-sustainability-and-patient-access)**. The consequences of coverage instability will further magnify these losses and jeopardize the ability of emergency physicians and hospitals to maintain 24/7 readiness," he added.

"This is an urgent matter that cannot wait," Dr. Cirillo said. "Today's House vote is an important first step, but the Senate must finish the job and pass legislation that stabilizes premiums to limit further coverage losses. Emergency care cannot be

America's health insurance plan of last resort."

The American College of Emergency Physicians (ACEP) is the national medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the more than 150 million people they treat on an annual basis. For more information, visit **www.acep.org (https://www.acep.org/)** and **www.emergencyphysicians.org (/)**.

Contact: Steve Arnoff | **sarnoff@acep.org (mailto:sarnoff@acep.org)** | **X @EmergencyDocs (https://twitter.com/EmergencyDocs)**

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ACEP Reaffirms Emergency Physicians' Duty to Uphold EMTALA, Provide Stabilizing Care in Emergencies

(/press-releases/2025/6-4-25-acep-reaffirms-emergency-physicians-duty-to-uphold-emtala-provide-stabilizing-care-in-emergencies)

The Policies Behind the Headlines

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The Importance Of Premium Tax Credits: Affording Health Insurance Coast To Coast

11.05.2025

Nearly 22 million Americans benefit from premium tax credits that help them afford comprehensive health coverage from the federal or state health insurance Marketplaces. These tax credits were enhanced in recent years, saving individuals and families money in insurance premiums and increasing enrollment. They are a lifeline for workers and their families, including those with serious and chronic health conditions like diabetes, heart disease, and cancer who need access to regular care to stay healthy and keep working when they don't get insurance through their job. Since Congress has not intervened, these workers are entering the annual open enrollment period for health coverage, hit with premiums that may be double or triple what they paid last year, and with no guarantee that any tax credit relief will be available to them later. The ripple effect on families, communities, and local economies will be devastating. Enhanced premium tax credits are having a profound impact in many areas of the country, with metrics differing state-by-state. National and some state-specific fact sheets include data and personal stories of individuals and families benefiting from premium tax credits. If you are a state advocate who does not see your state represented and would like to discuss a fact sheet, please contact **partnerships@familiesusa.org** and the appropriate parties will reach out.

National And State Fact Sheets

2025

- **National**
- **Alaska**
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- **California**
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- **Georgia**
- **Idaho**
- **Illinois**
- **Iowa**
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- **Maine**
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- **New Hampshire**
- **New York**
- **North Carolina**

- **Ohio**
- **Pennsylvania**
- **Utah**
- **West Virginia**

Spanish Translation Available

Our fact sheets are also available in Spanish. To learn more, please visit **La importancia de los créditos fiscales para las primas: Cómo costear un seguro médico a nivel nacional**.

Additional Resources

Access additional advocacy resources highlighting the **importance of enhanced premium tax credits**.

Tell Congress: Extend the Enhanced Premium Tax Credits Now!

Time is running out to extend the premium tax credit enhancements before millions face skyrocketing premium increases in just a few weeks. These subsidies are a lifeline for those who would otherwise be unable to afford health coverage or to access health care at all – but they are set to expire at the end of this year.

Congress has yet to act to prevent the expiration of these enhanced tax credits but promised to hold a vote on an extension in exchange for ending the government shutdown. Now, it is Congress's choice to either protect millions of people and families from seeing their health care costs skyrocket or let them risk losing health coverage altogether. Send a letter to your Senators and Representatives asking them to extend the enhanced tax credits and lower health care costs now.

*See the **Keep Americans Covered** coalition page for state-specific data and a cost of coverage calculator.*

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"BULLSHIT" — THE NEW WAY HEALTH GIANTS HIDE BILLIONS

JAN 6, 2026 1:00 PM EST

BY: Laura Wadsten Nathaniel Horwitz

EDITOR: Sam Koppelman Wendy Nardi

THREE MYSTERIOUS ENTITIES. TENS OF BILLIONS IN REVENUE.

OUR MULTINATIONAL INVESTIGATION REVEALS HOW CVS, UNITEDHEALTH, AND CIGNA CREATED NEW SUBSIDIARIES TO DIVERT BILLIONS OF DOLLARS FROM HEALTH PLANS AND PATIENTS.

ALL THREE TRIED TO KEEP IT SECRET. NONE ANSWERED REPEATED

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If you have information related to PBMs, PBM GPOs, or other topics investigated in this article, please contact ideas@hntrbrk.com to share with Hunterbrook Media, which can keep you anonymous.

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THE HIDDEN FLOW OF DRUG MONEY

Drug manufacturers pay billions in discounts, rebates and fees to pharmacy benefit managers (PBMs). But where does that money actually go? Follow the flow.

SCROLL TO EXPLORE

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REBATES FLOW FROM DRUGMAKERS

Drug manufacturers pay rebates directly to PBMs and PBM Group Purchasing Organizations (GPOs) to ensure their drugs are included on health plan formularies — meaning that their drugs are covered by insurance.

So a health plan might be getting 100% of the rebates the PBM received, but the plan has no idea if the PBM got everything the GPO earned, or how much money the GPO may have kept. And as far as we can tell, the GPO doesn't do much of anything at all to earn these billions of dollars worth of fees. In fact, Hunterbrook found that PBM GPOs are thinly veiled middlemen with few employees and largely empty headquarters — creations of United Health, Cigna, and CVS, the very healthcare corporations that own the three largest PBMs.

Vacant again.

Reception: empty. Offices: deserted. This time, mail piled by the door.

Multiple visits found no activity at the ghost headquarters in Minnesota. There was a logo on the wall: a company with no apparent website, contact email, or phone number.

An entity whose address only appeared in lawsuits.

Zinc Health Services.

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0:00 / 1:05

A reporter knocks on the door and rings the doorbell of Zinc's visibly empty headquarters inside an office suite in Bloomington, Minnesota Source Raffaella for Hunterbrook Media

Across the ocean in Ireland, the same phenomenon.

A security guard escorted a Hunterbrook Media reporter through a building in Dublin to the offices of a company supposedly headquartered within.[1]

Emisar Pharma Services.

Again, no website, email, or number.

A dozen or so cubicles. Fluorescent lights illuminating empty chairs.

No one there.

This one has a website.

There were a half-dozen employees in the office, and dozens of others apparently work remotely.

But after Ascent called the Swiss police on a Hunterbrook reporter observing from a neighboring kebab shack, two executives refused to answer questions or even share contact information for the company — despite a request from the Polizei.

Three supposed headquarters. Three countries. Three entities that seem to barely exist, relative to their purported revenue.

According to financial records, lawsuits, and dozens of interviews, these three entities — Zinc, Emisar, and Ascent — may be among the most lucrative companies in the world, bringing in tens of billions of dollars for their parent conglomerates.

If you're reading this investigation from the United States, there's about a nine-in-ten chance that one of these corporations plays a role in what you pay for healthcare.[2]

So what are these companies? And how do they appear to generate 25 times the revenue per employee as companies like Apple or Nvidia?

THE MIDDLEMEN OF MEDICATION COVERAGE

Who decides what drugs your insurance covers — and how much you'll pay for them?

It's not your doctor or employer. It's not even your insurer.

It's a middleman: a Pharmacy Benefit Manager (PBM).

The Big Three PBMs and their secretive newer PBM GPOs are subsidiaries of the dominant healthcare conglomerates CVS Health, Cigna Group, and UnitedHealth Group Source Hunterbrook Media

Over 80% of America's prescription drug market is reportedly controlled by the "Big Three" PBMs: Optum Rx, CVS Caremark, and Evernorth Express Scripts. Their parent companies UnitedHealth Group ($UNH), CVS Health ($CVS), and Cigna Group ($CI) are some of the largest corporations in the world, ranking third, fifth, and 13th, respectively, on the Fortune 100 list in 2025.

These three companies grip every corner of healthcare, from the drugmaker to the doctors who write prescriptions to the pharmacies that dispense drugs.

PBMs originally emerged in the 1960s to process insurance claims for prescriptions. Since then, they've evolved into complex intermediaries with enormous market power.

The premise is straightforward.

By combining the buying power of health insurance plans, PBMs are meant to secure better deals for those plans from drugmakers. These discounts often take the form of "rebates" — payments from drugmakers to PBMs, typically a percentage of the product's list price. Rebates are supposed

compensation, drugmakers offer bigger rebates in exchange for PBMs giving their products the best spot on a formulary.

Over time, PBMs began to keep a greater and greater slice of rebates for themselves.[3]

Eventually, scrutiny metastasized.

Red and blue states alike began to regulate PBMs.

State attorneys general, President Trump's first administration, and Lina Khan's Federal Trade Commission each shined a light on PBMs.

Efforts to crack down on the middlemen gained broad bipartisan support.

Clients started wising up to the scheme, demanding that 100% of rebates negotiated by PBMs be passed through to the health plans the PBM was acting on behalf of. Employers insisted that *they* should receive the discounts on drugs paid for by *their* health plans for *their* employees, not PBMs.

The days of rebate profiteering seemed numbered — at first.

THE MIDDLEMEN'S MIDDLEMEN: BIG THREE CREATE SECRETIVE "PBM GPOS"

With their cash cow at risk, the Big Three PBMs pivoted.

To keep more of the money while technically fulfilling promises to pass through all rebates, PBMs created secretive new subsidiaries.

The PBMs branded these new backroom entities PBM "Group Purchasing Organizations" (PBM GPOs).[4]

and employee data; visited offices from Ireland to Switzerland; applied to job posts; and reviewed thousands of pages of contracts and court records.

The takeaway: PBM GPOs appear to generate astronomical revenue with skeleton staff — making Zinc, Emisar, and Ascent among the world's most lucrative enterprises on paper, even though they appear barely to exist in the real world.

> "They are covers for the Big Three to say in a contract that they pass through 100% of the rebates they get."
>
> — MARK CUBAN, CO-FOUNDER OF COST PLUS DRUGS

"A lot of the functionality of PBMs has shifted away from the nucleus into its surrounding rings. If you look at a GPO level, the truth is that we're looking at around 95% of all claims transactions that are running through three companies," said Antonio Ciaccia, co-founder and CEO of the prescription drug data analytics nonprofit 46brooklyn Research and president at 3 Axis Advisors, a healthcare consulting firm.

A few health plans have caught on to the scheme through reviews of their own financials. These health plans have recovered tens of millions of dollars from PBMs and their GPOs, according to public audit reports and court filings.

Health insurance benefits are often a company's second-largest expense behind payroll.[5] Rising awareness of the PBM problem has some employers looking beyond Caremark, Optum, and Express Scripts.[6]

But thanks to the GPOs, switching PBMs doesn't necessarily free companies from the grip of the healthcare oligopoly: Other PBMs go through Zinc, Ascent, or Emisar to negotiate with

> "You get 100% back of what you know about, but not the stuff they're hiding."
>
> *— MICHAEL SHERMAN, FORMER CHIEF MEDICAL OFFICER OF HARVARD PILGRIM HEALTH CARE*

Industry insiders confirmed Hunterbrook's findings about PBM GPOs.

"They are covers for the Big Three to say in a contract that they pass through 100% of the rebates they get," the billionaire Mark Cuban, co-founder of Cost Plus Drugs, told Hunterbrook.

Dr. Steve Miller had helped create Ascent while chief clinical officer at Cigna and Express Scripts, where he successfully challenged Pfizer and other drugmakers to lower the price of medicines ranging from statins to the antiparasitic whose price was jacked up by Martin Shkreli. Miller explained that PBM GPOs "double-, triple-dip on fees." He said that at first, health plans and their consultants didn't know about it.

Kent Rogers, who helped create Emisar while senior vice president at UnitedHealth's Optum, confirmed that the PBM GPOs bring in "tens of millions, if not close to $100 million, per employee."

PBMs claim that PBM GPOs receive these payments from drugmakers for services they provide, like data processing and rebate negotiation.

But according to Hunterbrook's visits to these companies' ostensible headquarters, as well as its review of employment websites and interviews with numerous industry experts including former employees, few people work at Zinc or Emisar. While Ascent boasts a larger team, it is still one of the most lucrative companies in the world, relative to its actual size.

The Big Three and their affiliates were functionally unresponsive to this investigation.

"We reached out to PBMs and we said, 'Hey, can you explain to us what these GPOs do?' They said the GPOs are going to negotiate with the drug companies to get the very best deals, because they are going to aggregate all of the covered lives that we have, for all of our customers. And we said, 'That doesn't make any sense, because that's exactly what a PBM is supposed to do! So what exactly is the GPO going to do?' They gave us a Cheshire Cat grin, and no more information," James Gelfand told Hunterbrook.

Gelfand is president of the ERISA Industry Committee (ERIC), a lobbyist group that represents large, self-funded employers on health and benefit plans issues.

"The way the scam is intended to work, the PBM farms out what used to be the PBM's job to the GPO ... The entire thing was a scam in order to be able to do that fee function that we just described as a way of hiding that money so it is never disclosed to the plan sponsor," he added.

According to a former Zinc executive, the work PBM GPOs allegedly do for pharmaceutical companies is largely a mirage.

"It was all on paper and it was all transactional money flowing through contracts. There was nothing I had to send to you or to sell to you," they said, asking to remain anonymous due to what they described as a pattern of "retaliation" from the Big Three.

"THE STUFF THEY'RE HIDING"

UnitedHealth Group's then-CEO Sir Andrew Witty had promises to keep.

"This morning we are committing to a full 100% pass-through of all rebates we negotiate at the PBM back to the payer, the state, or the union," he proclaimed on his January 2025 earnings call.[7]

It was the first earnings presentation since the killing of Brian Thompson, CEO of the insurance division that provided three-quarters of the conglomerate's more than $400 billion in 2024 revenue.

Because by then, Optum and its peer PBMs had spent years moving money around: Optum was receiving payments from the pharmaceutical industry through its PBM GPO, Emisar.

"The pharma companies aren't paying less, they're paying differently," hypothesized Michael Sherman, former chief medical officer of the nonprofit Harvard Pilgrim Health Care system.

"By categorizing as fees not rebates, and laundering through the GPOs, they don't have to pass through the rebates, they're somehow carving it out."

Miller corroborated Sherman's speculation. Drugmakers "were reducing rebates to pay Ascent more," he told Hunterbrook.

Rogers echoed Sherman and Miller in testimony to the FTC. "The industry feared that the rule would make the rebate system illegal," he said, referring to the first Trump administration's "rebate rule," which removed rebates from a regulatory safe harbor that had protected drugmakers and PBMs from prosecution under the Anti-Kickback Statute.[9]

"The intention of the G.P.O. is to create a fee structure that can be retained and not passed on to a client," Rogers told The New York Times in 2024. (Years after the emergence of PBM GPOs, this article from the NYT appears to be the first time the PBM GPOs received substantive media scrutiny.)

Cigna recently made the same promise as UnitedHealth Group. In its latest earnings call, an executive all but admitted the commitment to rebate pass-through was performative.

"You should think of this as not meaningfully changing from today in terms of client level earnings contributions, meaning that we would expect comparable earnings contributions from our rebate-free model as we have today in our existing solutions," said Brian Evanko, president and chief operating officer of Cigna Group.

In an interview with Hunterbrook, Rogers said PBM GPOs were a necessary solution to replace the

"I've testified a number of times in front of Congress and had pharma at the table," Bricker told Hunterbrook.[11] "In every one of those hearings, drugmakers are asked, if we did away with rebates, would you lower your list price unilaterally to make up for those rebates? Not once was the answer yes."[12]

Rogers agreed, telling Hunterbrook: "You may not like it, but it's not illegal."

The legality appears to be an open question based on recent litigation.

In 2024, the Illinois Attorney General recovered $45 million from CVS Caremark for retaining money from Zinc that should have been passed through to the state health plan that Caremark and Zinc represented.

CVS capitulated in a settlement prior to any litigation. In addition to the money, the settlement explicitly modified the contract between Caremark and the state to ensure that rebates negotiated by Zinc, as well as Caremark itself, would be fully passed through to the state.

"The Illinois case tells you: Forget the cost of litigating. Even aside from that, they don't want to talk about this publicly: Let's make this go away," said Sherman.

The Pharmaceutical Care Management Association (PCMA)[13] — a lobbying group for the PBM industry — provided the following statement to Hunterbrook regarding PBM GPOs:

"GPOs are used in health care and many other industries to aggregate purchasing volume and obtain lower prescription drug costs for patients. Employers and PBMs should be able to use every tool at their disposal to push back against the high drug prices set by drug companies. PBMs, including smaller market companies, need the leverage provided by GPOs to aggressively negotiate with drug companies to secure savings on lifesaving medications for patients and employers."

releasing the information without significant redactions.

The information Hunterbrook did receive, however, showed a gap between what drugmakers paid Zinc and what Zinc ultimately passed through to CVS and therefore patients.

The same exhibit stated, "100% of rebates and [Redacted] passed from ZINC to Caremark to client."

Updated numbers as of 20240221

Quarter	Rebate ID	Gross Rebates	[redacted]	Total Invoiced	Client Share of Invoiced	Paid to Date	[redacted]	[redacted]	Total
2020Q2	109213	$ 26,361,521.50	$ 2,584,034.04	$ 28,945,555.54	$ 28,945,555.54	$ 28,939,396.89	$ 97,642.03	$ 127,447.72	$ 225,089.75
2020Q3	109213	$ 26,875,161.10	$ 2,640,992.45	$ 29,516,153.55	$ 29,516,153.55	$ 29,508,838.91	$ 305,803.79	$ 269,176.45	$ 574,980.24
2020Q4	109213	$ 28,437,916.17	$ 2,779,936.70	$ 31,217,852.87	$ 31,217,852.87	$ 31,170,658.89	$ 408,530.06	$ 482,265.65	$ 890,795.71
2021Q1	109213	$ 27,821,934.23	$ 2,651,395.86	$ 30,473,330.09	$ 30,473,330.09	$ 29,791,280.30	$ 552,437.44	$ 1,029,408.87	$ 1,581,846.31
2021Q2	109213	$ 29,445,769.67	$ 2,804,539.37	$ 32,250,309.04	$ 32,250,309.04	$ 31,712,677.02	$ 581,153.15	$ 1,106,408.74	$ 1,687,561.89
2021Q3	109213	$ 28,613,584.33	$ 2,737,193.55	$ 31,350,777.88	$ 31,350,777.88	$ 30,923,568.51	$ 583,847.98	$ 1,128,932.47	$ 1,712,780.45
2021Q4	109213	$ 30,435,446.44	$ 2,923,008.01	$ 33,358,454.45	$ 33,358,454.45	$ 32,698,087.50	$ 625,784.37	$ 1,219,055.96	$ 1,844,840.33
2022Q1	109213	$ 33,247,998.33	$ 3,149,488.79	$ 36,397,487.12	$ 36,397,487.12	$ 35,312,974.95	$ 758,457.48	$ 1,792,524.56	$ 2,550,982.04
2022Q2	109213	$ 35,396,411.52	$ 3,374,225.65	$ 38,770,637.17	$ 38,770,637.17	$ 37,688,684.91	$ 804,935.85	$ 1,951,663.93	$ 2,756,599.78
2022Q3	109213	$ 35,072,647.22	$ 3,380,559.74	$ 38,453,206.96	$ 38,453,206.96	$ 37,324,370.72	$ 830,715.11	$ 2,016,791.02	$ 2,847,506.13
2022Q4	109213	$ 36,043,725.02	$ 3,480,712.25	$ 39,524,437.27	$ 39,524,437.27	$ 37,705,899.11	$ 861,991.27	$ 2,094,718.75	$ 2,956,710.02
2023Q1	109213	$ 41,779,078.18	$ 3,875,215.56	$ 45,654,293.74	$ 45,654,293.74	$ 41,066,396.15	$ 1,130,852.01	$ 2,563,376.28	$ 3,694,228.29
2023Q2	109213	$ 45,298,902.02	$ 4,165,461.33	$ 49,464,363.35	$ 49,464,363.35	$ 43,711,967.27	$ 1,207,475.62	$ 2,776,600.67	$ 3,984,076.29
2023Q3	109213	$ 45,570,923.65	$ 4,076,776.66	$ 49,647,700.31	$ 49,647,700.31	$ 39,137,009.07	$ 1,266,653.54	$ 2,780,542.11	$ 4,047,195.65
2023Q4	109213	$ 48,016,967.62	$ 4,272,298.66	$ 52,289,266.28	$ 52,289,266.28	$ -	$ 1,343,390.41	$ 2,935,215.18	$ 4,278,605.59

[redacted]
100% of rebates and [redacted] passed from ZINC to Caremark to client

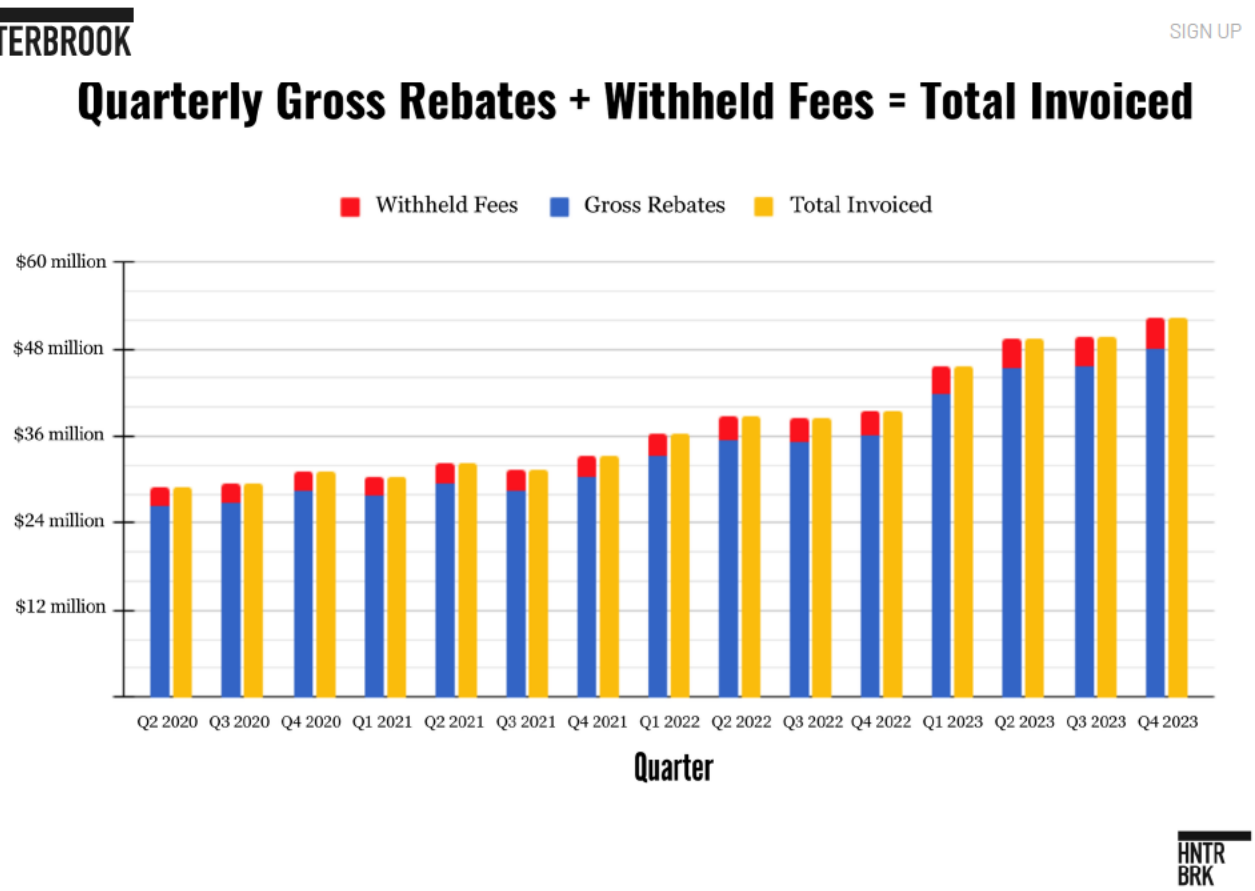
An excerpt of an exhibit in the Caremark settlement with the Illinois attorney general, showing rebates by quarter for the state health plan Source Illinois attorney general; document obtained by Hunterbrook via public records request

The share of funds not passed through (the left-most redacted column in the table above, outlined in red ("Column 4") — appeared to grow substantially from 2020 to 2023.

During that period, Column 4 payments totalled nearly $49 million — a similar amount to what Zinc was later forced to pay in settlement — accounting for 8.66% of the total invoiced each quarter, on average. And this was just one health plan among thousands across the country.

On the chart above, the numbers in Column 4 show the amount left when "Gross Rebates" are subtracted from the "Total Invoiced." Therefore, this difference likely represents fees — such as "Manufacturer Administrative Fees" — Zinc itself charged drugmakers for its services on behalf of a plan.

The amounts in Column 4 fluctuate in lockstep with rebates — whenever "Gross Rebates" increase



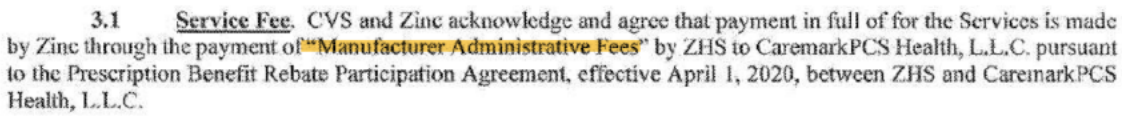
Hunterbrook Media data analysis of rebate records from the Illinois attorney general regarding the state's settlement with Caremark Note that "Withheld Fees" refers to the redacted Column 4 in the image above

The documents from the Illinois case also include Zinc's contracts with CVS Caremark (the PBM) and CVS Pharmacy.

The contract between Caremark ("Company") and Zinc ("GPO") states:

"Company and GPO acknowledge and agree that **a portion of the [Redacted] remitted by GPO to Company constitutes compensation for services rendered by Company to GPO** pursuant to that certain Services Agreement, effective April,1 2020, between Zinc Health Ventures, LLC, the parent company of GPO, and CVS Pharmacy, Inc., the parent company of Company."[14]

The redacted term appears to be "Manufacturer Administrative Fees" — based on the "Services Agreement" between Zinc and CVS Pharmacy.



3.1 Service Fee. CVS and Zinc acknowledge and agree that payment in full of for the Services is made by Zinc through the payment of "Manufacturer Administrative Fees" by ZHS to CaremarkPCS Health, L.L.C. pursuant to the Prescription Benefit Rebate Participation Agreement, effective April 1, 2020, between ZHS and CaremarkPCS Health, L.L.C.

Screen capture of p 3/A 1 of "SERVICES AGREEMENT effective as of April 1, 2020 by and between CVS PHARMACY, INC and ZINC HEALTH VENTURES, LLC " Source Illinois attorney general via public records request

It's tricky teasing out the exact division of work between Zinc and its parent company.

The "Services Agreement" suggests that CVS outsourcing to Zinc is mostly a formality: In fact, Zinc hires CVS Caremark to do work that the PBM says falls under the GPO's responsibilities. Zinc then pays a portion of the manufacturer administrative fees to Caremark in exchange for these services.

The services Zinc pays Caremark for include "General Support Services" — like Human Resources, IT Support, and Legal and Compliance Support — as well as "Administrative Support for Manufacturer Rebate Agreements."

In the latter category, CVS seems to handle the accounting, reporting, and drugmaker correspondence for rebate payments between Zinc and drugmakers.

What work is left for Zinc?

According to the contract, Zinc "is engaged solely to provide the rebate contracting and financial analysis and consultation services described herein."

The analysis and consultation services appear to involve modeling how different terms in plan contracts would impact the amount of money paid by plans. Aside from the parts of "rebate contracting" assigned to CVS, it seems as if Zinc is solely securing rebate deals with pharmaceutical manufacturers.

The agreement also shows that CVS Caremark sees how money flows between the drugmakers,

1) **Administrative Support for Manufacturer Rebate Agreements**. CVS shall, in accordance with ZHS instructions:

   a. Calculate amounts owed by pharmaceutical companies under the Rebate Agreements;
   b. Prepare and submit to pharmaceutical companies the invoices, client and plan reports, utilization reports, and, when applicable, market share reports, when and as required by the Rebate Agreements;
   c. Timely respond to inquiries from pharmaceutical companies concerning the invoices and reports;
   d. Review and address [redacted] from pharmaceutical companies;
   e. Provide reports to ZHS GPO participants pertaining to rebates and other amounts received under the Rebate Agreements and assist ZHS in the allocation of such amounts;
   f. Provide requested assistance in resolution of disputes with pharmaceutical companies;
   g. Assist in handling pharmaceutical company audits of the Rebate Agreements; and
   h. Provide such additional related services as the parties may from time to time agree.

2) **Portal Technology License**. CVS hereby grants to ZHS the non-exclusive right and license to use certain CVS software and technology to support the ZHS Data Portal (meaning the data portal that is made available by ZHS to pharmaceutical companies).

3) **Data**. Zinc intends to periodically contract with pharmaceutical companies for the provision of various research and analytical services and in connection therewith desires access to certain data and information held by CVS relating to prescription benefit claims, medical benefit claims, member enrollment and plan design ("**CVS Data**"). In such event, Zinc shall submit to CVS a data request form ("**Data Request Form**") specifying the desired CVS Data and the intended use of the CVS Data ("**Specified Use**"). Subject to approval of such Data Request Form by CVS, CVS shall provide the requested CVS Data to Zinc. The CVS Data shall constitute CVS Confidential Information and may be used by Zinc solely for the Specified Use. Zinc shall comply with HIPAA in connection with it use of the CVS Data. CVS grants to Zinc a limited, non-exclusive license to use the CVS Data provided to Zinc solely for the Specified Use. CVS shall retain ownership of the CVS Data. CVS shall have no obligation to provide CVS Data where the provision of such Data would be restricted by HIPAA or other privacy laws or by any contract between CVS and a client or other third party.

4) **General Support Services**. CVS shall provide the following support services, to the extent requested by Zinc from time to time:

   a. Human Resources services including recruitment, payroll processing and benefit administration
   b. IT support services including contracting, development and coding, and support with procurement, development, use and integration of software, databases, and information technology systems.
   c. Real estate and facility support services
   d. Legal and compliance support

Screen capture of Exhibit A on p 8 of "CVS Services" from "SERVICES AGREEMENT effective as of April 1,2020 by and between CVS PHARMACY, INC and ZINC HEALTH VENTURES, LLC " Source Illinois attorney general via public records request

Greg Baker, the CEO of AffirmedRx — an independent PBM that positions itself as a more transparent alternative to the Big Three — called claims that Zinc, Ascent, and Emisar lower drug prices "a blatant joke."

"It's profiteering that hurts patients in the long run," Baker told Hunterbrook.

"Where there's mystery there's margin." U.S. Rep. Jake Auchincloss, a Democrat from

In response to an FTC lawsuit last year, Optum Rx confirmed that Emisar was a separate, stand-alone legal entity.

They claimed to have launched Emisar "to focus on negotiating rebate agreements with pharmaceutical manufacturers and developing manufacturer-facing technology solutions," as well as providing "innovative data analytics services."

But despite Irish offices, no entity named Emisar was registered to operate in Ireland, according to the Irish business database.

Emisar also appears to lack a website or phone number. It only has about two dozen employees on LinkedIn. And its job openings intermingle with those of UnitedHealth and Optum, suggesting it may not be a particularly independent operation.

The Optum roles of "Pharma Account Manager" and "Associate Director – Pharma Account Manager" both "report to the Director of Pharma Services, Emisar."

A job posting for an "Associate Director – Industry Relations" at UnitedHeath would "report to the Senior Director of Industry Relations, Emisar." There's also a posting for a "Senior Account Manager" role at Optum "within our Emisar team."

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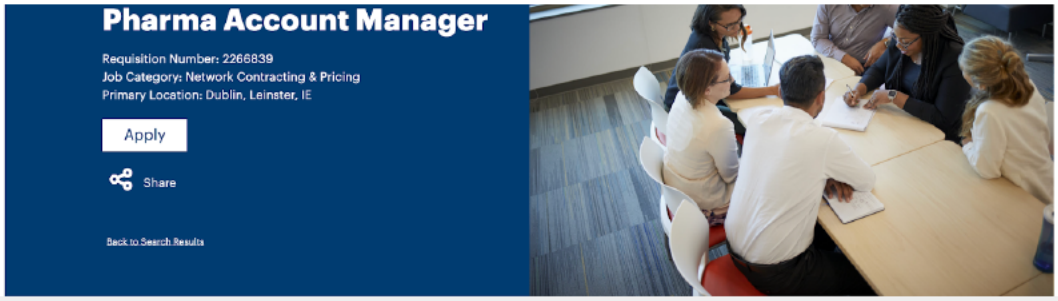


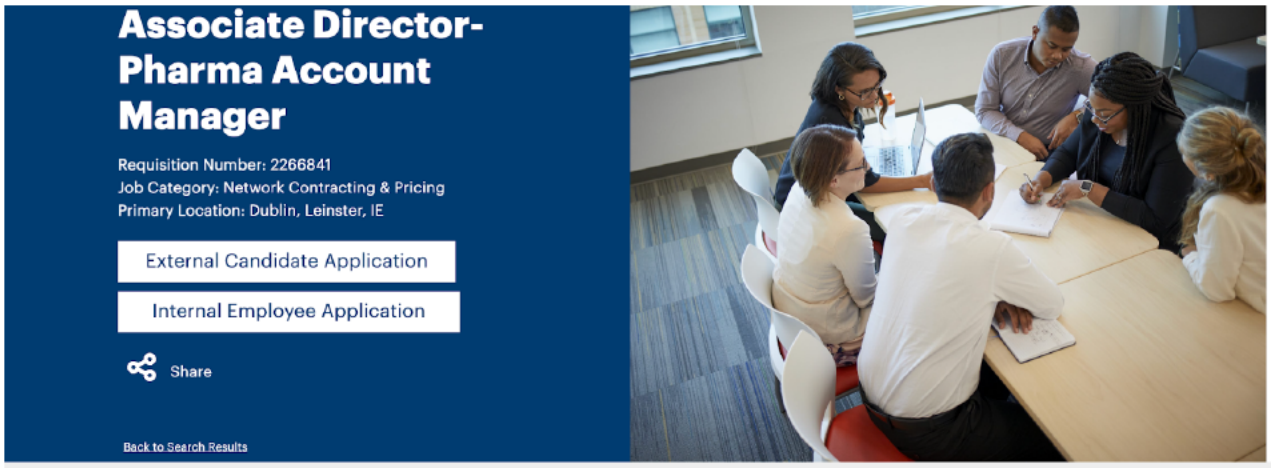
Optum is a global organization that delivers care, aided by technology to help millions of people live healthier lives. The work you do with our team will directly improve health outcomes by connecting people with the care, pharmacy benefits, data and resources they need to feel their best. Here, you will find a culture guided by diversity and inclusion, talented peers, comprehensive benefits and career development opportunities. Come make an impact on the communities we serve as you help us advance health equity on a global scale. Join us to start Caring. Connecting. Growing together.

About the Role:

As a Fortune 5 business, we're one of the world's leading healthcare companies. There are no limits here on the resources you'll have or the challenges you'll encounter.
We have been supporting global healthcare systems from Ireland and the UK for more than 20 years, building a dynamic and diverse team of more than 2,100 talented individuals. With a continued record of growth and stability, we're on the constant lookout for fresh talent to join our expanding teams.
We are looking for an experienced, curious and self-motivated individual who will be responsible for working within a Pharma Services team dedicated to providing key account management to major Pharmaceutical Manufacturers based in the US. The successful candidate will report to the Director of Pharma Services, Emisar. We are looking for people who can collaborate cross-functionally with various business and data analytics teams, demonstrate exceptional attention to detail, have a customer focused mindset, and the ability to manage multiple competing business projects at one time.

Careers with Optum offer flexible work arrangements and individuals who live and work in the Republic of Ireland will have the opportunity to split their monthly work hours between our Dublin or Letterkenny offices and telecommuting from a home-based office in a hybrid work model

Job Posting for "Pharma Account Manager" in Dublin, Ireland Live as of 12/3/25 at link Source UnitedHealth Group Careers



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Associate Director, Industry Relation- Dublin/ Hybrid

Optum is a global organization that delivers care, aided by technology to help millions of people live healthier lives. The work you do with our team will directly improve health outcomes by connecting people with the care, pharmacy benefits, data and resources they need to feel their best. Here, you will find a culture guided by diversity and inclusion, talented peers, comprehensive benefits and career development opportunities. Come make an impact on the communities we serve as you help us advance health equity on a global scale. Join us to start Caring. Connecting. Growing together.

About the Role:

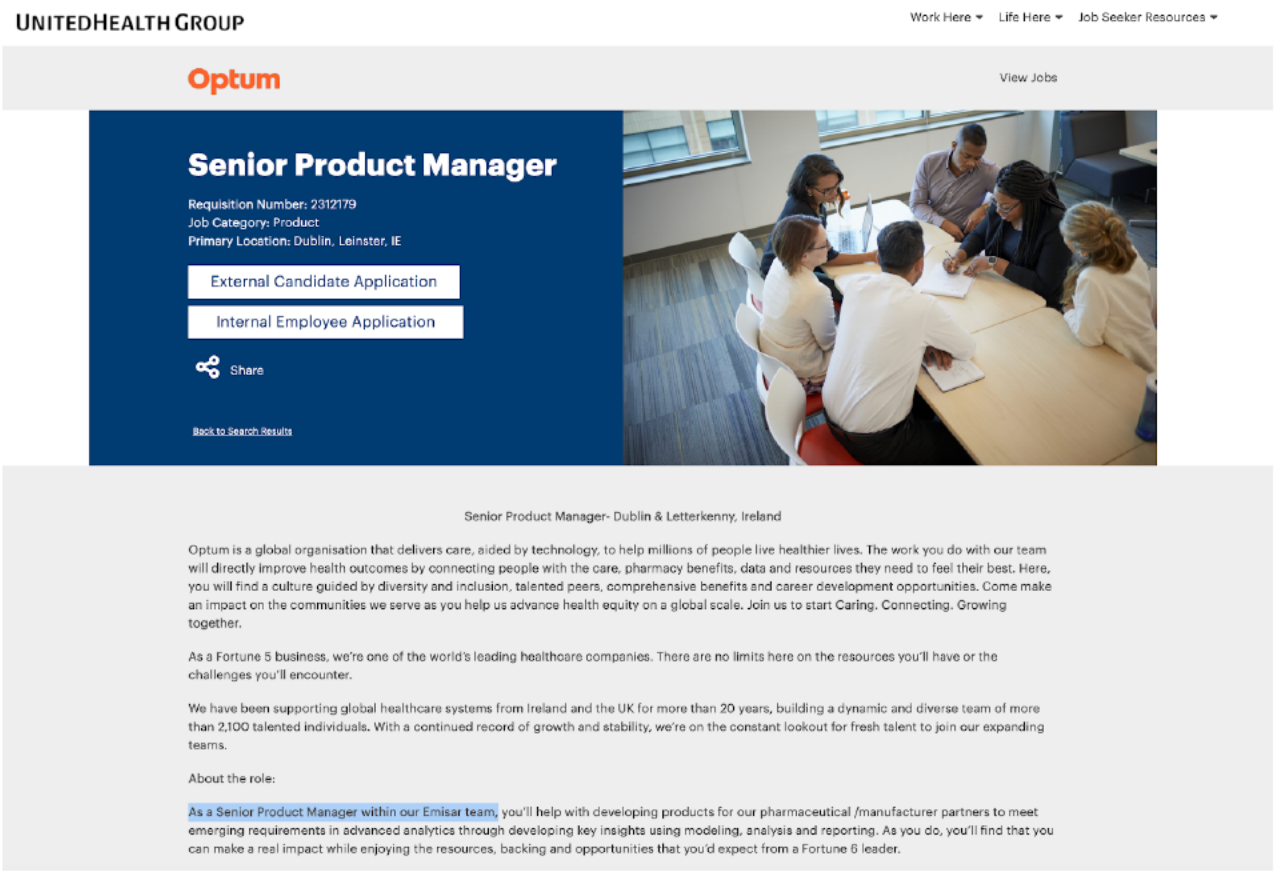
As a Fortune 5 business, we're one of the world's leading healthcare companies. There are no limits here on the resources you'll have or the challenges you'll encounter.

We have been supporting global healthcare systems from Ireland and the UK for more than 20 years, building a dynamic and diverse team of more than 2,100 talented individuals. With a continued record of growth and stability, we're on the constant lookout for fresh talent to join our expanding teams.

Optum is looking for an experienced, curious and self-motivated individual who will be responsible developing and managing relationships with pharmaceutical manufacturers in order to negotiate rebate discounts in exchange for formulary access to UHG enterprise Commercial books of business (OptumRx, UHC). The successful candidate will report to the Senior Director of Industry Relations, Emisar. We are looking for people who can collaborate cross-functionally with various business, finance, operations and clinical teams, demonstrate exceptional attention to detail, and the ability to manage multiple competing business projects at one time.

Careers with Optum offer flexible work arrangements and individuals who live and work in the Republic of Ireland will have the opportunity to split their monthly work hours between our Dublin or Letterkenny offices and telecommuting from a home-based office in a hybrid work model.

Job Posting for "Associate Director – Industry Relations" in Dublin, Ireland No longer live, accessed January 29, 2025 Source UnitedHealth Group Careers



Job Posting for "Senior Product Manager" in Dublin, Ireland No longer live, last accessed December 3, 2025 Source UnitedHealth

extent it exists.

A single room in the Optum building.

An Emisar logo by the door.

About 10 cubicles.

That room — from which Emisar supposedly negotiates billions of dollars of discounts, while also purportedly selling drugmakers a wide array of data, analytics, and administrative services in exchange for massive fees that UnitedHealth claims are *not* Optum rebates requiring pass-through to health plans, and certainly not kickbacks — was empty.

No one was working there.

Source: Doug Donovan for Hunterbrook Media

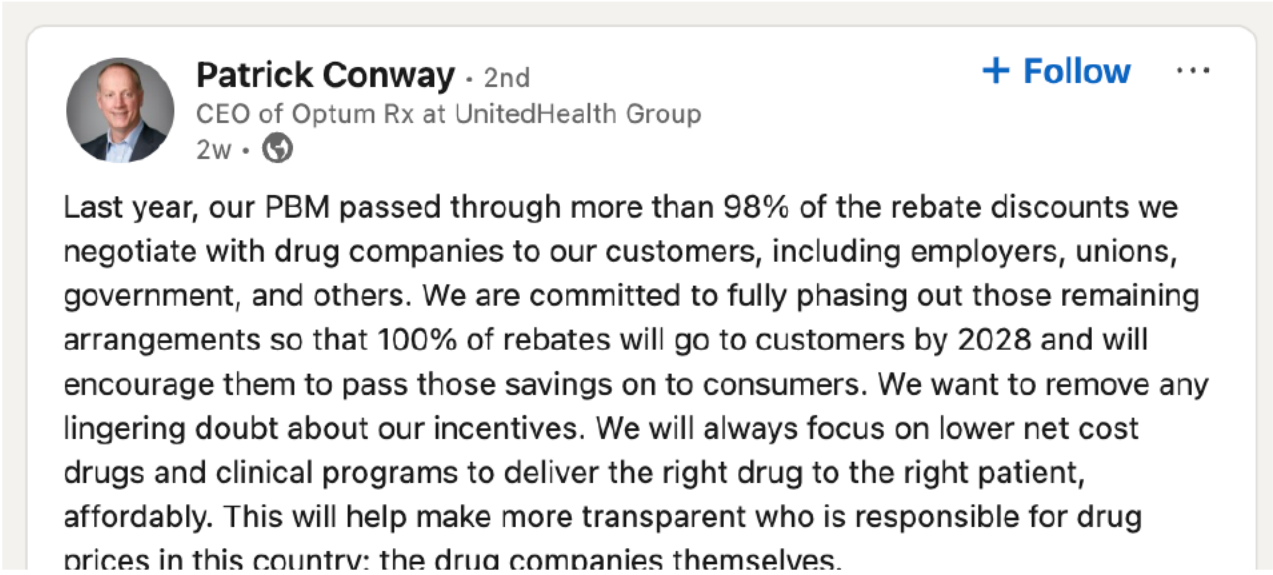
"Emisar, which operates out of Ireland, was established in 2021 by Optum and it still doesn't have a website. When you look at Ireland registered entities, it doesn't exist. You can hardly find any employees on LinkedIn. Something feels way off here," Baker told Hunterbrook.

"Emisar is acting behind the scenes on behalf of UnitedHealth Group's OptumRx PBM. They do not serve any other PBM or external members. If Emisar is adding so much value, why isn't it actively pursuing other customers?"

Criticizing similar remarks Baker made while testifying before Congress in 2023,[15] a longtime PBM GPO executive told Hunterbrook, "He's calling out the problems, I don't think he's bringing the solutions."

On UnitedHealth's fourth-quarter 2024 earnings call, Witty insisted, "We are committed to full transparency" — but never mentioned Emisar.[16]

The CEO of Optum posted a LinkedIn message echoing his boss, Witty, promising to "make more transparent who is responsible for drug prices in this country."



"Claiming that nearly 100% of rebates are or will go to customers is a twist of words," wrote Nicolas Ferreyros, who runs a nonprofit that advocates for cancer patients.

"And what about the offshore GPO $$$?" asked Mike Sharp, a pharmacist and industry consultant with SharpRx Pharmaceutical Consultation Services.

Sharp added in an interview with Hunterbrook: "It's a shell game by PBMs to scrape more money."

"Are you also going to clarify that 'non-rebate cash flows' from pharma will also be passed through? And that this includes the cash flows wrt Emisar?" posted Jens Thorsen, who runs a business that advises health plans on their policies and interactions with PBMs.

In an interview with Hunterbrook, Thorsen called the PBM GPOs a "bait and switch" to hide revenue from PBM contracts. "This is bullshit, they're passing through some but not others."

The conclusion: Emisar appears to be essentially a front for Optum and UnitedHealth.

Zinc — owned by CVS Caremark: Firewall? Or No Wall?

Like Emisar, Zinc does not appear to have a website or phone number.

According to LinkedIn, Zinc may have even fewer employees than Emisar.

And its headquarters — whose address was revealed in a lawsuit — turned out to be a single, empty suite in an office building outside Bloomington, Minnesota.

Image of the office building in Bloomington, Minnesota, that purportedly houses the Zinc headquarters. Source: Google Maps

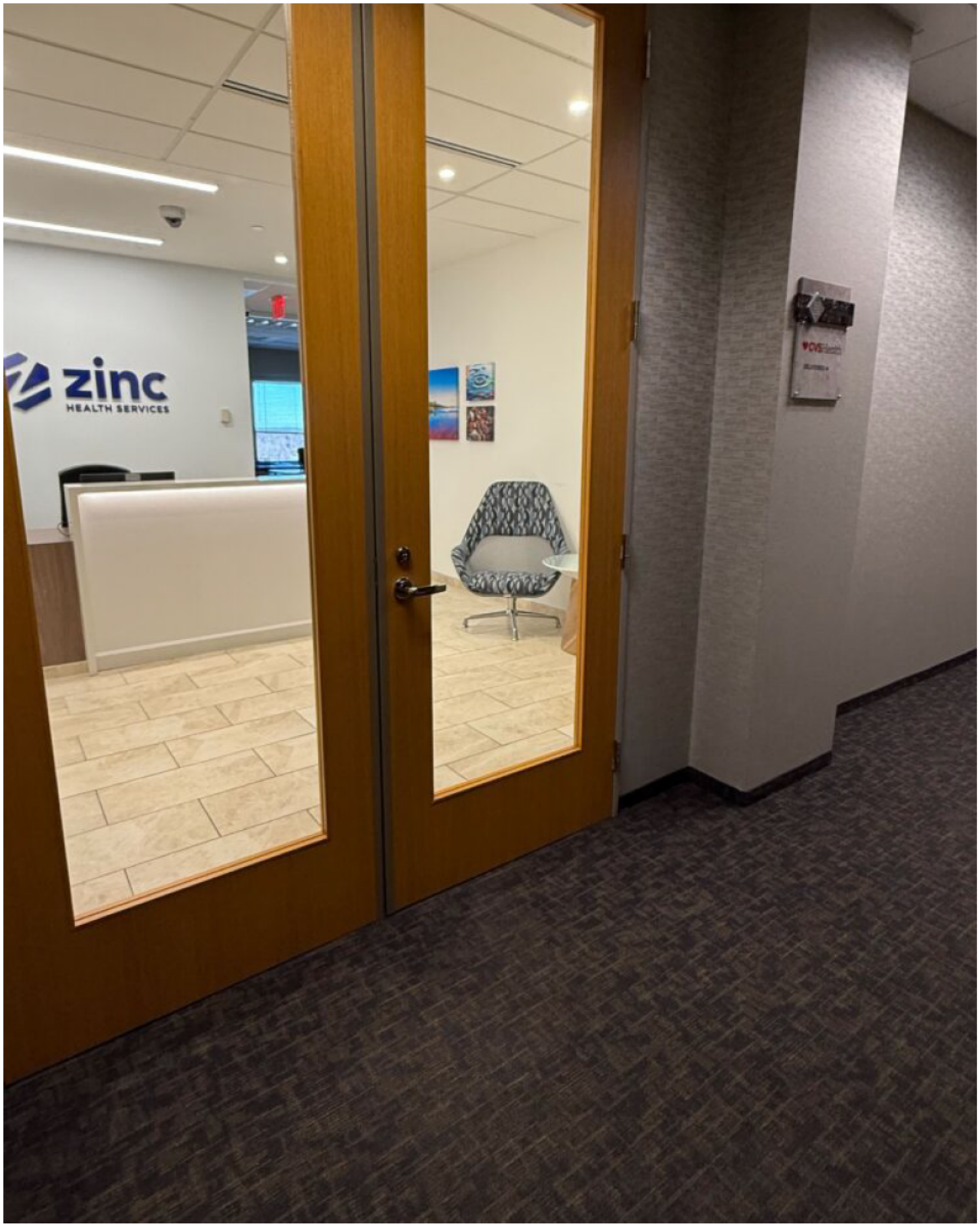
"It looked like a caricature of a front," said the Minnesota-based singer-songwriter Raffaella, who visited Zinc at Hunterbrook's request during two separate workdays in early 2025.

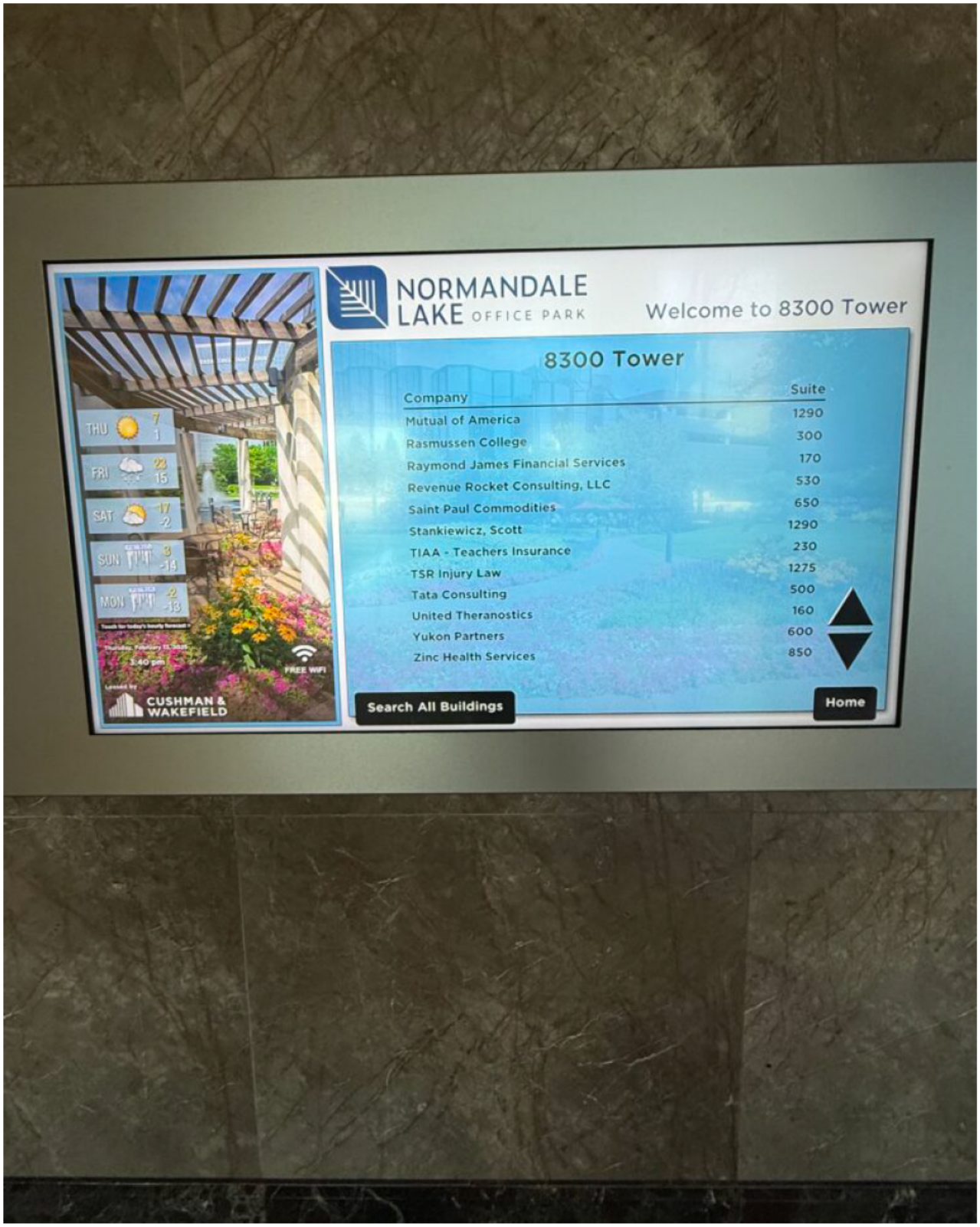
She interviewed two CVS employees from the adjacent office, who said they did not know anyone who worked at Zinc.

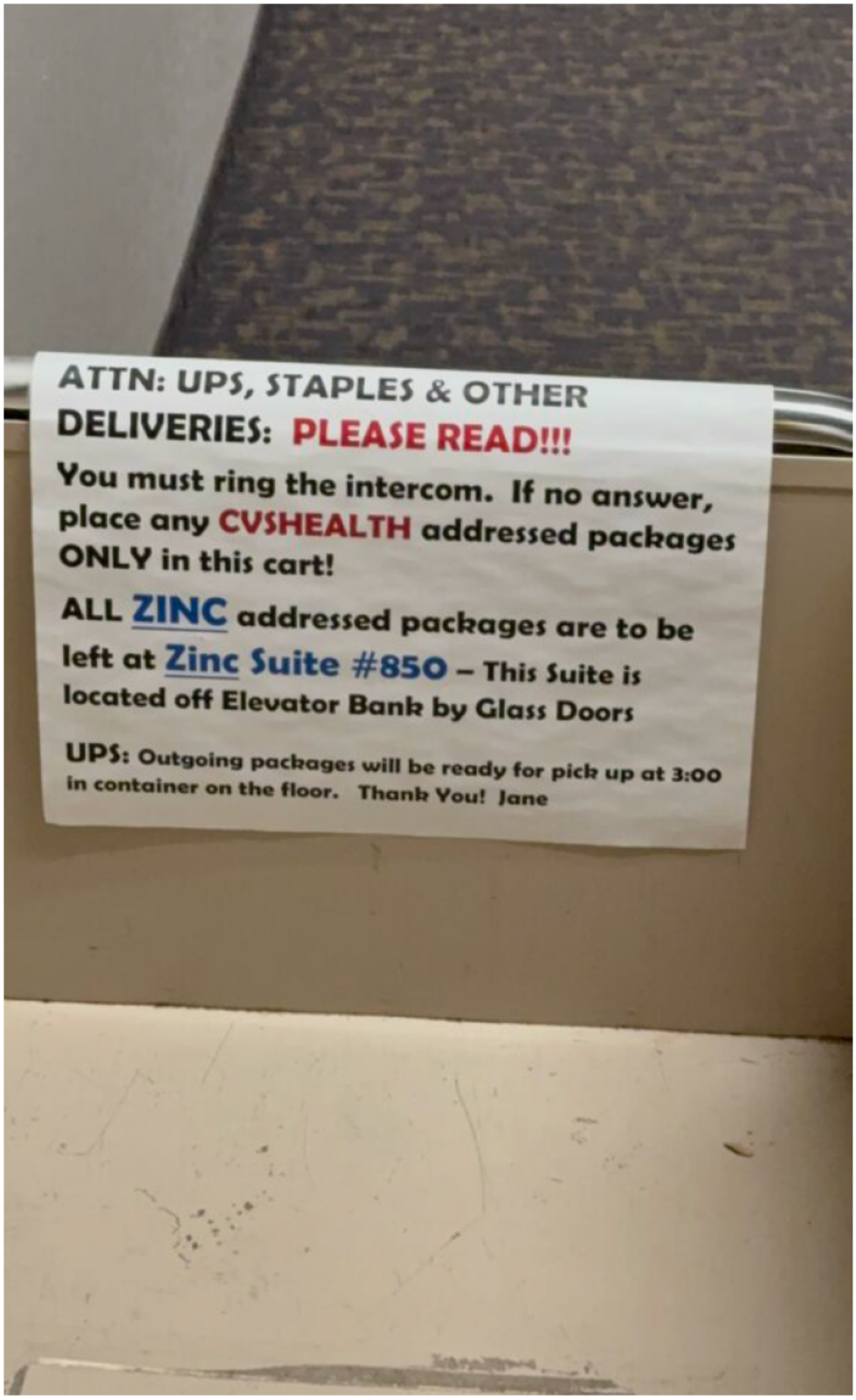
HUNTERBROOK

SIGN UP

On Hunterbrook contributor Raffaella's second visit to Zinc's office, once again nobody answers when she rings the doorbell
Source Raffaella for Hunterbrook Media







"They keep it locked," said the other. "If you've got information we can email them ... I don't think there's a general email, but if you've got your information, I'd be happy to pass it along to them."

"It's walled off from us."

Both claimed not to know what Zinc does, or how a person would make an appointment, given the absence of a phone number or an email for Zinc, which could only be contacted through CVS.

A former Zinc executive also employed by CVS Caremark explained the dynamic, requesting anonymity due to risk of retaliation.

They corroborated what numerous industry insiders told Hunterbrook: CVS carefully guards information about Zinc, often intimidating current and former employees to keep quiet.

"Other people at CVS may be scared to talk to you. Leadership, especially Caremark, is very heavy-handed, will threaten them if they say anything publicly negative about the company. They may try to do something via the PBM formularies."

The former executive scoffed at the healthcare conglomerate's claim of separation.

"You really don't know a PBM from a GPO because there is no difference," they said. "Think of the PBM/GPO as one entity ... there was literally a temporary wall put up between Zinc and Caremark. No separate building. ... Zinc and Caremark reported to the same VP."

The purpose of Zinc, they explained, was to rack up charges from drugmakers.[17]

The best example was making drugmakers pay Zinc for data access. They described how the conversation went with drugmakers.

"'I don't need it, I don't want it,'" the drugmakers would say. And in return, Zinc would threaten to "disadvantage you versus your competitors."

perspective. … It was minimal.”[18]

What about Ascent?

Ascent — owned by Cigna’s Evernorth Express Scripts

The takeout shack didn’t open until 11 a.m., local Swiss time.

Next door, on the fourth floor of a small office building about an hour from Zurich, a subsidiary of a subsidiary of a subsidiary of the American conglomerate Cigna had its headquarters: Ascent Health Services.

HUNTERBROOK

SIGN UP

tiny slice of its parent Evernorth Express Scripts, which has tens of thousands of employees.

"Small Company Feel, Big Company Benefits," reads Ascent's website. (This one has a website, unlike Emisar or Zinc.)

"We have the energy and boldness of a startup and the expertise and pragmatism of a scale-up, all in one place," reads another section.

"We are a boutique rebate contracting organization," reads a third.

An industry expert questioned the branding.

"Isn't that the exact opposite of their argument now?" asked Sherman. "'You don't want a boutique, you want scale.' It seems like bullshit."

"I used to do my own rebates at Harvard Pilgrim. I didn't want to give them up because I didn't trust the PBMs," recounted Sherman. Speaking figuratively, he continued: "They came in and put a gun to my head with our CFO and said: 'Your guys want to keep this because they like doing it, but we have scale.' We were the boutique contracting shop in that case."

"In my opinion, it's corporate fiction," said Ann Lewandowski, a whistleblower and fractional compliance officer for health plans. Lewandowski founded the consultancy Healthcare Rebel Alliance to help employers improve oversight and compliance of their medical and pharmacy benefits.

Thorsen, the healthcare insurance advisor who had said, "This is bullshit" — referring to the fees collected by PBM GPOs from pharmaceutical companies — was especially skeptical of the Swiss headquarters.

"If there's a good explanation that's not sheltering cash, I'll be darned."

A receptionist at Ascent took the package and walked the reporter through the open floor-plan office past a dartboard to the kitchen for a glass of water. She confirmed Ascent had the entire floor and guessed the company numbered "maybe about a hundred" people.

How many came to the office?

"It really depends. Just a few," she told Hunterbrook.

That day, it appeared to be about a half-dozen, between the office visit and observation from the outdoor patio of the neighboring takeout shack.

"I started with just kebabs and donuts. Now I have more. And different sauces," said Ahmed, the proprietor of Albeek Take Away.

Did he have any customers from Ascent?

"No, no, no, from Ascent, nobody," he said. He pointed at two other small offices in the area. "I get people from there and there, not there," he said, pointing back to the Ascent office.

Did he ever deliver to Ascent?

"No, no, no delivery."

At the closest café, the barista, Chiarra, recognized the name Ascent, though she said she did not have any regular customers from the office.

"They order from here once or twice a month," she said.

By 5 p.m., Ascent had called the police on the Hunterbrook reporter at the outdoor patio of the takeout shack.

"We think it is stupid in America," he told Hunterbrook. "Our medicine is also expensive … But as a regular working man or woman, it is affordable, you do not end up on the street," he said, referring to the Swiss healthcare system. "In America there are people on the street. Someone gets cancer they end up on the street. You hear about it in the media, in movies. Not many positive things."

"We think it is stupid in America … Someone gets cancer they end up on the street. You hear about it in the media, in movies." —

A SWISS POLICE OFFICER CALLED BY ASCENT, THE OFFSHORE SUBSIDIARY OF CIGNA AND EVERNORTH/EXPRESS SCRIPTS, TO CHECK OUT A HUNTERBROOK REPORTER

The other police officer returned with two men from Ascent. Both declined to share their names.

"That's not relevant," replied one of the men, who later confirmed via LinkedIn that he was Ascent's chief commercial officer. According to LinkedIn, the CCO previously worked for Cigna's Express Scripts from Orlando, Florida, before moving to Switzerland in 2022.

In response to hearing about the empty Emisar office in Dublin, he said, "We are not a fake company, there are ways for press to reach us."

But there was no press contact on Ascent's website. The "Contact Us" link didn't work on certain browsers. And after initially offering to share a corporate contact, the Ascent executive instead asked for a Hunterbrook contact.

The next day, the U.S.-based managing director of external affairs for Cigna followed the reporter's public account on X and sent a request to follow the reporter's private Instagram account.

During the conversation outside the Swiss office, the Ascent executive said he'd called the cops because of concerns raised by the December 2024 killing of UnitedHealthcare CEO Brian Thompson, allegedly by Luigi Mangione.

"Look, with everything that's been going on, you know, the shooting in New York, and you come here this morning, then disappeared for a few hours, and then you're back," he said. "And we've got anxious people here. Look, I hope you won't come back again and try to talk to people."

The reporter offered not to return if they'd answer a couple of questions. What was the purpose of this Swiss subsidiary, and were he and his colleague from America?

"We work at Ascent, that's all I'll say," he replied.

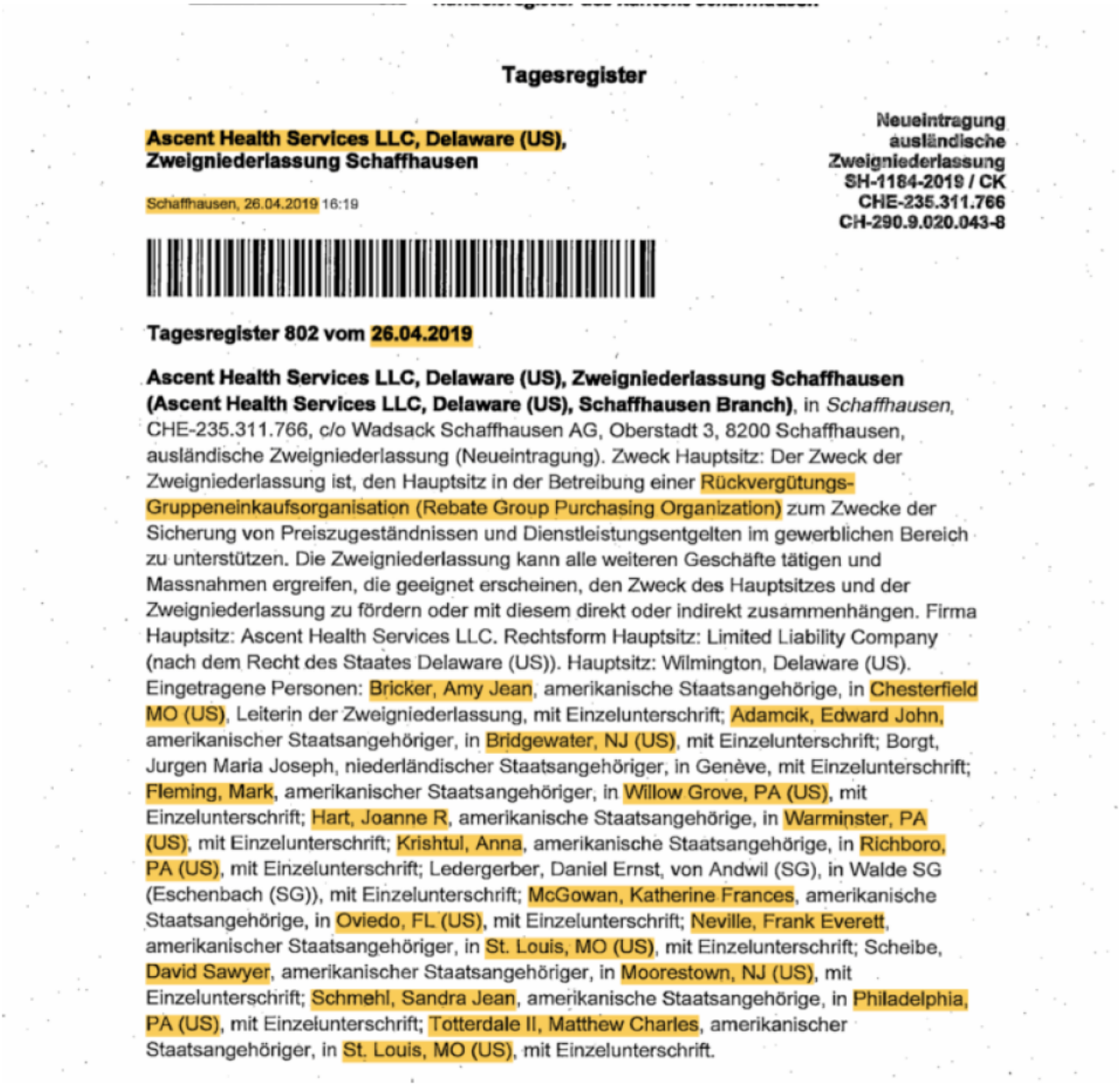
The police officer wrapped up the impromptu interview, asking that the Ascent executive share a contact email and Hunterbrook write to that email rather than returning to the office.

The officer concluded, "There are many other beautiful things to see in Schaffhausen."

One proved to be the newsroom of the regional business paper AZ, which investigated the proliferation of the "many letterbox companies in Schaffhausen," as an AZ journalist called the local shell companies.

The journalist pulled a copy of Ascent's filings from the town's commercial registry, dating back to Ascent's incorporation in April 2019. Ascent's many signatories are almost exclusively American and include Amy Bricker, the former president of Express Scripts.

"The 8:05 a.m. train from Zurich to Schaffhausen is full of Americans every morning, big sign of this small town as U.S. tax haven," the journalist said.



Tagesregister

Ascent Health Services LLC, Delaware (US), Zweigniederlassung Schaffhausen

Schaffhausen, 26.04.2019 16:19

Neueintragung ausländische Zweigniederlassung
SH-1184-2019 / CK
CHE-235.311.766
CH-290.9.020.043-8

Tagesregister 802 vom 26.04.2019

Ascent Health Services LLC, Delaware (US), Zweigniederlassung Schaffhausen (Ascent Health Services LLC, Delaware (US), Schaffhausen Branch), in *Schaffhausen*, CHE-235.311.766, c/o Wadsack Schaffhausen AG, Oberstadt 3, 8200 Schaffhausen, ausländische Zweigniederlassung (Neueintragung). Zweck Hauptsitz: Der Zweck der Zweigniederlassung ist, den Hauptsitz in der Betreibung einer Rückvergütungs-Gruppeneinkaufsorganisation (Rebate Group Purchasing Organization) zum Zwecke der Sicherung von Preiszugeständnissen und Dienstleistungsentgelten im gewerblichen Bereich zu unterstützen. Die Zweigniederlassung kann alle weiteren Geschäfte tätigen und Massnahmen ergreifen, die geeignet erscheinen, den Zweck des Hauptsitzes und der Zweigniederlassung zu fördern oder mit diesem direkt oder indirekt zusammenhängen. Firma Hauptsitz: Ascent Health Services LLC. Rechtsform Hauptsitz: Limited Liability Company (nach dem Recht des Staates Delaware (US)). Hauptsitz: Wilmington, Delaware (US). Eingetragene Personen: Bricker, Amy Jean, amerikanische Staatsangehörige, in Chesterfield MO (US), Leiterin der Zweigniederlassung, mit Einzelunterschrift; Adamcik, Edward John, amerikanischer Staatsangehöriger, in Bridgewater, NJ (US), mit Einzelunterschrift; Borgt, Jurgen Maria Joseph, niederländischer Staatsangehöriger, in Genève, mit Einzelunterschrift; Fleming, Mark, amerikanischer Staatsangehöriger, in Willow Grove, PA (US), mit Einzelunterschrift; Hart, Joanne R, amerikanische Staatsangehörige, in Warminster, PA (US), mit Einzelunterschrift; Krishtul, Anna, amerikanische Staatsangehörige, in Richboro, PA (US), mit Einzelunterschrift; Ledergerber, Daniel Ernst, von Andwil (SG), in Walde SG (Eschenbach (SG)), mit Einzelunterschrift; McGowan, Katherine Frances, amerikanische Staatsangehörige, in Oviedo, FL (US), mit Einzelunterschrift; Neville, Frank Everett, amerikanischer Staatsangehöriger, in St. Louis, MO (US), mit Einzelunterschrift; Scheibe, David Sawyer, amerikanischer Staatsangehöriger, in Moorestown, NJ (US), mit Einzelunterschrift; Schmehl, Sandra Jean, amerikanische Staatsangehörige, in Philadelphia, PA (US), mit Einzelunterschrift; Totterdale II, Matthew Charles, amerikanischer Staatsangehöriger, in St. Louis, MO (US), mit Einzelunterschrift.

The first filing of Ascent Health Services in Schaffhausen in April 2019, which includes former Express Scripts President Amy Bricker as a co founder Source Regional business newspaper AZ

A former employee of Ascent contradicted this purpose. "From here it looks like shifting money," they told Hunterbrook, requesting anonymity to avoid retaliation. "They move money here and there."

"There's just zero transparency with the cross-border cooperatives," he said, referring to Ascent and Emisar.

"There's no broker disclosure law, for example, that requires them to tell you what's going on. So I view them with a good deal of suspicion, especially if you are a fiduciary of a plan, which a lot of my clients are," Bianchi continued.

"How do you possibly exercise your fiduciary duty over some oversight when you're dealing with an offshore cooperative?"

The broker disclosure law Bianchi mentioned is part of the Consolidated Appropriations Act of 2021, which implemented transparency and reporting requirements for employer-sponsored health plans and the vendors that deliver these benefits.

Were taxes the reason for the Swiss jurisdiction?

"Yes, it's nothing else," a former Ascent employee told Hunterbrook.

Miller, the Ascent co-founder, independently confirmed the tax advantages.

"We had a skunks team that looked at all the regulations and tax implications," he told Hunterbrook, referring to a team within the overall Cigna/Express Scripts organization that helped create Ascent.

"There's obviously the advantages of being offshore also."

After starting out as a physician, Miller became the chief medical officer of his hospital system and then joined Express Scripts when the PBM had just begun scaling up.

He was widely credited for his pioneering work to dramatically reduce the price of statins, which

with a compounding pharmacy to undercut Shkreli with a $1 alternative.

In other words, Miller embodied what PBMs were originally meant to do: reduce healthcare costs.

When Cigna acquired Express Scripts, Miller became the chief clinical officer of both companies.

"I spent an enormous amount of time fighting inevitable regulations, legislation, and sort of hatred in the marketplace," he told Hunterbrook.[19]

This onslaught led to the creation of the PBM GPOs.

"Hand-in-glove to the whole conversation of how do you sustain your profitability over time is you've just got to continually be evolving new things," he told Hunterbrook.

Miller explained that a core benefit of the PBM GPOs is that they can charge fees that are not considered rebates, and therefore do not need to be passed through to health plans and patients.

"There are lots of different fees you can charge. You can charge data fees. You can charge administrative. You can charge clinical fees. The fees fall into different buckets," he explained.

"You can double-, triple-dip on fees."

"This is why there's so much hatred now, because as these details become more known, people are like, what a screwy business this is, right?"

Baker of AffirmedRx elaborated on the kinds of "details" Miller was referring to.

Baker showed Hunterbrook an example of an Express Scripts client letter that displayed a single number, versus the itemized breakdown AffirmedRx provides in its pursuit of differentiation through transparency.

Mark Cuban's Cost Plus Drugs is already testing this hypothesis, cutting out PBMs by selling drugs directly to consumers – and contracting directly with employers.

Were Ascent's fees adding profit on top of what could be taken from rebates, or were drugmakers adapting by reducing the rebate payment as they paid Ascent more?

"They were reducing rebates to pay Ascent more," Miller said, confirming the core issue: Health plans were getting less money because of payments to PBM GPOs.

This was, Miller explained, the nature of the PBM business: facing off against the consultants hired by the health insurance plans to review bids by the PBMs.

"When you're dealing with these PBMs, they're much more aggressive, smarter people, a little more creative," he said. "It's a pretty sharp-elbowed business."

"When you first create something, you're trying to get ahead of the consultants and their knowledge, right? So when you initially set up an Ascent, they're unaware of this," Miller said, apparently indicating that the PBM GPOs were at least in part deceiving the health plans and their consultants.

"Nothing stays quiet for long. Someone starts understanding, oh, there's this new pool of money, so we're going to put it in our contracts to cover that also. And so it's a whack-a-mole thing. And this is why consultants are involved in almost every bid."

Referring respectively to health plans, consultants, and PBMs, Miller said: "Because you're [health plans] paying them [consultants] essentially to try to understand where's the next innovation of how they're [PBMs] going to try to rob me [health plans]."

"Once it gets discovered, the consultants narrow in on it, you end up disclosing more and more," Miller concluded.

THE NUMBERS: MILLIONS OF DOLLARS IN REVENUE PER EMPLOYEE

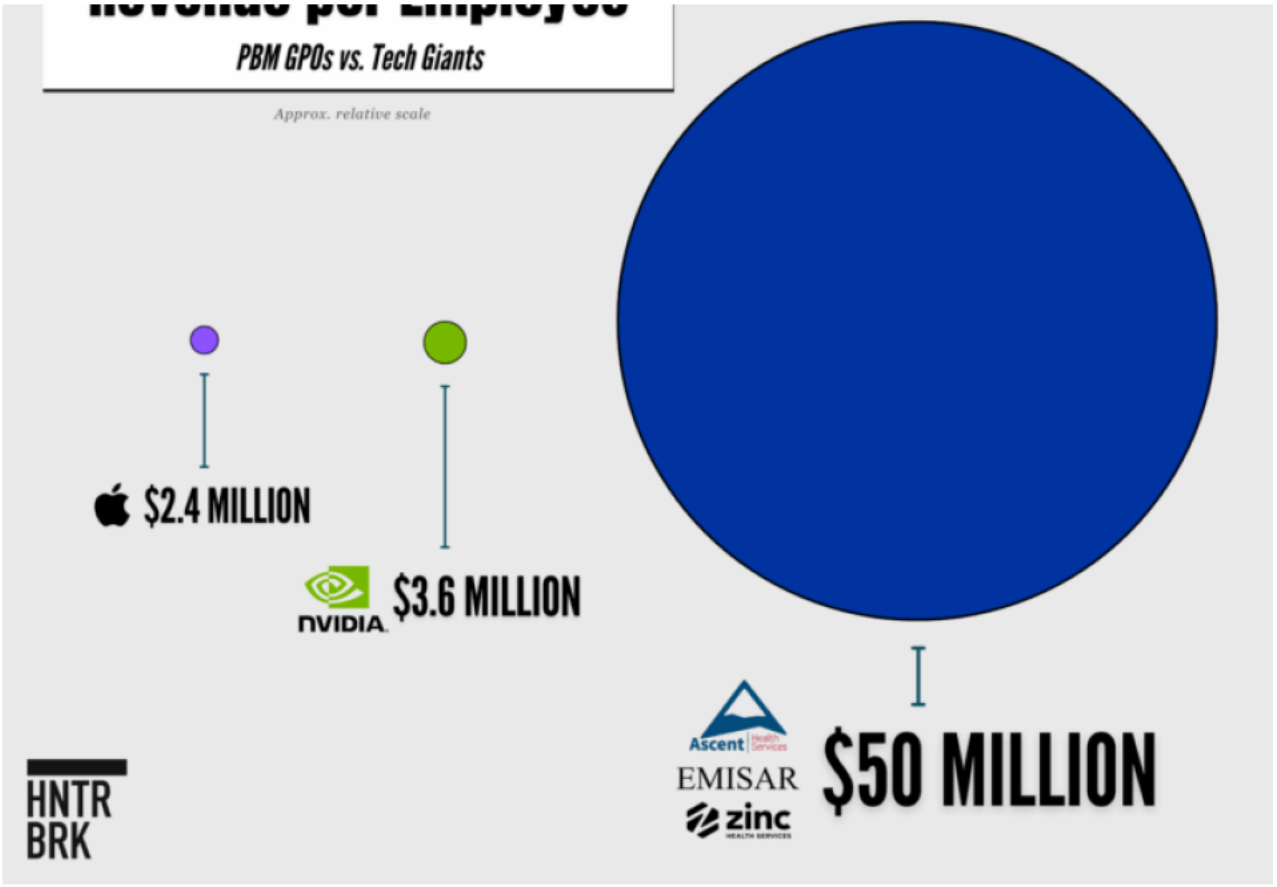
Despite the ghost offices, tiny head-counts, and opaque operations, a staggering amount of money flows through these subsidiaries.

Hunterbrook reviewed LinkedIn profiles, team photos, corporate filings, and job listings to determine the staffing at all three entities. We identified fewer than 150 employees total — about 88 at Ascent, and roughly two dozen each at Emisar and Zinc.[20]

These skeleton crews apparently handle billions of dollars a year.

Neither the PBM GPOs nor their parent companies report financial information for these specific entities, but the limited data available suggest these businesses are improbably lucrative.

A 2023 Nephron Research report cited by the FTC estimates PBMs earned $7.6 billion in fees related to their GPOs in 2022. With fewer than 150 employees across all three entities, these PBM GPOs generate more than $50 million in revenue per employee. By comparison, Apple — long considered one of the world's most profitable companies — generated approximately $2.4 million per employee in 2024. Nvidia, the AI chip giant whose market cap has surpassed $4.5 trillion, brings in about $3.6 million per employee.



Graphic comparing revenue per employee of PBM GPOs (Ascent, Emisar, and Zinc) vs Apple Inc and Nvidia Circles sized approximately to scale Source Hunterbrook Media

This napkin math was backed up by the former Optum and Emisar executive Rogers, who estimated to Hunterbrook that the GPOs bring in at least "tens of millions" per employee.

The persistent lack of transparency surrounding PBM GPOs makes it difficult to untangle any value they may be adding, according to Ben Link, a pharmacist who previously worked for a PBM and now leads 46brooklyn and 3 Axis Advisors alongside Ciaccia.

"When these GPOs were created, was there a transfer of assets into the GPO? Like, either they actually did develop something, or from an account management standpoint, there would have had to have been a transfer of assets, right?" Link posited. He added, "Because, again, if you didn't do those things, well, that would certainly seem to suggest more so, again, this is a shell, right?

The federal government has looked into PBMs as well. As part of a sweeping investigation of the pharmaceutical supply chain, the FTC sued the Big Three PBMs and their PBM GPOs for inflating insulin prices in 2024. The FTC also specifically flagged PBM GPOs as entities of concern in a July 2024 interim report on PBMs.[21]

A spokesperson for the FTC declined to comment for this story.

Calling Emisar, Ascent, and Zinc "rebate aggregators," the FTC found evidence of financial engineering on a massive scale: "Internal PBM documents appear to show novel methods of fee generation from these new rebate aggregators. One report estimates that since the PBMs spun off their rebate aggregators, they have extracted from drug manufacturers billions of dollars in additional fees, which doubled from $3.8 billion in 2018 to $7.6 billion in 2022."

The FTC cited data from Nephron Research, showing that "Fees & GPO" overtook "Rebates & Price Protection" and the "Spread" PBMs collect as a percentage of PBM gross profits. This growth accelerated between 2016 and 2020. That coincided with a proposal by the first Trump administration to remove the safe harbor for PBM rebates from federal anti-kickback laws.

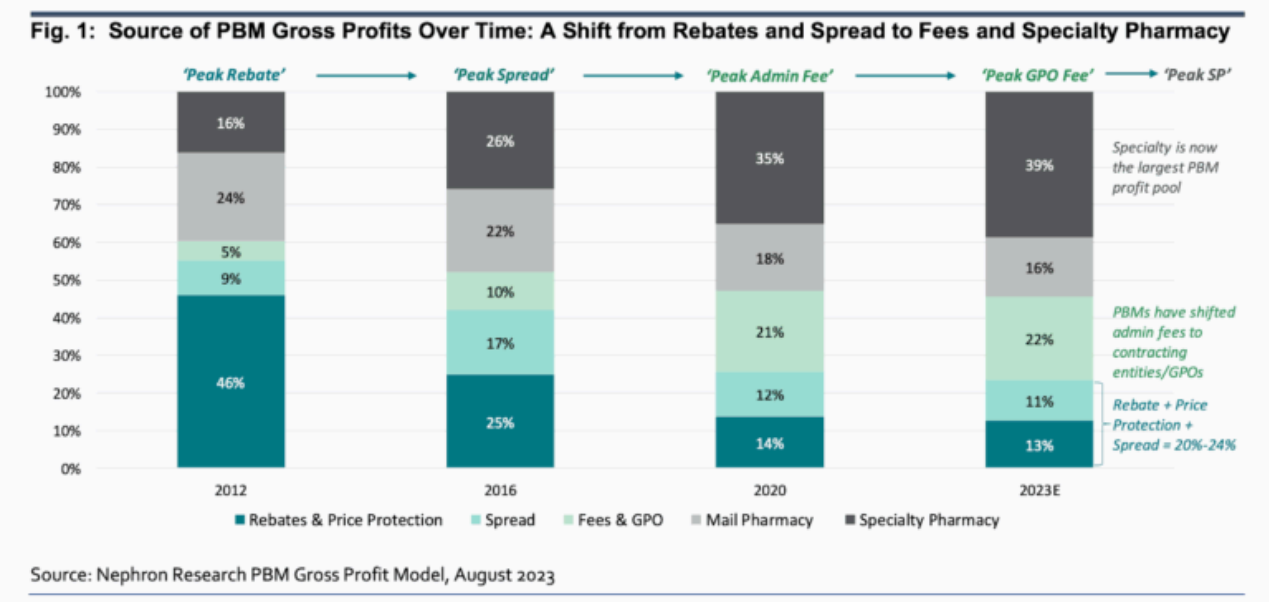


Chart depicting trends in the sources of PBM gross profits from 2012 to 2023 (estimated) Source Nephron Research, September 18, 2023, "Trends in Profitability and Compensation of PBMs and PBM Contracting Entities"

and revenue. Now, they're in the 15-to-20% of total rebate amounts."

This extraordinary revenue flows through a labyrinth of payment categories sources say are carefully engineered to avoid transparency: entity administration fees, prescription data services, data portals, enterprise fees, and other charges that PBMs insist are not rebates and therefore don't require pass-through to health plans. These revenue streams exist on top of the PBM's typical administrative service fees of about 3% to 5% of the wholesale price of each drug, further inflating healthcare costs.

The effectiveness of the scheme is enhanced by its invisibility. Most healthcare payers (health plans, unions, self-insured employers) — and certainly patients — have no idea these PBM GPOs or their fees even exist.

"It's fight club. First rule of fight club, you don't talk about fight club," Link, the pharmacist and former PBM employee, told Hunterbrook, referencing the film "Fight Club."

"You don't know what you don't know, and to the extent the PBMs themselves are delivering what they said, it wouldn't even occur to a health plan," said Sherman.

"Even when I was a health plan CMO, I don't know, barring some shock or data point, how I would figure out that there were tens of millions of dollars that they were sucking up somewhere," Sherman told Hunterbrook. "I always assumed they were screwing with me somehow, and if you can minimize that, you're ahead of the game. But I wouldn't have known how to look for it."

PBM GPOS BEGIN RECEIVING LEGAL SCRUTINY

Beyond the FTC, a few others have begun to wise up to the scheme.

States including Illinois, Ohio, Louisiana, Vermont — as well as the Office of the Inspector General (OIG) of the United States Office of Personnel Management — have each begun to tackle the PBM GPO scheme.[22]

Louisiana and CVS Caremark are discussing a settlement, Attorney General Liz Murrill said in December 2025. CVS would pay around $50 million to resolve the lawsuit concerning Zinc, as well as two related cases over Caremark's practices.

"We can confirm we have an agreement in principle with CVS. The suits will be dismissed, and they are eligible for the discretionary one-year extension as a Managed Care Organization. We will announce the specifics once finalized," a spokesperson for Attorney General Murrill told Hunterbrook.

In Ohio, the attorney general is pursuing a case similar to the one in Illinois, claiming that Express Scripts used Ascent to fix prices and rebates among a handful of supposed competitors.[24]

In April 2025, Michigan's attorney general accused Express Scripts and Prime Therapeutics of using Ascent as part of an illegal price-fixing cartel.

Prime Therapeutics is a separate PBM with a minority ownership stake in Ascent. Prime's then-CEO Ken Paulus described Ascent as a "real shared effort" between the two PBMs in a 2021 interview.

"We have direct access to all of the contracts in the GPO. We have employees that work in the GPO with, with their employees," Paulus said. He noted that, at the time, Ascent represented "100 million lives" and had generated "literally in the billions of dollars of, I think, savings for our clients that we wouldn't have otherwise seen."

Prime Therapeutics declined to provide comment for this story.

Rather than compete against each other, Express Scripts and Prime Therapeutics agreed to leverage their combined buying power to undercut independent pharmacies in the state — leading to "pharmacy deserts" and bolstering Express Scripts' market power, according to the Michigan attorney general's complaint.

In August, the House Committee on Oversight and Government Reform opened a probe into Emisar and Ascent. The creation of offshore GPOs "appears to be yet another example of the institutional intent at opacity and avoidance of oversight within your company," read the letters sent to Cigna and Optum Rx.

The Committee's Majority staff did not respond to repeated Hunterbrook inquiries about the status of the probe.[25]

Federal watchdogs have also been clawing back funds from PBM GPOs.

In March 2024, the Office of Personnel Management reported on its audit of pharmacy benefits administered by Express Scripts, which had been hired by the American Postal Workers Union Health Plan. According to the report, the union was supposed to receive "'the value of the PBM's negotiated discounts.'"

But in 2019, Express partnered with Ascent to "handle all drug manufacturer rebate administration." Now, the PBM and GPO split drug company rebates between them. When the time came to pass through the money, Express sent along its share — but Ascent didn't. Instead, it pocketed about $15 million that should have gone to the union.

The PBM GPO agreed to return the $15 million. But their counsel insisted Express Scripts "contracted with Ascent to perform rebate management services," and the payment was a good faith measure. (The letter was included as Appendix B in the OIG Final Audit Report.)[26]

Later in 2024, the Office of Personnel Management had déjà vu: Its audit showed Ascent had kept nearly $10.6 million in rebates it owed the Compass Rose federal employee health plan. Once again, the contract apparently required "pass-through transparent drug pricing" so the plan would "receive the value of the PBM's negotiated discounts, rebates, credits, and other financial benefits."
Yet, millions in rebates were withheld from Compass Rose because of "lower rebate percentages agreed to internally between the PBM and Ascent," according to the OIG's Audit Report.

"Of the few that have raised the issue, they've immediately caved," said Sherman. "Why would you think that any health plan is not subject to the same gaming?"

"I think they exist for the sole purpose of hiding data and taking fees," Jonathan Levitt told Hunterbrook, referring to PBM GPOs.

Levitt is a founding partner of Frier Levitt LLP, a healthcare law firm. He provided testimony on PBM GPOs to the Senate Finance Committee in 2023, and his firm has helped plan sponsors recover millions of dollars PBMs wrongfully diverted to rebate aggregator GPOs.

He told Hunterbrook it is a fiduciary responsibility for plans to audit PBMs, and if the health plan finds underpayment, a fiduciary responsibility to recover it. "If you do an audit, and you're in the middle of an RFP, I almost guarantee that you will get better terms in the next contract."

"The manufacturer contracts with the GPOs that we've seen reveal a delta between what the plan received and what the manufacturer paid," he said. "We've seen GPO manufacturer agreements that discuss the administrative fees and other fees that the PBM contract with the plan does not mention."
Zinc, Emisar, and Ascent have also been looped into major multi-district litigation against PBMs, insurers, and pharmaceutical companies for driving up the price of insulin. Over 400 companies, unions, school districts, universities, and state and local governments have signed onto the suit as plaintiffs.

Last January, the plaintiffs moved to add the PBM GPOs as defendants.

Similar drug pricing lawsuits are making their way through state and federal courts, including cases filed by the attorneys general of Hawaii and Rhode Island.

Critics of rebates and high drug prices had only just begun sinking their teeth into PBMs when the conglomerates began ramping up these PBM GPOs. They get just a cursory mention on three

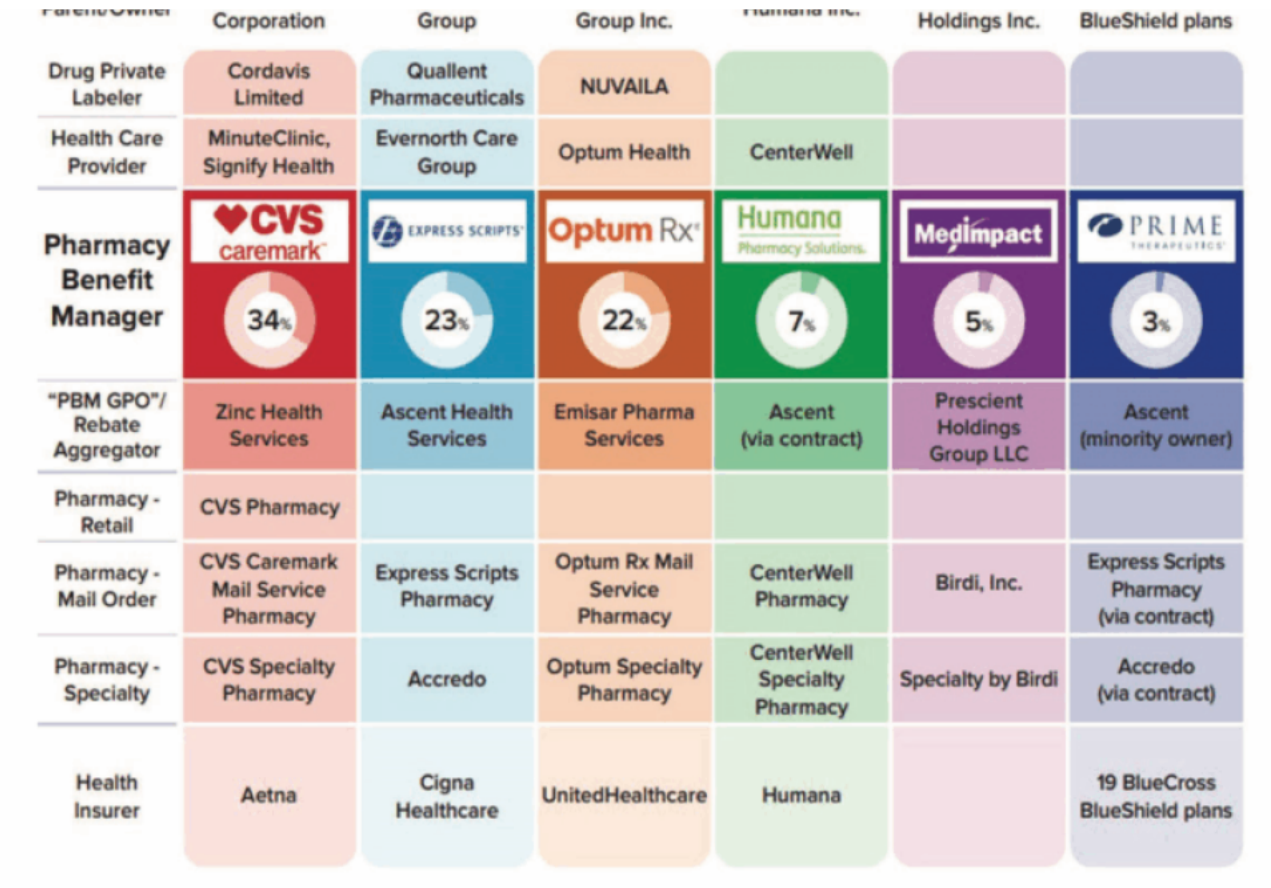


Figure 1 prepared by FTC staff PBM shares are based on the total equivalent prescription claims managed in 2023 Source FTC

In a brief section about PBM GPOs, a subheading reads: "Corporate Restructuring of PBM Rebate Negotiation Services Raises Concerns."

Figure 7. Overview of "PBM GPOs" / Rebate Aggregators[104]

"PBM GPO" / Rebate Aggregator	Parent / Owner	Year Established	Headquarters Location	Selected Clients
Ascent Health Services	Cigna (ESI), Prime, Kroger	2019	Switzerland	ESI, Prime, Kroger, HPS
Zinc Health Services	CVS	2020	United States	CVS Caremark
Emisar Pharma	United			

Justice and FTC this summer.

"The largest PBMs created new GPO structures under their own parent companies that are now offshore, primarily in places like Switzerland and Ireland, that negotiate rebates on behalf of almost every patient in the country, at least in commercial markets," said Joe Shields, founder and president of TransparencyRx. "That's not reform, that's not meaningful transparency or market integrity."

"You can imagine how many times I've been physically to the FTC," said Miller, the former Cigna and Express Scripts CMO. "The PBMs underestimated the problem that was going to create."

In January 2025, the Trump administration fired the inspector general who had recovered $15 million for the postal workers union and $10 million for other federal employees from Cigna's Express Scripts and Ascent.

In March 2025, Trump fired the two Democrats of the five-member FTC leadership, leaving the agency without a single commissioner able to oversee the FTC's insulin lawsuit.[30]

As a result, the case was administratively stayed from April 1 through August 27.

Lina Khan, the chair of the FTC at the time the lawsuit was filed, called the firings "A gift to the PBMs."

Express Scripts accused Khan of having an "anti-PBM bias" when they sued the FTC last fall, alleging the FTC's July 2024 report on the industry was "unfair, biased, erroneous, and defamatory."

A month after the proceedings resumed, the FTC's case was once again put on hold for all of October and most of November, thanks to the month-and-a-half-long government shutdown. An evidentiary hearing is currently scheduled for June 17, 2026.

"(v) (1) 'Rebates' means compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer by a pharmacy benefit manager, affiliated entity, or subcontractor, including a group purchasing organization, directly or indirectly, regardless of how the compensation or remuneration is categorized, including incentive rebates, credits, market share incentives, promotional allowances, commissions, educational grants, market share of utilization, drug pullthrough programs, implementation allowances, clinical detailing, rebate submission fees, and administrative or management fees.

"(2) 'Rebates' also includes fees, including manufacturer administrative fees or corporate fees, that a pharmacy benefit manager, affiliated entity, or subcontractor, including a group purchasing organization, receives from a pharmaceutical manufacturer.

"(3) 'Rebates' does not include pharmacy purchase discounts and related service fees a pharmacy benefit manager, affiliated entity, or subcontractor receives from pharmaceutical companies that are attributable to or based on the purchase of product to stock, or the dispensing of products from a pharmacy benefit manager's affiliated mail order and specialty drug pharmacies. 'Rebates' does not include a pharmacy benefit management fee."

PBMS FAIL TO DISCLOSE PBM GPOS IN CONTRACTS WITH HEALTH PLANS

Hunterbrook reviewed several contracts between health plans and each of the Big Three PBMs — Optum, Express Scripts, and CVS Caremark — as well as marketing materials presented to PBM clients.

Across thousands of pages of contracts and presentations, the PBMs did not include any direct explicit mentions of Emisar, Ascent, or Zinc whatsoever.

"They're hiding it contractually," said Sharp, who was instrumental in establishing the CMS NADAC system for tracking pharmacy prices and who helped implement Indiana Medicaid's

"When I last met with them, it was not on the radar," Sherman, the former CMO of Harvard Pilgrim, said of his meetings with PBMs, and any mentions of PBM GPOs. "They didn't differentiate between the PBMs and the companies that were a level down," despite fiduciary responsibilities and transparency laws.

Certain contracts claim 100% pass-through of rebates to the client. But they limit the scope of rebates, similar to the statement by former UnitedHealth CEO Sir Andrew Witty on the aforementioned earnings call.[32]

PBMs generally don't consider the new "fees" drugmakers pay to their affiliated PBM GPOs to be rebates. Because contracts are between PBM and plan sponsor (not the PBM GPO and plan sponsor), PBMs can argue that their clients are only entitled to rebates that actually hit the PBM's account.

Consider a hypothetical example:

Company A hires Caremark to be the PBM for its employee health plan. The contract says Caremark will pass through 100% of rebates received by the PBM in relation to claims by Company A's plan members.

Zinc receives $100 million in total payments from drugmakers for patients on Company A's health plan. Zinc sends $80 million of this to Caremark, keeping $20 million that it classifies as fees or other GPO compensation. Caremark passes through $80 million — 100% of the rebates Caremark received — to Company A.

The other $20 million belongs to Zinc, not Caremark, even though the funds still ultimately pad the bottom line of their shared parent company: CVS Health.

And because Company A only has a contract with CVS Caremark (not Zinc), Company A has no way to know about the $20 million Zinc kept.

UnitedHealth Group.

The contracts that Hunterbrook reviewed also say that the PBM won't contract with drugmakers for non-rebate revenue that reduces rebates, contradicting the Cigna CMO's assertion that drugmakers reduced rebates to pay higher fees.

At least one contract also said that the PBM wouldn't alter a drug's status on the formulary list of insured drugs based on fee payments, only rebates.

Sharp said his manufacturer contacts "categorized these as bullshit fees," he told Hunterbrook. "Manufacturers refer to it as extortion for formulary access."

"My view of these aggregator fees is it's another way to recategorize that rebate money and create new revenue streams in their contracts with manufacturers," Sharp continued.

Baker, the CEO of AffirmedRx, echoed this. "Most of the fees are payment for market access, in my opinion. If I'm being generous, only 5% of the fees are for administering those negotiations," he told Hunterbrook.

Sharp posed the question: "Are rebates being cannibalized by the aggregator fees?"

Former Emisar executive Rogers said, "As the bubble is bursting, premiums have been set for the next three years and there's not going to be enough rebates to pay them. And so they're gonna have to raise premiums for employees."

Rogers added, "There's no more money left."

The former executive of a drug company told The New York Times "he had a set pool of money to cover fees to G.P.O.s and rebates to employers. When he paid more in fees, he offered less in rebates."

GPOs. The CEO of one billion-dollar, publicly traded pharmaceutical company, who is contracted with all three PBMs, described a byzantine process.

"It's a little absurd," he told Hunterbrook. "They own the GPO and the PBM of course, so the GPO is sort of a smokescreen to say we didn't make a decision on the pharmacy benefits, this GPO did."

He went on, "When they're owned by the same corporation, as you said, they're sitting in the same building, the same people, they just artificially separated them ... and they're doing the same thing."[34]

The executive partly countered a couple of claims made by other experts Hunterbrook interviewed.

The difference between rebates and fees wasn't a significant component of his negotiations, he said. And the data portal was useful for the company to get information on "the copays, who's paying what, what demographics" — which larger companies already had access to, according to the former Zinc/Caremark/CVS executive.

Cuban co-founded the public benefit corporation Cost Plus Drugs to remove middlemen like PBMs from the supply chain.

In an email exchange with Hunterbrook regarding the PBM GPOs, he wrote, "They are covers for the Big Three to say in a contract that they pass through 100% of the rebates they get. And it is also used as a way to keep us and others from being able to get full access to brand drugs."

Miller countered: "Mark Cuban — and I suspect he's losing money in his effort — if you think about Mark Cuban's efforts, they have these limited products. For instance, they charge you for mail. Our patients in mail-order get mail for free. ... you will almost always spend more on the Cuban market basket than using your benefit."

"I think there are ways to fix this. But we don't have the political will to name a postal office anymore, what's more, take on a big issue like this," he told Hunterbrook. He added, "Every time

company to publish a price list for our medications," Cuban told Hunterbrook via email. "As far as charging for mail delivery, we charge $5. It's typical PBM nonsense to suggest that the price to ship anything is free. Like everything else, Mr. Miller and PBMs just hide the cost of shipping and hope that patients and sponsors are ignorant."

Rogers called out benefit plan consultants as part of the problem, questioning how they're paid.

Experts told Hunterbrook that compensation to brokers and consultants who advise health plan sponsors on their PBM contracts can range from flat fees to a percentage of "savings" — which could either be defined as overall plan savings or tied to rebates. The latter could encourage higher rebating without creating an incentive to target PBM GPO fees.

Brokers and consultants also can be incentivized to steer their clients toward major PBMs: PBMs sometimes pay brokers bonuses or commissions based on how much business they drive to the PBM.

"I'm not popular with those consultants unless they're transparent," said Levitt, the litigator who represents health plans against PBMs, calling some benefit consultants "crooked."

Congress did give transparency advocates a win: The Consolidated Appropriations Act of 2021 created disclosure and reporting requirements for health plans, as well as brokers and consultants. This has driven progress on the broker transparency front, Bianchi said, but both he and Gelfand — president of the large employer lobbying group ERIC — noted that the law's reach is limited when it comes to PBMs.

"Congress just did it wrong," Bianchi said. "In HIPAA, Congress directly regulated the service provider. They called them business associations, but they're service providers. In this law, they did not directly regulate the service provider, they just regulated the plan. I think that was shortsighted."

Gelfand's group, ERIC, has lobbied for legislation explicitly designating PBMs as fiduciaries of

write the contract. And the vast majority of even the companies that I represent, which are the biggest companies in the country, with the most leverage to negotiate with the PBM, even they can only negotiate certain things within those contracts."

PBM "GPOS" AREN'T EVEN GPOS

Purchasing cooperatives like GPOs let groups of buyers pool their purchasing power for greater leverage.

"I mean, it's not like anybody's really reinventing any wheel here," Bianchi told Hunterbrook. "Now, the problem is mechanically, *who* exactly does the purchasing cooperative? In an ideal world, there would be some overarching employer association, like a mega Chamber of Commerce, but … it's not easy to pick a group that could sponsor it."

Of all the possible configurations for drug purchasing coalitions, putting a PBM at the helm raises conflicts of interest, according to Bianchi.[35] Bianchi continued, "The other possibilities, and this is where it gets a little bit more dicey, they can be organized by brokers and consultants, and all of the large brokers have them, you know, you look at the Mercer's of the world or whoever, and this is almost a benefit add-on to their services that they provide their clients. And so brokers, in many ways, are natural, makes sense… The second worst alternative is for the PBMs to sponsor these collaboratives because they don't have any incentives, It's a conflict of interest, in my view. And then the worst of all is when PBMs create a buyer cooperative that is made to look like an independent. That is, they're not disclosing their participation… Is it absolutely true that a PBM-led consortium is necessarily bad? Maybe the answer to that is no, or it doesn't have to be."

He also distinguished genuine purchasing groups from rebate aggregators like Zinc, Ascent, and Emisar.

"These things are good ideas because they leverage purchasing power, but they need to be managed. And maybe that's the bottom line right there," he said.

negotiate contracts, including rebates, with drug manufacturers — a task that PBMs historically engaged in directly."

Industry experts interviewed by Hunterbrook agreed that "GPO" is a misnomer.

"A GPO is an independent organization that stands in collaboration with a healthcare company and a healthcare system," said Keith Palmer, a former Marine Corps captain who has spent decades as a senior healthcare executive.

"They aggregate the volume of a healthcare system to negotiate better pricing for products and services," he added.

Traditional GPOs have also criticized PBMs for calling their new entities "GPOs." Both the Health Care Supply Chain Association and Healthcare Group Purchasing Industry Initiative have posted materials distinguishing PBM GPOs from traditional ones.[36]

"These group purchasing 'captive' entities, commonly described as 'rebate aggregators,' have an entirely different mission, structure, and purpose than the healthcare group purchasing participants in HGPII," wrote the latter. "They operate with limited transparency to maximize revenue and capture rebates for their corporate parent, rather than leveraging savings for participating health systems."

At first, even Express Scripts wasn't sure about the GPO label, according to Adam Fein, president of Drug Channels Institute.

In a 2023 post, Fein wrote, "A couple of years ago, Express Scripts' PR team told me in no uncertain terms: 'Ascent is not a GPO.' The company has since changed its tune, judging by this page on its new The Facts about Express Scripts website."

Sherman faced the Big Three PBMs as CMO of Harvard Pilgrim. He rattled off the supposed functions.

exist?"

"I've always believed there were other fees and other ways they're paying themselves internally in ways that manage to carve it out of anything you see," he said. "You get 100% back of what you know about, but not the stuff they're hiding."

Emma Freer, a senior policy analyst for healthcare at the anti-monopoly advocacy group American Economic Liberties Project, concurred.

"These PBM GPOs only exist as a routing mechanism for the PBM itself. It's designed to be confusing. I don't see what purpose they serve other than being a way to funnel fees," Freer told Hunterbrook.

"These PBM GPOs are not GPOs," she concluded.

FROM DRUG COSTS TO DEATH

The costs of the current system go beyond higher drug prices, as evidenced by the death of 22-year-old Cole Schmidtknecht, reported by The Washington Post and explained in a lawsuit filed on January 21, 2025, by his bereaved parents.[37]

The defendants are Optum Rx — the PBM that owns Emisar — and the pharmacy Walgreens. In July, a federal judge denied Optum's attempt to have the case dismissed.

Walgreens did not respond to Hunterbrook's request for comment.

One way that PBMs negotiate with pharmaceutical companies in return for rebates is through "step therapy." While step therapy can lower drug spending, in some cases, patients must instead try a more expensive drug for a certain time, determined by the PBM, prior to being able to fill a prescription with a cheaper alternative.

even go without them entirely, sometimes with fatal results," wrote the FTC.

In late 2023, Optum decided to replace the relatively cheap asthma drug Advair Diskus and its generic equivalents with newer, more expensive branded products.[38]

Why would the PBM want patients to switch to pricier alternatives? Most likely, because Optum and potentially Emisar could then earn more in rebates and fees.

So beginning in January 2024, a patient could only get a script for the cheaper version filled if their doctor had prior authorization from the PBM. Prior authorization is slow and often rejected.

Cole grew up with chronic asthma. He successfully used his preventative inhaler — an affordable asthma treatment with multiple generic equivalents — for more than a decade, his parents said.

On January 10, 2024, Cole went to his local Walgreens in Wisconsin to refill his usual script for the affordable drug.

According to the lawsuit, he expected to hand over his $66.86 copay and leave with the preventive inhaler that helped him breathe. But due to the recent PBM change negotiated by Optum — and likely Emisar, as the PBM GPO was built in 2021 — his asthma inhaler was no longer covered by insurance.

To get his inhaler, it would now cost him $539.19 out of pocket, a more than eightfold increase. Cole couldn't afford the unexpected leap in cost from the PBM's formulary change.

So he left the pharmacy without his inhaler, according to the lawsuit.

Five days later, Cole had a severe asthma attack, asphyxiated, and lost consciousness. His roommate rushed him to the emergency room.

Cole never woke up. He died within a week.

The staff at that pharmacy informed her of the formulary change and made sure she didn't leave without medicine.

"She came home, Pandora's box was opened," Bil explained, "and we were like, 'Holy shit, this is what happened to our son.'"

Since then, Bil has become a vocal advocate for PBM reform. He quit his job and founded the nonprofit Patient Protector, which is producing a docuseries about PBMs, Modern Medical Mafia.

Shortly after the first episode was published on Amazon and Vimeo last spring, Optum Rx's parent company UnitedHealth Group reportedly got the platforms to take it down. It remains available on YouTube.

Sitting next to a life-size photo of his late son in the Wisconsin capitol rotunda, Bil spoke to a Hunterbrook reporter via video call in early November 2025. He was there advocating for a PBM reform package called Cole's Act.

"This shit can't happen anymore. I mean, it just can't. Cole was freaking 22 years old and had a life ahead of him," Bil said.

"All the money in the world isn't bringing Cole back. So let's make sure we just save people."

If you have information related to PBMs, PBM GPOs, or other topics investigated in this article, please contact ideas@hntrbrk.com to share with Hunterbrook Media, which can keep you anonymous.

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Statement for the Record
U.S. House Energy & Commerce Committee Subcommittee on Health
Hearing: Health Care Affordability
January 22, 2026

Lauren Aronson
Executive Director, The Campaign for Sustainable Rx Pricing (CSRxP)

Committee Chairman Guthrie, Committee Ranking Member Pallone, Subcommittee Chairman Griffith, Subcommittee Ranking Member DeGette, and members of the U.S. House Energy & Commerce Committee Subcommittee on Health, the Campaign for Sustainable Rx Pricing (CSRxP) thanks you for the opportunity to submit a statement for the record on our shared goal of improving health care affordability for all Americans. We commend your bipartisan leadership in seeking to address this critically important issue that impacts patients, their families, and taxpayers every day.

CSRxP is a broad-based, nonpartisan coalition of leaders committed to fostering an informed discussion on sustainable drug pricing. Our member organizations represent consumers, employers, health plans, hospitals, nurses, pharmacists, pharmacy benefit companies, and physicians. Our coalition is united behind one goal: to lower the cost of prescription drugs for patients. We are committed to developing bipartisan, market-based solutions that promote competition, improve affordability, and enhance list price transparency while maintaining patient access to innovative medications that improve health outcomes and save lives. We believe innovation and affordability must go hand in hand.

I. Prescription Drug Prices are the Largest Driver of Health Care Spending

U.S. spending on healthcare continues to outpace inflation and wages, placing increasing financial pressure on patients, their families, employers, and federal and state budgets.[1] **The single largest contributor to healthcare spending growth is the excessively high cost of drugs: 24 cents of every health care dollar goes toward prescription drugs.**[2] Spending on prescription drugs is simply unaffordable and unsustainable because of the anti-competitive, price-gouging tactics Big Pharma deploys: drug makers set the list prices of their products too high, routinely raise those prices at unjustifiably high rates, and keep those prices high by gaming the system to block more affordable alternative medicines from entering the market.

[1] Cox et al. Health Care Costs and Affordability. KFF. October 8, 2025.
[2] AHIP. Where Does Your Health Care Dollar Go? October 24, 2024.

Indeed, American patients, families, taxpayers, businesses, and our economy as a whole cannot continue to bear the inexorable and unsustainable growth in prescription drug prices and spending. List prices for drugs at launch have more than doubled since 2021 – with the median list price exceeding $370,000 in 2024 and representing a substantial increase over the median launch prices of $300,000 in 2023 and $220,000 in 2022.[3] List prices are even higher for many gene therapy treatments, with the highest one priced at $4.25 million for a single dose in 2025.[4] Net median annual launch prices have skyrocketed in recent years, growing by 51 percent from 2022 to 2024.[5]

II. Health Care Costs Are High Because the U.S. Pays the Highest Prices

Drug makers raised U.S. prices on at least 872 brand-name drugs to start 2026 – imposing a median price increase of 4 percent, a median price hike that exceeds the current rate of inflation.[6][7] The price increases implemented at the outset of 2026 follow years of unsustainable price increases imposed on consumers and taxpayers by Big Pharma. In 2025, for example, manufacturers raised prices on more than 250 drugs to start the year.[8] In 2022, drug makers raised prices on more than 4,200 drugs by an average increase of 15.2 percent – even faster than the prior year of 11.5 percent.[9] Reflecting these unsustainable pricing trends, the top 25 best-selling prescription drugs in Medicare Part D not selected for price negotiation have nearly doubled in price since entering the market, increasing by an average of 98 percent.[10] Indeed, even after adjustments for rebates, a report from the Department of Health and Human Services (HHS) concluded that **U.S. prices for brand-name drugs are at least 3.2 times higher than those in comparable countries**.[11] The unsustainable drug pricing trends have led to needless spending on prescription drugs in the U.S. overall; in 2024, drug expenditures totaled $467 billion and grew at a rate of 7.9 percent, reflecting years of annual increases in prescription drug spending far exceeding the rate of inflation.[12]

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[3] Beasley, D. Prices for new US drugs doubled in 4 years as focus on rare disease grows. *Reuters*. May 22, 2025.
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[11] HHS ASPE. Comparing Prescription Drugs in the U.S. and Other Countries: Prices and Availability. January 31, 2024.
[12] Hartman et al. National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated. *Health Affairs*. January 14, 2026.

III. Brand Biologics and Specialty Medicines Drive Spending Growth

Critically, high-priced brand biologics are driving much of the excessive spending on prescription drugs. **Brand biologics made up 5 percent of all prescriptions in the U.S., but comprised 51 percent of total spending on drugs in 2024**.[13] Spending on biologics grew 12.5 percent annually from 2017 to 2021 – a rate that far surpassed the 1.3 percent annual spending growth on traditional small molecule drugs over that same period.[14] In Medicare Part D, prices for biologic medicines have grown more rapidly than traditional drugs, rising by more than 300 percent from 2006 to 2022.[15] Similarly, biologics accounted for nearly 90 percent of spending growth on prescription drugs between 2008 and 2021 in Medicare Part B and accounted for 79 percent of all of Part B drug spending in 2021.[16]

IV. Trump Administration: "A Patient Affordability Crisis"

Despite efforts from the branded pharmaceutical industry to suggest otherwise, drug makers – and drug makers alone – are the drivers of the unsustainable growth in drug prices and excessive spending on prescription drugs today. Drug companies set exceptionally high list prices at launch for new drugs and raise those prices every year, oftentimes at rates that far exceed inflation. Manufacturers impose these extremely high prices on patients and consumers despite the fact that far too many Americans still cannot afford the medications they need to get well and remain healthy.[17] **The anti-competitive, price-gouging practices of Big Pharma have led the FDA to assert that "patient affordability crisis" now exists, "creating insurmountable financial barriers for many Americans who need these life-saving treatments**."[18] Far too often today, Americans experience the unfortunate and unfair choice of purchasing medications and paying their bills for food and housing. Patients and their families simply should never be presented with such a choice.

[13] Food and Drug Administration. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.
[14] IQVIA. Biosimilars in the United States 2023 – 2027: Competition, Savings, and Sustainability. January 31, 2023.
[15] Medicare Payment Advisory Commission. The Medicare prescription drug program (Part D): Status Report. Slide 15. January 11, 2024.
[16] HHS ASPE. Medicare Part B Drugs: Trends in Spending and Utilization, 2008 – 2021. June 9, 2023.
[17] Sparks et al. Americans' Challenges with Health Care Costs. KFF. December 11, 2025.
[18] FDA. Fact Sheet: Bringing Lower-Cost Biosimilar Drugs to American Patients. October 29, 2025.

V. Congressional Action to Address Pharmaceutical Costs Must Be Part of the Solution

CSRxP again applauds the bipartisan leadership of the Committee in seeking to tackle the healthcare affordability crisis affecting millions of Americans today. **Given the outsized impact that high-priced prescription drugs have on healthcare affordability, CSRxP respectfully urges the Committee to invite Big Pharma's chief executive officers to testify before the Committee to attempt to justify their unjustifiable pricing practices and describe the actions they intend to take to address the "patient affordability crisis."** The American public and policymakers deserve to know and understand why drug makers continue to set prices for their products that are simply unaffordable and unsustainable for patients, families, employers, and taxpayers. Policymakers can use this information to formulate workable solutions to thwart the anti-competitive, price-gouging tactics of Big Pharma so that prescription drugs are affordable and accessible for all who need them.

In conclusion, CSRxP thanks you for the opportunity to submit a statement for the record on improving healthcare affordability for all Americans. Without taking major actions to combat the unsustainable growth in prescription drug prices and spending, the brand pharmaceutical industry will continue to excessively profit from its anti-competitive pricing practices that needlessly increase drug costs and make healthcare unaffordable for the very people who depend on it most. CSRxP looks forward to our continued work with the Committee and the Congress to develop bipartisan, market-based policies that promote transparency, foster competition, and incentivize value to lower costs for consumers and taxpayers while at the same time maintaining access to the treatments that can improve health outcomes and save lives.

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Statement for the Record

Submitted to Committee on Energy and Commerce

Health Subcommittee

Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

January 22, 2026

By: David Merritt, Senior Vice President of External Affairs

We know Americans are struggling with the high cost of health care, from the mom who doesn't pick up a prescription because of the price to the worker who skips a visit to the doctor because they can't afford it. Those are the unfortunate challenges too many Americans face when the prices for medical care and medications continue to rise far faster than everyday costs like gas and groceries. Families see and feel those higher health care costs every day in the form of higher premiums.

The Blue Cross Blue Shield Association (BCBSA) and Blue Cross and Blue Shield (BCBS) Plans share the Committees' ongoing commitment to improving access to and lowering costs of health care for all Americans. We thank the Chairman and Ranking Member for holding this important series of hearings to discuss how to lower costs.

BCBSA is a national federation of 33 independent, community-based and locally operated BCBS Plans that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. Almost 180 million Americans receive insurance through their jobs making employer-provided coverage the foundation of affordable care in this country. Blue Plans cover over 83 million employees and their dependents, including 18 million union workers, retirees and dependents and many Fortune 100 companies. In addition, Blue Plans collectively cover 8.3 million Americans through the individual market, 5.3 million through Medicare Advantage, 6.8 million through standalone Medicare Part D plans and 10.9 million through Medicaid.

Health insurance providers have an important role to play to help ensure that patients receive the care they need at the most affordable cost, which is why BCBSA is laser-focused on tackling the root causes of rising costs. Creating real change will require actions at every level by every leader in health care, and we are working in partnership with hospitals, pharmaceutical companies and policymakers to create savings

that lower premiums. We stand ready to work even more closely with the members of this committee and everyone with a shared commitment to lower costs because we know Americans expect us to lead and drive solutions together that make coverage more affordable.

The Root Causes of Rising Costs

Rising health care costs are driven by many factors across a complicated health care system: hospital prices, drug costs, advances in technology, changing regulations and how health care is financed and administered.

Premium rates are based on expected medical costs and utilization of services. When underlying costs and utilization rise, premiums follow. Unfortunately, trends in medical spending and the price of medical care continue to go up:

- Drug spending was up 10% in 2024, driven by high launch and list prices for specialty drugs.[1]
- Spending on weight loss drugs, GLP-1s, increased nearly 40% in just one year.[2]
- According to the Bureau of Labor Statistics, hospital prices have increased 281% since 2000.[3]

A study published in Health Affairs this month using CMS data noted that half of the growth in health care spending in 2024 was driven by high utilization of health care services. Adding to these pressures are the costs we pay for an explosion of new AI technologies designed to drive revenue for providers, as well as inefficient and ineffective government processes.

A financial lifeline that millions of Americans rely on to cover these higher costs is the individual health care tax credit. With the expiration of the enhanced health care tax credit at the end of 2025, CMS data shows 800,000 fewer people enrolled in plans offered through the individual marketplace for 2026. We expect that number to grow as more people allow their coverage to lapse when they receive their first, higher bill at the end of January. Typically, healthier people are the first to drop coverage when prices rise, taking the gamble that they won't need coverage. That leaves the marketplace with a smaller and less balanced pool of enrollees, which will further increase premiums for those who remain covered.

More broadly, BCBS Plans negotiate with drug manufacturers and health care providers every day to secure the lowest possible prices for the 118 million members we serve. We play this critical role on behalf of patients because out of every premium dollar, more than 80 cents go directly to pay for the medical care and prescription drugs they need. So, our negotiations directly reduce the premium prices that patients pay.

We know that explaining the reasons behind rising costs won't fix the problem, which is why we are taking real action and driving real solutions that will.

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[1] U.S. Drug Spending Up 10.2% in 2024, with Weight Loss Drugs Remaining Top Driver-ASHP

[2] National trends in prescription drug expenditures and projections for 2025 | American Journal of Health-System Pharmacy | Oxford Academic

[3] www.bls.gov

The Blues Affordability Roadmap

Our number one priority is to lower costs for the people we serve. Our roadmap outlines nearly $1 trillion for Congress in potential savings over 10 years. These commonsense solutions can deliver lower costs for patients, consumers and taxpayers by curbing excessive hospital markups, lowering prescription drug prices and streamlining unnecessary administrative burdens. When those underlying costs of care are lower, health insurance premiums will be lower as well.

Congress can take strong action right now to lower premiums and out-of-pocket costs for patients, particularly for those who purchase coverage on their own. The December expiration of the enhanced health care tax credits has led to immediate price spikes for many of the 25.2 million people enrolled in the market. Congress should create a short-term fix for families that rely on those enhanced credits now, while making other improvements to the individual marketplace as well as addressing the underlying causes of premium increases.

On reasonable hospital billing, Medicare should require unique national provider identifiers (NPIs) for off-campus, hospital-owned offices to verify care sites and enforce correct payment rates. Passing S. 2497,[4] the Fair Billing Act, sponsored by Sens. Maggie Hassan (D-NH) and Roger Marshall (R-KS), would add critical transparency and, according to the Congressional Budget Office,[5] reduce direct spending by $403 million and increase government revenue by $1.9 billion over 10 years.

Building on the NPI fix, Congress should expand site neutral policies that protect Medicare patients from higher bills simply based on where they were treated — and who owns the facility. Congress can lower health care costs through fair and reasonable billing practices, such as applying site neutral payments for hospital outpatient departments, which would end these unreasonable markups and save the country and taxpayers nearly $500 billion over 10 years.[6]

BCBSA strongly supported the Administration's first step advancing site neutral reform when the Centers for Medicare & Medicaid Services (CMS) lowered out-of-pocket costs for patients receiving physician-administered drugs. We urge Congress to expand these reforms to other Medicare services, so patients never pay more simply because of where they receive care.

Congress must also act to lower drug prices by driving more competition, more patient choice and faster access to lower-cost generics. For example, pharmaceutical companies delay patient access to lower-cost generic and biosimilar drugs by filing numerous additional patents to extend the exclusivity of a brand-name drug. Passing S. 1041, Affordable Prescriptions for Patients Act, sponsored by Sens. John Cornyn (R-TX) and Richard Blumenthal (D-CT), would cut through the 'patent thicket,' provide more lower-cost choices for patients and save hardworking taxpayers $1.8 billion over 10 years.[7] This

[4] United States Congress, Fair Billing Act. 2025, S.2497 - 119th Congress (2025-2026): Fair Billing Act | Congress.gov | Library of Congress.
[5] Congressional Budget Office. "Estimated Direct Spending and Revenue Effects of H.R. 5378, the Lower Costs, More Transparency Act | Congressional Budget Office." Congressional Budget Office, 2023, www.cbo.gov/publication/59825.
[6] Harmonic Consulting. "Savings Estimates for Solutions to Reduce Spending on Health Care and Private Insurance Premiums: 2025 Update." January 2025. https://www.bcbs.com/media/pdf/BCBSA_affordability_solutions_for_the_health_of_america_2025_update.
[7] Congressional Budget Office Cost Estimate. "At a Glance S. 150, Affordable Prescriptions for Patients Act of 2023." June 13, 2024. https://www.cbo.gov/system/files/2024-06/s150.pdf.

legislation and other bipartisan reforms would bring lower-cost generic and biosimilar competitors to market more quickly by closing patent and regulatory loopholes.

Fixing the Broken Independent Dispute Resolution (IDR) Process

The No Surprises Act was meant to protect patients from unexpected medical bills. But its system to settle payments between hospitals and insurers — Independent Dispute Resolution or IDR — is being abused. IDR was intended to be used as a backstop, with CMS originally estimating 17,000 cases annually. Last year, more than 2.2 million cases were sent through the IDR process.[8] Our research found that nearly 40% of those submitted cases were not eligible for the process, yet half of those still result in determinations.[9] The consequence of this broken process is higher costs for patients and employers.

In many cases, the determinations do not reflect local market prices at all. For example, CMS data shows one health plan offered $1,388 in arbitration for an emergency department consultation, which was already above the median in-network rate of $1,195. This offer was also well above the Medicare rate of just $370.[10] Somehow, the arbitrator sided with the provider's request of more than $250,000 — 150,000% higher than Medicare.[11] This is just one example of thousands like it. And when providers prevail in more than 85% of cases,[12] receiving payments averaging more than 450% of the rates negotiated and agreed to with in-network providers,[13] everyone pays more.

Recent research showed the broken process added at least $5 billion in health care spending in just two years. As these trends continue to rise and as these costs ripple through the system, they result in higher premiums and higher out-of-pocket costs.[14]

To ensure the No Surprises Act works as intended, CMS needs to implement targeted, commonsense reforms:

- Finalize the IDR Operations Final Rule, implementing a dynamic IDR portal to improve efficiency and transparency in the process.
- Discourage improper filings by introducing an upfront eligibility fee for initiating parties to reduce ineligible disputes.
- Increase transparency by requiring arbitrators to share submissions and provide detailed rationales as part of the final decisions.
- Create a formal process for parties to challenge arbitration outcomes before CMS.
- Monitor arbitrator performance and develop penalties for arbitrators that show bias or poor performance.
- Track patterns of abuse by providers and their vendors to curb manipulation of the system.

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[8] https://www.cms.gov/nosurprises/policies-and-resources/reports
[9] https://www.ahip.org/news/press-releases/new-ahip-bcbsa-survey-shows-nearly-40-of-providers-surprise-billing-disputes-are-ineligible-under-no-surprises-act
[10] https://www.cms.gov/nosurprises/policies-and-resources/reports
[11] https://www.cms.gov/nosurprises/policies-and-resources/reports
[12] *Ibid*.
[13] https://www.healthaffairs.org/content/forefront/substantial-costs-no-surprises-act-arbitration-process
[14] *Ibid*.

These changes would better align incentives and curb abuse by those who are gaming the system. That will help lower costs for everyone.

The Blues are Creating Lower-Cost Options for Patients

BCBSA and several Blue Plans helped create CivicaScript to bring affordable versions of commonly prescribed but highly priced generic medicines to the market, increasing competition. A study in the *New England Journal of Medicine* found that CivicaScript's generic prostate cancer drug saved patients nearly $1,000 a year. Earlier this month, Civica began to offer affordable insulin pens with the lowest list price in the current long-acting insulin market — capped at $55 per box of five pens for consumers, compared to $150–$500 per box.[15]

We also connect families to lower cost, high-quality specialty care through our centers of excellence program. The Blue Distinction Center+ designation covers eight different specialties, including cancer care and transplants. To earn this designation, a facility needs a history of delivering exceptional results at lower costs. Members are saving 23% on spine surgery and 30% on knee/hip replacements.

The Blues are Promoting Preventive Care

The Blues are working closely with hospitals and physicians to shift away from fee-for-service medicine and toward paying for quality care. Blue High Performance Networks reward providers for keeping patients healthy rather than ordering more tests. Our research shows this model reduces the total cost of care by an average of 11%.[16]

Blue Plans are working to improve health and lower costs by covering preventive screenings like mammograms and colonoscopies at zero cost to patients. These screenings help detect cancer at an earlier stage and avoid invasive tests and treatments. Early detection improves outcomes and can cut treatment costs by up to two-thirds. We have seen the data: An ounce of prevention is worth a pound of cure. We strongly encourage members to access these services and promote their availability directly to members, from websites, member portals and onboarding materials to personalized reminders, on social media and direct member outreach.

The Blues are Taking on Fraud, Waste and Abuse

Fraud, waste, and abuse contributes to the mounting cost of health care and undermines trust in the health care system. As health insurance providers, Blue Plans play a unique role helping identify, eliminate and prevent fraud, waste and abuse. Every BCBS company operates Special Investigation Units (SIUs) that use data analytics, claims reviews and referrals to identify and uncover suspicious billing patterns and behaviors. SIUs conduct comprehensive investigations when potential misconduct is detected, and findings support overpayment recovery and inform administrative or criminal actions.

[15] https://www.bcbs.com/news-and-insights/article/new-era-of-lower-cost-insulin
[16] https://www.bcbs.com/about-us/programs-initiatives/blue-high-performance-network

BCBSA's National Anti-Fraud Department supports these efforts, overseeing antifraud activities and enhancing BCBS systemwide SIU operations through a robust framework of information sharing, investigative collaboration along with government and industry partnerships. From 2020 through 2024, BCBS company SIUs completed more than 67,000 investigations, collectively recovering and preventing losses exceeding $22 billion. This critical work helps keep premiums low, returning value to beneficiaries.

More can and should be done to prevent fraud, waste, and abuse. BCBSA has long advocated for stronger program integrity measures in public programs. In September 2024, we urged Congress to address unauthorized individual market enrollees, with most of our recommendations having been made into law. We continue to support:

- Tougher penalties for fraudulent brokers
- Expanding multi-factor authentication for brokers and consumers
- Enhanced eligibility checks as consumers move between Medicaid and marketplace coverage

We also support significant steps that this Congress and Administration have taken to combat fraud, waste and abuse and bring more accountability to the health care system, including:

- **CMS Actions:**
  - Social Security Number-based identity verification
  - Suspended 850 brokers for unauthorized enrollments
  - Introduced 3-way calling to block bad actors
  - Ended marketplace tax credits for dually enrolled Medicaid/CHIP consumers
  - Finalized 2025 Marketplace Integrity and Affordability Rule limiting special enrollment periods, requiring a minimum payment to prevent auto-renewal into zero-cost plans, and improving income eligibility checks
- **Congressional Actions**:
  - The *One Big Beautiful Bill Act* ended automatic reenrollment and presumptive eligibility, tightened all eligibility verifications and required full repayment of excess tax credits.

BCBSA also applauds the creation of the Wasteful and Inappropriate Service Reduction (WISeR) Model, which directly targets low-value and fraudulent claims for high-risk, high-growth services in Original Medicare, and we support CMS's new Fraud Defense Operations Center, which uses data analytics, investigative expertise and AI to stop improper payments before they occur.

Addressing fraud, waste and abuse is an important component of strengthening our health care system and should remain a focus; however, it is not sufficient to control rising health care costs. Meaningful, sustainable cost reduction will also require policies that address the root causes of rising costs.

We will continue to use the tools available to us to bring down costs when drug makers and providers drive prices up. And we stand ready to work with Congress to tackle the root causes of our nation's health care affordability crisis. We also are eager to partner on a bipartisan agreement to extend health care tax

credits for the millions of Americans who rely on them. If you have any questions or would like to discuss this issue further, please contact me or my colleague, Amanda Schwartz, associate vice president of government relations, at Amanda.Schwartz@bcbsa.com.

Sincerely,

David Merritt

Senior Vice President, External Affairs

Blue Cross Blue Shield Association

CYSTIC FIBROSIS FOUNDATION®

January 22, 2026

Statement for the Record
House Energy and Commerce Subcommittee on Health
Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

Dear Chairs Guthrie and Griffith, Ranking Members Pallone and DeGette, and Members of Health Subcommittee,

On behalf of the nearly 40,000 people with cystic fibrosis (CF) living in the United States, we appreciate the opportunity to submit this statement for the record for the hearing on Lowering Health Care Costs for All Americans. CF has been transformed from a fatal childhood disease to one where the adult CF population is larger than the pediatric population. However, without affordable coverage for the complex care the disease requires, these advancements cannot be realized.

During this year's open enrollment, our call center -- which helps people with CF evaluate health insurance options -- identified several troubling trends. Premiums surged, high-deductible plans became more prevalent, and some plan policies continue to circumvent the traditional plan design. These compounding financial pressures are forcing people with CF and their families to choose less comprehensive coverage, go without essential specialty medications or multidisciplinary care, or forego insurance entirely. For someone living with a serious, progressive disease, these decisions create harmful tradeoffs that undermine the everyday social and economic needs essential to supporting positive health outcomes for people with CF. The challenges observed during open enrollment reflect broader and worsening affordability pressures facing people with CF across all insurance types.

Enhanced Advanced Premium Tax Credits

After months of Congressional inaction, time has run out: people with CF and their families are starting the year with delays in care, higher costs, and increased uncertainty. Many are struggling with skyrocketing premiums and walking away from critical, comprehensive Marketplace coverage. Here are just some examples:

- A woman with CF and her husband in **Louisiana** (age 63 and 62) paid $500 a month in premiums in 2025 using advanced premium tax credits (APTCs). At an income of $90,000 a year (425% FPL), they are no longer eligible for APTCs in 2026. The lowest premium that covered their providers and all of their medications is a high-deductible bronze plan costing $3,160 a month. A silver plan that meets their needs would jump to $4,500 a month. In 2025 the couple was paying a total of $6,000 in premiums; in 2026, they would be responsible for $37,000. This dramatic increase caused the person living with CF to choose to be uninsured until they can qualify for Medicaid coverage.

- An adult with CF in **New York** with an annual income of $70,000 (442% FPL) currently pays $550 a month in premiums. In 2026, her anticipated premium for the same plan will rise to $1,073 per month – a nearly 50% increase. Due to plan network changes and benefit restructuring, she will

pay at least $4,000 more in out-of-pocket costs in 2026, which are expected to reach approximately $23,000.

- A person with CF in **North Carolina** was seeking to enroll himself and his family in a new marketplace plan for 2026 because his current plan was no longer offered. In 2025, he was paying $1,032 per month for his insurance premium. For 2026, the cheapest plan that covered his needs and keeps his CF care team in-network cost $1,427 per month – a near $5,000 annual increase from 2025. The family's total estimated out-of-pocket costs for 2026 are $28,000, almost double the $15,000 paid in 2025. This family of three with a household income of $140,000 (535% FPL) cannot afford these additional costs.

- An adult with CF in **Pennsylvania** currently pays $745 a month on the marketplace for his family of three. With a household income of $150,000 (562% FPL), this family is no longer eligible for APTCs in the upcoming year. For 2026, the same plan will cost $1,616 per month, an increase of $10,452 annually.

- An adult with CF in **Utah** currently pays $808.50 a month in marketplace premiums. In 2026, that premium will rise to $1,392 per month – 53% increase. All available plans exclude copay assistance from counting toward their deductible and out-of-pocket maximum. With an income of approximately $67,000 next year (431% FPL), her total healthcare costs including premiums, copays, and other expenses are projected at $22,500, roughly 30% of her annual income.

Because Congress failed to act, the eAPTCs expired at the end of December 2025. Patients are now feeling the real fallout of this inaction.

Non-Comprehensive Insurance Products

Lowering the cost of health insurance premiums alone is not a solution for people with CF, their insurance must also provide coverage for comprehensive specialized care. Federal policy changes over the last year have reduced the affordability of ACA Marketplace coverage while simultaneously expanding the marketing and availability of non-comprehensive insurance products. Several types of insurance or insurance-like arrangements present themselves as alternatives to ACA-compliant plans in the individual market, yet they do not offer the same consumer protections. Because many of these products can use underwriting practices to screen out people with pre-existing conditions, the proliferation of these plans will likely attract a younger and healthier group of people. This shift leaves issuers of ACA-compliant plans with smaller, sicker risk pools, which in turn drives Marketplace insurers to raise premiums even further.

Any legislation that promotes health savings accounts (HSAs) as an affordability solution do not work for people with cystic fibrosis or anyone with a pre-existing condition. These proposals will increase financial hardships and worsen health outcomes for the people who need health care coverage the most. Throughout the insurance market, HSAs are paired with high-deductible health plans. HDHPs require high upfront spending each year when deductibles reset and expose enrollees to significant cost-sharing. In the 2026 plan year, HDHP maximum out-of-pocket expense limit increased to $8,500 for individual coverage and $17,000 for family coverage.[1] HSAs do not help mitigate the high out-of-pocket cost burden and financial risk of these plans. For people with cystic fibrosis, who need ongoing specialized care-- including multiple daily medications and regular multidisciplinary clinic visits--the high upfront costs required with HDHPs can create substantial barriers to disease management, even with an HSA. This is especially true for lower-income individuals, who have less discretionary income to contribute to HSAs, receive fewer tax

[1] Rev. Proc. 2025-19

benefits due to lower tax brackets, and still face high deductibles. These proposals fail to address the significant concerns of rising health care costs in a way that protects access to health care. Instead, they establish a regressive system that deepens disparities, threatens health outcomes and silos people with an chronic condition into higher cost and unaffordable plans that still fail to cover the care and therapies they need.

In addition, patients enrolled in HDHPs paired with HSAs are uncertain of their financial obligation given the inconsistent interpretations of IRS regulations by insurers and conflicting state laws around the use of copay assistance. Currently, HDHPs with HSAs do not count copay assistance towards the enrollee's deductible and out-of-pocket maximum, even in states that have banned this practice. These plans are incorrectly and inappropriately treating copay assistance like prescription discount cards under outdated IRS guidance[2]. Enrollees are told that the mere presence of a tax-advantaged account linked to their health plan (whether they contribute or not) deters the copay assistance from counting towards their out-of-pocket obligations. This rule is applied inconsistently across plans and states creating confusion for enrollees and barriers that undermine patient access to essential medications. Because individuals with cystic fibrosis face high treatment costs and often rely on copay assistance to afford their medications, this uncertainty forces patients into a difficult choice: forgo contributing to an HSA or refrain from applying copay assistance toward their deductibles.

For people with CF, these plans can translate into higher out-of-pocket costs, inadequate coverage for essential specialty care, and greater financial uncertainty. Replacing premium tax credits with HSAs is not a viable solution to the current health care affordability crisis. These plans fail to provide adequate, affordable coverage for the millions of Americans with serious, chronic health conditions.

Pharmacy Benefit Manager Reform

Congress has a critical opportunity to protect patients and restore fairness in the prescription drug system. PBM reform is a patient-centered solution that will lower costs, improve access, and ensure transparency in healthcare. We strongly support the advancement of comprehensive PBM reform legislation that includes transparency and accountability measures for PBMs and insurers, a ban on spread pricing to eliminate hidden markups, and de-link of PBM compensation from drug prices to remove perverse incentives.

These reforms have bipartisan, bicameral support and the potential to make a measurable difference for millions of Americans, including people with CF. We are delighted to see some of these provisions included in the House legislative package and strongly support the passage of these reforms in that vehicle as they will have a direct and immediate impact on how people with CF will access their medications.

Affordability Concerns with Cost-Containment Strategies in the Commercial Market

While nearly all people with cystic fibrosis have at least one form of health insurance, that is often not enough. A recent study that assessed the impact of health care costs on the CF community found that over a 12-month period, nearly 70% of people with CF experienced a financial challenge due to CF-related medical bills.[3] This can be due to commercial health plan's (both individual marketplace and employer-sponsored insurance market) resistance to covering high-cost therapies. When this happens, the insurance plan may rely on cost-containment strategies such accumulators, maximizers, and alternative funding programs (AFPs). Because PBMs, insurers, and their subcontractors aren't transparent, patients often don't know who to contact for coverage questions or appeals. This confusing system creates extra paperwork,

[2] Internal Revenue Service, Notice 2004-50, Part III – Administrative Procedural, and Miscellaneous. Health Savings Accounts – Additional Qs & As. Accessed March 14, 2025 https://www.irs.gov/pub/irs-drop/n-04-50.pdf

[3] Survey Highlights the Burden of Health Care Costs on the CF Community | Cystic Fibrosis Foundation

delays access to needed treatments, and forces patients and care teams to constantly deal with new and unclear rules.

Health insurers are increasingly adopting accumulator and maximizer programs that prevent patients from using copay assistance to help meet the patients' out-of-pocket cost obligations. For people with CF, affordable access to prescribed treatments can be extremely challenging, especially when health insurance plans impose significant cost-sharing obligations. To help pay those significant out-of-pocket costs, patients often rely on assistance from various sources -- including charitable foundation or manufacturer assistance. All assistance programs help people with CF afford the therapies their providers have determined are medically necessary and appropriate to manage their condition. The CF Foundation recognizes that copay assistance programs are not a long-term solution, but cost-containment strategies like accumulator and maximizer programs further burden people with cystic fibrosis and are unacceptable.

While copay accumulators and copay maximizers attempt to seek the maximum amount of financial assistance from copay assistance programs, AFPs attempt to source the drugs by pursuing patient assistance programs (PAP), enrolling patients in secondary insurance and nonprofit assistance programs, and international importation. Each of these options may create financial and administrative burdens, could pose a serious risk to safety by circumventing US quality control measures, and potentially delay access to medication and jeopardize a patient's health. If a medically necessary drug is not available through one of these sourcing mechanisms, then the AFP may then pursue copay assistance through either a maximizer or accumulator program.

These programs highlight the challenges patients face when accessing high-cost therapies and signal concerns that will likely intensify as more expensive treatments enter the market. Congress must act to protect people with CF from tactics that shift significant burdens onto patients by reinforcing and establishing better standards for patient protections in commercial health plans, as well as strengthening regulations on insurers, pharmacy benefit managers, and third-party subcontractors.

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Thank you for the opportunity to provide a statement for the record. The Cystic Fibrosis Foundation is committed to working with Congress on solutions that protect people with CF and address the ongoing affordability crisis in health care.

Sincerely,

Mary B. Dwight
Senior Vice President
Chief Policy and Advocacy Officer
Cystic Fibrosis Foundation