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LOWERING HEALTHCARE COSTS FOR ALL AMERICANS:

AN EXAMINATION OF HEALTH INSURANCE AFFORDABILITY

THURSDAY, JANUARY 22, 2026

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 9:45 a.m., in Room 2123, Rayburn House Office Building, Hon. H. Morgan Griffith [Chairman of the Subcommittee] presiding.

Present: Representatives Griffith, Harshbarger, Bilirakis, Carter of Georgia, Crenshaw, Joyce, Balderson, Miller-Meeks, Cammack, Obernolte, James, Bentz, Houchin, Langworthy, Kean, Rulli, Guthrie (ex officio), DeGette, Ruiz, Dingell, Kelly, Barragan, Schrier, Trahan, Veasey, Fletcher, Ocasio-Cortez, Auchincloss, Carter of Louisiana, Landsman, and Pallone (ex officio).

Also Present: Representatives Latta, Hudson, Weber, Allen, Pfluger, Evans, and Fedorchak.

Staff Present: Marjorie Connell, Director of Archives; Jessica Donlon, General Counsel; Sydney Greene, Director of Finance and Logistics; Jay Gulshen, Chief Counsel, Subcommittee on Health; Annabelle Huffman, Clerk, Subcommittee on Health; Megan Jackson, Staff Director;

A.T. Johnson, Special Advisor; Daniel Kelly, Press Secretary; Sophie Khanahmadi, Deputy Staff Director; Jonathan Kupperman, Professional Staff Member, Subcommittee on Health; Brayden Lacefield, Special Assistant; Sarah Meier, Counsel and Parliamentarian; Joel Miller, Chief Counsel; Lillian Noland, Staff Assistant; Seth Ricketts, Special Assistant; Jake Riith, Staff Assistant; Chris Sarley, Member Services and Stakeholder Engagement Director; Emma Schultheis, Policy Analyst, Subcommittee on Health; James Stursberg, Professional Staff Member, Subcommittee on Health; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Jane Vickers, Press Assistant; Katie West, Press Secretary; Nick Wooldridge, Professional Staff Member, Subcommittee on Health; Lydia Abma, Minority Policy Analyst; Jacquelyn Bolen, Minority Counsel, Subcommittee on Health; Keegan Cardman, Minority Staff Assistant; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Perry Hamilton, Minority Deputy Director of Member Services and Outreach; Brent Langellier, Minority Health Fellow; Una Lee, Minority Chief Counsel, Subcommittee on Health; Gayle Mauser, Minority Health Advisor; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Hannah Treger, Minority Staff Assistant; Laurel Uhomba, Minority Health Fellow; Kyle Wolf, Minority Press Intern; and C.J. Young, Minority Deputy Communications Director.

Mr. Griffith. The subcommittee will come to order.

Before we begin, I would like to take a moment to address the guests in our audience.

First of all, thank you for coming. We think engaged citizens are a welcome and valuable part of this political process.

I do want to remind our guests in the audience that the chair is obligated under the rules of the House and the rules of the committee to maintain order and preserve decorum in the committee room. I know that we all have deep feelings on these issues and that we may not agree on everything, but I ask that we all abide by these rules and be respectful of our audience members, our viewers, our witnesses, and, of course, members of the committee.

The chair appreciates the audience's cooperation in maintaining order, as we have a full discussion on these important issues.

The chair recognizes himself now for 3 minutes for an opening statement.

Today, we will discuss healthcare costs and patient access challenges by examining affordability across the entire health insurance marketplace.

This hearing builds on work Republicans have done in this Congress to address healthcare affordability. We plan to have future hearings with other leaders and experts across the healthcare continuum to understand the root causes of rising healthcare costs.

Specifically, this hearing will focus on the role insurers play in the delivery of care.

The insurance market is dominated by a handful of Fortune 50 companies that control the majority of the national market. In some States, a single insurer may even control 80 or 90 percent of a particular market.

The biggest health insurers today often manage several facets of the healthcare supply chain, such as owning the pharmacy benefit managers, the group purchasing organizations, multiple provider groups, and specialty or mail-order pharmacies.

Even with owning those, complicated benefit designs, narrow networks, prior-authorization requirements, and opaque coverage decisions often leave patients feeling like they are paying more for less. The market also lacks transparency, and it is not easily navigable.

One contributor to health insurance unaffordability for millions of Americans is the so-called Affordable Care Act, also known as Obamacare, that was signed into law in 2010.

When Democrats passed Obamacare without Republican support, they sold the bill on the promises that premiums would fall, competition would rise, and if you like your insurance plan, you can keep it.

Instead, Obamacare has increased healthcare costs, warped incentives, federalized benefits, restricted plan design, and limited access to care. Many patients have fewer plan choices than they did before Obamacare was enacted. In fact, a constituent of mine told me recently that his family only had one provider option in the Obamacare exchanges.

Therefore, Obamacare coverage is not translating to patient or taxpayer affordability.

Unfortunately, employer-sponsored insurance is also becoming unaffordable, and, each year, more American small businesses choose not to offer health insurance because it is too costly. This impacts the ability for a small business to be competitive and to attract talent.

We know two things are true: Competition and -- we know two things are true: Competition is essential for patient access. Lack of competition and consolidation within the insurance marketplace has led us to higher healthcare costs as a whole.

The healthcare system needs to work for patients. That means empowering individuals with real choices, transparent prices, and coverage that fits their needs. We must strive to have more competitive plan options that reward quality and focus on affordability, access, and outcomes.

Our discussion today is meant to move beyond politics and spur debate about how we can work toward delivering meaningful, innovative solutions for the Americans that we all serve. We owe it to patients to get to the root cause of the challenges we see across the health sector.

And I look forward to hearing from our witnesses.

I now recognize the subcommittee ranking member, Representative DeGette, for her 3-minute opening statement.

[The prepared statement of Mr. Griffith follows:]

******** COMMITTEE INSERT ********

Ms. DeGette. Thank you, Mr. Chairman.

Americans know that healthcare is far too expensive. As it takes up a greater percentage of our economy than any other developed country, Americans' health outcomes lag far behind others, with our life expectancy now falling behind Spain, Panama, and Oman. And millions of Americans who get insurance on the individual marketplace saw their premiums shoot up, doubling on average, at the beginning of the year.

Because of the ACA, now the lowest number of Americans ever are uninsured. Right now, there are 21 million people enrolled in the marketplaces under the ACA. But because Congress failed to extend the enhanced premium tax credits, healthcare coverage is shooting up.

Now, 2 weeks ago today, the House did the right thing by passing a 3-year extension of these critical tax credits, even as the Republican leadership worked against it. Just 17 House Republicans joined Democrats to do the right thing and help millions of Americans, like our witness Ellen Allen, who is sitting right here today, continue to afford health coverage, and just 1 Republican on this subcommittee voted for affordability.

The enhanced premium tax credits we enacted into law 5 years ago were predicated on a simple premise: No American should have to pay more than 8.5 percent of their income for health insurance.

But even when people do have coverage, good care can still be a fight to get through denials, prior-authorization requirements, and sky-high co-pays and deductibles that create additional barriers between America's patients and the care that they need.

Just last year, this majority's top priority was to enact massive tax cuts for the wealthy, for people just like the insurance CEOs who are sitting in front of us today. These handouts to the rich were funded by cutting healthcare for hardworking Americans.

In the same bill -- in the same bill with the tax cuts -- this majority chose not to extend

premium assistance for middle-class Americans, causing healthcare costs to skyrocket. And that is what has led now to this current crisis.

In the big picture, the chairman and I can agree: What we need is access to quality, affordable healthcare for every American. That is why, frankly, I have long supported a solution like Medicare for All. But Americans need relief now, and we need immediate action to bring down healthcare costs in this country.

Open enrollment for 2026 ended a week ago, as the Republicans in Congress failed to pass any legislation to make healthcare coverage more affordable. We are simply out of time.

The Senate must act immediately to join House Democrats and the 17 courageous House Republicans to send this critical help for middle-class Americans to Donald Trump's desk, and he must sign it. To do anything else is to accept a poorer and sicker America.

On a positive note, Mr. Chairman, I have 15 seconds left, and I want to thank the majority for finally including the health extenders package that we were supposed to pass over a year ago and which DOGE cut. Finally it is going to be included, and it is going to help get research and healthcare to millions of Americans.

Thank you, and I yield back.

[The prepared statement of Ms. DeGette follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Does that mean we can count on your vote this afternoon? Rhetorical question.

Ms. DeGette. Good.

Mr. Griffith. I now recognize the chairman of the full committee, the gentleman from Kentucky, Chairman Guthrie.

The Chair. Thank you. Thank you, Chairman Griffith.

And I want to thank our panel of CEO witnesses for being here today.

Today's hearing is the first in a series of hearings focused on healthcare affordability. And we begin by hearing testimony from our Nation's top health insurance CEOs.

According to CMS, America spent $5.3 trillion on healthcare in 2024. That represents a staggering 18 percent of our country's gross domestic product.

Over 200 million people in the U.S. get their health insurance through the private marketplace. Of that total, around 178 million people receive their coverage through their employer and 24 million get their coverage through Obamacare.

Across these markets, healthcare costs have been increasing at an unprecedented rate. In the Obamacare markets, healthcare premium increases for 2026 were as high as 40 and 50 percent. In the employer marketplace, year-over-year cost increases for 2026 are at a 15-year high. Despite what my Democrat friends would have the American people believe, healthcare affordability is far from a one-market issue.

It also isn't a new issue. This committee has previously worked in a bipartisan way to pass major reforms across the healthcare sector to make healthcare more affordable for all Americans.

I hope we can rise above the politics and have a real discussion about the root causes of affordability and how we can help all Americans have access to more affordable care.

And that is why we have convened this panel of CEOs today, who can speak authoritatively on

the market forces affecting affordability.

The goal of this hearing is to have a conversation about these rising healthcare costs, and your companies sit at the center of our healthcare financing system. Nearly every dollar spent on healthcare in America runs through your companies or one of your competitors. And we, as a country, are spending a lot on healthcare.

A core component of your industry's value proposition is working on behalf of Americans to lower the cost of healthcare along with improving access and quality. Yet, healthcare costs are increasing every year, and more and more Americans have become frustrated by the feeling that their insurance isn't working for them and working against their health.

I want to be clear in what we expect to hear answers on today:

As some of the largest companies in our economy and amongst the companies that benefit the most from government subsidies, how do you justify the continuing skyrocketing costs for your beneficiaries?

What are you doing that is working to lower healthcare costs, and what isn't working? And what are the barriers we need to address?

What should insurance companies be doing better to live up to your promises to the American people?

I thank you all for being here. I look forward to a spirited discussion and great information.

And I will yield back.

[The prepared statement of the chair follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. The gentleman yields back.

I now recognize the ranking member of the full committee, Representative Pallone, for his 3-minute opening statement.

Mr. Pallone. Thank you, Chairman.

Today, Republicans are looking for a scapegoat to blame for the fact that 24 million Americans saw their healthcare premiums skyrocket at the beginning of this year. By calling health insurance executives before us today, Republicans are attempting to divert attention from their failure to extend the Affordable Care Act's enhanced premium tax credits.

Make no mistake, congressional Republicans and President Trump are to blame for the healthcare affordability crisis Americans are experiencing today. And it is only going to get worse. That is because Republicans are sabotaging our Nation's healthcare system, driving up costs, taking away coverage, and undermining access to care at every turn.

As a result of Republicans' actions, including passage of their cruel "Big, Ugly Bill," 50 million people will be left uninsured, driving up healthcare costs for everyone with private health insurance.

Now Republicans are proposing further dismantling the ACA in favor of junk insurance and health savings accounts that won't help when you or your family gets sick. Chairman Griffith talked about "competition," but it is not competition if your alternative doesn't provide coverage.

For example, a policy without hospitalization, which a few years ago Republicans were advocating. You could buy a policy without hospitalization. That is not healthcare coverage.

If I get a policy that has a deductible of $7,000 or $8,000 and then you give me $2,000 in a health savings account, that doesn't help me either unless I am rich. Their policy is for the rich guy, not for the average guy.

We set up the ACA because people couldn't buy health insurance that covered -- that had good coverage and was affordable. And nothing Republicans have discussed so far changes that.

If costs go up -- which is what they have done because, you know, of the health crisis and the cost of healthcare -- then the only way to help people is to provide more subsidies or tax credits so they can afford the insurance.

Giving them junk insurance or giving them high deductibles and some kind of $2,000 amount of money for a health savings account isn't going to help them. It is not going to provide any real competition or alternative, and it is not the way to make healthcare more affordable.

So I appreciate the opportunity to hear from the executives of our Nation's largest health insurance companies today.

This is not your fault. This is the Republicans' fault. It is not your fault. Don't let them drag you in here and blame you for what is going on. It is not your fault.

Democrats stand ready to continue to fight to lower healthcare costs for the American people.

We have a witness today, Ellen Allen, who joins us here from West Virginia, and we will hear her story about how healthcare premiums have skyrocketed this year as a result of Republicans' inaction just as she is preparing for retirement.

Americans like Ellen deserve to have peace of mind that they can afford the healthcare they need and their life savings won't be drained if they get a life-threatening disease or have a health emergency. Unfortunately, the Republicans' assault against quality and affordable health insurance puts that at risk. It is not going to help Ellen Allen.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Mr. Pallone follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. The gentleman yields back.

We now conclude with member opening statements.

The chair would like to remind members that, pursuant to committee rules, all members' opening statements will be made a part of the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. We want to thank our witnesses for taking their time to testify before the subcommittee today.

Although it is not the practice of this subcommittee to swear in witnesses, I would remind our witnesses that knowingly and willfully making materially false statements to the legislative branch is against the law under Title 18, section 1001 of the United States Code.

You will each have an opportunity to give an opening statement, followed by questions from members.

Our witnesses today are Stephen Hemsley, CEO, UnitedHealth Group; David Joyner, chairman and CEO, CVS Health; Gail Bordeaux -- Boudreaux -- sorry; I will get it right -- president and CEO, Elevance Health; David Cordani, president, CEO, and chairman of the board of The Cigna Group; Paul Markovich, president and CEO, Ascendiun; and patient advocate Ellen Allen.

Per committee custom, each witness will have the opportunity for a 5-minute opening statement, followed by a round of questions from members.

The light on the timer in front of you will turn from green to yellow when you have 1 minute left and then to red when your time is up.

I now recognize Mr. Stephen Hemsley for 5 minutes to give his opening statement.

STATEMENTS OF STEPHEN HEMSLEY, CEO, UNITEDHEALTH GROUP; DAVID JOYNER, CHAIRMAN AND CEO, CVS HEALTH; GAIL BOUDREAUX, PRESIDENT AND CEO, ELEVANCE HEALTH; DAVID CORDANI, PRESIDENT, CEO, AND CHAIRMAN OF THE BOARD, THE CIGNA GROUP; PAUL MARKOVICH, PRESIDENT AND CEO, ASCENDIUN; AND ELLEN ALLEN, EXECUTIVE DIRECTOR, WEST VIRGINIANS FOR AFFORDABLE HEALTH CARE

STATEMENT OF STEPHEN HEMSLEY

Mr. Hemsley. Thank you, Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, and Ranking Member DeGette. Members of the committee, thank you for inviting me to testify today.

Every day, people count on our company not just to help them when they are sick but to help keep them healthy and well at every stage of their lives. And we take that responsibility seriously.

Mr. Griffith. Sir, could you move the mic a little closer to your mouth so everybody can hear you?

Mr. Hemsley. Thank you.

Like all of you, we are dissatisfied with the status quo in healthcare and know we must all do better. And so we are committed to doing exactly that. And that is in part why I returned to UnitedHealth Group as chief executive.

Our mission as a company is to help people live healthier lives and to help the health system work better for everyone -- better outcomes, better experiences, lower costs.

Achieving these goals means being candid about why healthcare costs continue to rise. The cost of healthcare insurance fundamentally reflects the cost of healthcare itself. It is more an effect than a cause. If insurance costs are going up even as we compete aggressively against other

companies, it signals rising costs of health services and drugs and rising volumes of care activity. And it is a fact, hospital and drug spending has soared at three times the rate of inflation since before 2000.

We limit these pressures as much as possible. We continue -- we use negotiations, data insight, better care coordination to moderate the cost growth, improve outcomes, and protect access. And we focus on preventative care so people get care before a condition worsens or before becoming sick at all.

Insurance is the only sector in healthcare incentivized to help keep the cost of care as low as possible while still seeking high-quality health outcomes for people and helping them avoid getting sick in the first place. And it is a virtuous circle. Generally, the healthier people are, the fewer health resources they need.

We are innovating to make high-quality healthcare easier to find, simpler to navigate, and, most importantly, more accessible and affordable. Last year alone, we negotiated nearly $300 billion in savings for our customers. Without those efforts, recent premium increases would easily have been twice as high.

Nearly 90 percent of our premiums go to direct medical care, including in Affordable Care Act plans. Our enterprise margins are around 5 percent, with Medicare, Medicaid, and ACA margins being far less than that.

Additionally, we have made notable progress in areas such as value-based care, which incentivizes better care and health outcomes and simplifies the experience, and in Medicare Advantage, which provides lower total costs than traditional Medicare with more benefits and lower overall costs to seniors, a majority of whom choose it each year.

We have introduced innovative health plans that offer people the information they need up front, enabling them to comparison-shop for care. These plans often have no deductibles and no co-insurance, and members pay, on average, more than 50-percent less in out-of-pocket costs

compared to traditional plans. And employers offering these transparent plans are also seeing lower total costs.

We are committed to extending these consumer-centric features wherever we can to consumers, give them more choice, more control, more transparency and certainty, and more value.

We are mindful of the current moment and the debates about affordability in Congress and throughout the country, and we appreciate the current bipartisan talks focused on ideas around affordability, transparency, and possible short-term tax-credit extensions.

Because we want to continue to be part of the solution with respect to ACA individual plans, we will voluntarily eliminate and rebate our profits this year for these coverages.

I know there are aspects of our products and services that are still confusing and complicated for people. We are intensely focused on setting a new standard of transparency, simplicity, and ongoing improvement as we continue taking costs out of the system and making healthcare more affordable.

In addition, we have provided policy ideas in our written testimony intended to lower premiums, address rising health costs, and better align what we pay for healthcare with the rest of the world.

We look forward to our discussions today about what more can be done to improve affordability and expand the availability of quality care.

Thank you.

[The prepared statement of Mr. Hemsley follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. The gentleman yields back.

I now recognize Mr. Joyner for his 5-minute opening.

STATEMENT OF DAVID JOYNER

Mr. Joyner. Thank you.

Chairman Griffith, Ranking Member DeGette, and members of the committee, thank you for the opportunity to share our perspective on the drivers of healthcare costs and the market and policy solutions needed to address them.

CVS Health engages with millions of Americans every day in their communities, helping families struggling with an often confusing, disconnected system and the rising cost of healthcare. What is driving this cost is understood: greater demand for care, growing medical provider cost, and persistently high prices for hospital care and prescription drugs.

Every day, we are addressing the fragmentation and the underlying cost of care. It starts by making care for Americans accessible and affordable and, most importantly, simplifying the patient experience at every point. Our 300,000 employees across the country work every day to meet this moment.

CVS Health supports the committee's goal of addressing rising medical costs, and we want to be a partner in addressing these challenges together.

We are working to ensure our members have access to the right care at the right cost. And we are expanding low-cost primary care, covering preventative care at no cost to patients, and offering free virtual care to eliminate barriers to access.

We are leading the industry in developing new solutions to lower cost, investing in technology to identify health problems before they become serious, and tailoring treatment to individual patient

needs.

Today, I will share four ways we are making care more affordable and accessible.

First, we are expanding access to coverage that rewards providers for keeping patients healthy.

Second, we are reducing administrative burden, so instead of filling out forms, doctors can spend that time caring for patients, all while driving lowered administrative cost of care.

We know denial of care is a major frustration for patients and their doctors, so we continue to reduce the number of claims subject to prior authorization. And by independent measures, we have the fewest number of services subject to it.

When we do receive an authorization request, 77 percent are approved in near real-time, and that number is growing. The medications, nearly half are approved immediately, and for others, the average approval times have decreased from 3 hours in 2024 to just 34 minutes today.

CVS Health's bundled approach now gives providers one approval covering medical procedures like repeat imaging and medications for specific conditions. For patients undergoing breast cancer treatment, that means a single authorization for the entire series of procedures.

Third, we are using competition to address rising drug costs. We are aggressively promoting the use of biosimilars. We now have the vast majority of members paying zero dollars out of pocket for the once-pricey drugs that have generated more than $1.5 billion in savings for our customers.

Fourth, we are building a modern consumer healthcare platform that we will open to all plans and providers. For patients, it is simple: open one app that allows them to own and manage their own healthcare. For our 17 million monthly active app users, we will schedule appointments, refill prescriptions, access preventative care -- all in one place -- with the goal of helping them stay healthier at lower costs. For the healthcare system, it is a shared foundation we believe will make healthcare more coordinated and affordable.

I took this role 15 months ago because I wanted to help shape the future of healthcare in this country. I am proud of the work we have done so far to simplify the healthcare experience and make healthcare more affordable and accessible for American families.

I know there is much to do. It requires health plans, providers, and employers working together. That is why we support reforms that increase transparency, competition, and innovation, particularly among hospitals and in the pharmaceutical supply chain.

We encourage policymakers to preserve flexibility for employers to offer benefits that meet their workforce needs and to avoid policies that reduce competition or add bureaucracy.

We want to work together to:

First, explore solutions that bring younger and healthier people into the risk pools.

Secondly, expand the definition of preventative care to services that keep people healthy and out of the hospital, and allow people in high-deductible plans to access these services in their pre-deductible phase.

Third, address the bad actors who are gaming the No Surprises Act. Centralizing eligibility, automating processes, and increasing oversight can help address this abuse.

Fourth, accelerate the interoperability of health records to reduce friction and help patients manage their health.

And, finally, pass the ECAPS legislation, allowing pharmacists to practice at the top of their license and receive Medicare reimbursement. This will benefit every pharmacy in this country while improving access for patients and reducing costs.

We welcome the committee's partnership in these efforts as we continue to work to make healthcare more affordable for all Americans.

Thank you, and I look forward to your questions and to the additional hearings in this series.

[The prepared statement of Mr. Joyner follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you very much.

I now recognize Ms. Boudreaux.

STATEMENT OF GAIL BOUDREAUX

Ms. Boudreaux. Thank you, Chairmen Griffith and Guthrie, Ranking Members DeGette and Pallone, and members of the committee.

I am Gail Boudreaux, president and CEO of Elevance Health. For over 80 years, we have served individuals, families, and communities.

I appreciate the opportunity to be with you today on an issue that is weighing on households across the country: healthcare affordability.

Families are frustrated by the rising cost of healthcare, and they are right to be. Rising premiums and out-of-pocket costs strain household budgets and cause people to delay care. This is personal, and for many families it is frightening.

We can all do better. Americans want solutions, and we are taking concrete steps to deliver them.

Our responsibility is to provide coverage people can afford, provide clear information in plain language about coverage and costs, and make timely decisions. That includes negotiating for fair prices that affect premiums and out-of-pocket costs.

Our role isn't just to explain costs; it is to act and make healthcare easier to navigate for patients and doctors. Every redundant step and paperwork delay adds costs and frustrations without improving care.

Prior authorizations apply to about 3 percent of our claims, and since January 1st of 2024, we have removed more than 400 services from prior-authorization requirements. For what remains,

we are expanding electronic prior authorization to reduce paperwork and speed decisions and using technology, including AI, to handle routine steps and move information faster, while clinical judgment remains in human hands.

The United States now spends more than $5 trillion a year on healthcare. Health insurance premiums are primarily shaped by medical care and drug costs and where care is delivered. When the prices charged for care rise, premiums and out-of-pocket costs rise too.

Hospital spending increased by nearly 10 percent in 2023 and again in 2024, the fastest rate in more than three decades, outpacing inflation and wage growth. Prescription-drug spending grew nearly 8 percent in 2024 and now represents a quarter of what employers spend on healthcare.

Costs also rise when the same service is billed at a much higher price in a hospital setting than in a physician office or urgent care. Fraud, improper billing, and administrative requirements also add costs that ultimately show up in premiums.

We are focused on practical solutions that lower costs and make healthcare easier to navigate. Our approach of coordinating medical and pharmacy benefits is helping employers lower medical and prescription-drug costs, saving some employers up to $212 per person per month, underscoring our whole-health approach.

We also promote preventative care so problems can be caught early. And we work with doctors and hospitals to help patients get the right care at the right time and in the right setting. For example, our concierge care oncology program has lowered chemotherapy-related hospital admissions by more than 60 percent.

We are committed to being part of the affordability solution, because when healthcare is too expensive, people delay care, employers struggle to offer coverage, and families lose peace of mind.

Keeping care within reach requires commonsense reforms that address root causes, such as hospital price growth, rising prescription-drug prices, unnecessary paperwork, and a lack of transparency. With discipline and partnership, progress is possible.

Thank you again for the opportunity to be here. I look forward to your questions and to working with you to make healthcare more affordable.

[The prepared statement of Ms. Boudreaux follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. I thank you.

We are going to hold for just a second, and I am going to make a housekeeping announcement.

We are expecting votes at 10:30. The ranking member and I will do our questions, and then we will recess until after the vote is completed. But we will start as soon as we have the ranking member and myself and a majority of the subcommittee here, we will start with questions again in order to meet our time deadlines.

That being said, I now recognize Mr. Cordani for his 5 minutes.

STATEMENT OF DAVID CORDANI

Mr. Cordani. Chairman Guthrie, Chairman Griffith, Ranking Members Pallone and DeGette, and members of the subcommittee, thank you for the opportunity to testify here today on one of the most pressing challenges facing American families and employers, which is the cost of healthcare.

My name is David Cordani, and I serve as the chairman and CEO of The Cigna Group. We are a global health service company. We serve millions of Americans through employer-sponsored coverage and union-based coverage programs, and our services are designed to improve affordability, broaden access, and make care easier to navigate.

And while I am proud of the work we do, we know there is more to be done. At a high level, there are three areas where we could further improve the U.S. healthcare system for the benefit of patients.

First, we must focus more resources on the patient earlier in the care journey, especially programs that prevent chronic disease and support long-term health.

Second, we need to better align incentives for providers and pharmaceutical manufacturers that reward based on the clinical outcomes, not just the volume of services that are consumed.

And, third, we must further leverage competition in America where it has proven to lower costs and improve care for the benefit of patients.

I joined Cigna more than 30 years ago, and during that time I have seen amazing advancements in medical care. Over that time, I have also seen medical costs continue to rise at multiples of inflation. And, as discussed, many Americans feel that pressure every day at the kitchen table or at the coffee table, which is why this discussion is so important.

The U.S. healthcare system does generally provide quick access to high-quality care. But we know access is only meaningful if it is affordable. The system requires health plans, hospitals, drug

manufacturers, physicians, and policymakers to work together, with the patient at the center.

At Cigna, we are focused on expanding access to preventative care, coordinating services around patient needs, and increasing transparency so people better understand how their healthcare costs are being spent.

But, today, our system overwhelmingly pays for care after people become sick. Prevention and sustained engagement are more the exception than the rule.

We do know a better approach works. For people living with chronic conditions, we have redesigned coverage and care models supporting prevention and treatment adherence. This means eliminating or lowering out-of-pocket costs for lifesaving medications; it means coordinating medical, pharmacy, and behavioral care for the whole person; and it means giving patients the support they need to stay healthy and avoid costly complications.

But expanding these solutions requires us to confront the underlying cost drivers as well. For example, since 2000, the cost of a hospital stay has increased 220 percent in America. In 2024, the median launch price of a new pharmaceutical was $370,000. That is up from $2,000 less than 20 years ago, or a 12,000-percent increase. These prices put many treatments out of reach for individuals or employers, especially when competition is delayed or blocked.

We also need to recognize there are broader forces at work here as well. Our population is aging, and more Americans are living with chronic conditions. That increases costs across the entire system and drives premiums up, just as increasing fuel prices might drive up costs across the economy more broadly.

At Cigna, we work tirelessly to counterweight these pressures. Our ability to drive competition, for example, amongst generic drugs has led to some of the lowest generic drug pricing in the world. And where we can effectively harness competition with brand drugs, we are driving meaningful savings for patients. For example, we have been able to cap the cost of insulin at $25. We have biosimilars available to many patients at zero dollars out of pocket. And we are further

modernizing prescription benefits to deliver lower costs at the pharmacy counter through greater transparency.

This focus on solutions matters most for people when they are at their most vulnerable. For example, a cancer diagnosis is devastating for both the patient and the family member. We build care models that eliminate out-of-pocket costs and connect patients quickly with top specialists, supported by focusing, again, on outcomes, not volume. Our goal here is simple: Get the right care at the right time without adding financial stress.

We do recognize that no single company or sector could solve this alone. That is why we at Cigna stand ready to work with Congress, this committee, and the administration more broadly, and partners within the healthcare sector to further prioritize focusing on prevention; rewarding based on value, not volume; and leveraging competition to further lower costs for the benefit of Americans.

I look forward to your questions today. Thank you.

[The prepared statement of Mr. Cordani follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you.

I now recognize Mr. Markovich for his 5-minute opening.

STATEMENT OF PAUL MARKOVICH

Mr. Markovich. Thank you.

Dear Chairmen Guthrie and Griffith, Ranking Members Pallone and DeGette, members of the committee, thank you very much for the opportunity to testify before you today.

My name is Paul Markovich. I am president and CEO of Ascendiun, a nonprofit and the parent organization of Blue Shield of California.

Our healthcare system is bankrupting and failing us. It is way too expensive, it is too impersonal, it doesn't cover everybody, it has inferior quality scores relative to other countries, and it is mistrusted by far too many Americans. This is unacceptable.

We all are mortal, and therefore we are all going to need the healthcare system. When our loved ones need to access it, we want them to be able to afford it and they get treated the way they deserve to be. Our nonprofit organization describes this as a healthcare system that is worthy of our family and friends and sustainably affordable for everyone -- or, simply, worthy of us.

We are a long way from that ambition right now, because there are too many times when the participants in the healthcare system -- health plans, hospitals, physicians, pharmaceutical companies, and others -- put profits ahead of patients and are complacent about how complex, inconvenient, and inefficient our current system is. This leaves consumers, employers, and the government financially stressed and frustrated with the impersonal and inconsistent service that they receive.

The good news is, we can fix this -- if we have the collective courage and conviction to do so.

It starts by recognizing that we must fundamentally change this flawed system and we must all take accountability for doing so. We don't need more explanations as to why healthcare costs so much or more attempts to blame others for the problems. We need to enact bold reforms as soon as possible that force everyone in the healthcare system to improve the health of Americans more efficiently.

Specifically, there are four things we need to do:

First, ensure every American has access to a comprehensive, real-time digital health record that can be used to personalize their healthcare and take a lot of administrative cost out of the system.

Second, break the "do more, get paid more" fee-for-service model and, instead, start paying for outcomes.

Third, make prescription drugs accessible and affordable by eliminating kickbacks in the form of rebates, fees, and spread pricing.

And, finally, we need to put the entire healthcare system on a budget. We need your help to make this a reality. While it is possible for the healthcare industry to adopt changes on its own, based on my experience, including 13 years as a CEO who has been trying to pursue change, I have come to the conclusion that the system will not fix itself. The healthcare system needs some tough love and clear direction, and the American Government is in the best position to provide both.

I am proud of the many things that nonprofit Blue Shield of California has done to try and address this healthcare crisis. For example, to my knowledge, we are the only major health plan in the country to have voluntarily pledged to cap our profit at 2 percent of revenue and have given back more than $800 million to our customers in the community as a result; actively supported legislation for the Federal Government to negotiate directly with pharmaceutical companies; moved to a new pharmacy distribution model that does not rely on a pharmacy benefit manager; and supported a statewide Office of Health Care Affordability in California, which has put the California industry on a

budget and has the authority to enforce it.

But, in the spirit of accountability, we have not done enough fast enough. The average cost of a family health insurance policy is now more than $27,000, or the cost of a new car, every year. I and we are a part of the problem, with the unaffordable, highly flawed healthcare system we have today. But I am committed to doing our part to fix it.

We have an affordability crisis. Our healthcare system is broken, but we are not. On behalf of Blue Shield of California, I am ready to work together to create a healthcare system that is truly worthy of us.

Thank you.

[The prepared statement of Mr. Markovich follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you.

Ms. Allen, you are now recognized for 5 minutes.

STATEMENT OF ELLEN ALLEN

Ms. Allen. Chairs Guthrie and Griffith, Ranking Members Pallone and DeGette, and members of the committee, thank you for the opportunity to testify on the importance of the Affordable Care Act and the essential premium tax credits that make health insurance accessible and affordable for more Americans.

My name is Ellen Allen. I am from Pinch, West Virginia. I am a daughter of Appalachia who has formally worked since I was 15 and informally since I was 12 years old. I mowed the lawns of many of my neighbors and picked up discarded glass bottles, soda bottles mostly, took them to the local grocer, and leveraged those for a soda pop and a Moon Pie.

While I wasn't born into great wealth, I did enjoy the privilege of growing up in a middle-class, working family in southern West Virginia. I ate well, I was dutiful to my annual physicals, and I took good care of myself. Still do so today.

One of the privileges I have enjoyed throughout my life is access to high-quality, affordable health insurance. I am 64 years old, and I have essentially never lived a day without health insurance. Until the last 3 years, I always had employer-sponsored health coverage.

I changed jobs in 2023. The small organization that I work for today can't afford the $50,000 for the annual premium to cover two of its employees -- two employees. I enrolled in the ACA in August of 2023 and remain enrolled today.

Last month, I did what millions of Americans and tens of thousands of West Virginians did; I went online to re-enroll in my health insurance through healthcare.gov, the ACA marketplace.

When I saw my new premium, I felt a pit in my stomach. While I was expecting to see an increase, it was a punch in the gut to see my premium had jumped 323 percent.

In 2025, I paid just under $500 per month, nearly $6,000 a year, for a bronze plan that included vision and dental. I liked this healthcare plan, and it was somewhat affordable even though I had a high deductible and $9,200 maximum out-of-pocket costs.

In 2026, with the expiration of the enhanced premium tax credits, my monthly premium is now just under $2,000. And that is without vision or dental. I simply couldn't afford it. I was forced to drop that. And my maximum amount out of pocket now is $9,900 for this year, almost $10,000.

Despite taking good care of myself, eating well, maintaining an active lifestyle, I have developed conditions that can be managed with medications and sometimes a more invasive procedure. But this means I am likely to hit my maximum out-of-pocket expenses.

So far, for the first 8 months of this year -- I will be eligible for Medicare in September -- it will cost me almost $16,000 in premiums only. Then add 40 percent of coinsurance I am responsible for, and I am likely to face over $25,000 in healthcare-related costs for me alone. And that is just the first 8 months of 2026.

This is a lot to ask of a hardworking American who has worked every day of her adult and teen life.

For the last few years, millions of Americans, including 67,000 West Virginians, have been able to afford marketplace coverage thanks to the enhanced premium tax credits. They kept people insured. They kept small-business owners covered. They kept families healthy. The tax credits helped reduce West Virginians' uninsured rate from approximately 20 percent to below 6 percent. I think that that is an extraordinary achievement in healthcare.

West Virginians know what it means to work hard and play fair. We expect fairness. We expect fairness. And, right now, there is nothing fair about a system that makes us choose between

saving for retirement or dipping into our savings to pay for a procedure that is life-preserving; or, as several people I know are doing, they are dropping their health insurance altogether and rolling the dice.

In conclusion, I just want to emphasize, this is fixable. Congress could act now to restore and make permanent the ACA's expanded premium tax credits. Doing so would save lives, protect families, and strengthen our economy.

I urge this body to consider a 3-year extension of the credits, and, during that time, please work on bipartisan ways that truly make healthcare more accessible and affordable for every American in every stage of our lives.

The expiration of the EPTCs is not an economic inevitability; it is a political choice.

Healthcare is not a luxury; it is a necessity. The ability to access and afford coverage should never depend on how much money you make, where you work, or who you voted for.

In conclusion, again, when lawmakers choose to cut taxes for the wealthy instead of keeping healthcare affordable for working families, they are choosing who wins and who loses. And it is clear that people like me and my fellow West Virginians are being asked to lose. The policy decision sacrifices our healthcare.

It is time for our leaders to put people before profits, families before corporations, and patients before politics. Because when we say healthcare is a human right, it is time we act like it.

Thank you again for the opportunity, and I look forward to your questions.

[The prepared statement of Ms. Allen follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Thank you, Ms. Allen.

We now begin questioning.

I ask that members not begin a new question to our witnesses as their 5 minutes expire and would encourage members to submit written questions for the record.

I now recognize myself for 5 minutes.

Ms. Allen, it is great to have you here today. You brought up fond memories. I, too, grew up in and am a son of Appalachia. I grew up in Virginia, on the other side of the line, and used to collect bottles at the waysides between Christiansburg and Salem, where I grew up.

All right. Panel, as a whole, I believe competition lowers costs. Do any of you disagree with me that taking away the ban on physician-owned hospitals would increase competition in some provider markets? And if you do disagree, please raise your hand.

Seeing none. I appreciate that.

Well, then the question becomes, do you think there should be more insurance competition, or more competition in the insurance market, particularly in light of the fact that many of your companies own huge swaths of healthcare, including pharmacies and mail pharmacies and PBMs?

Mr. Hemsley, got any thoughts on that?

Ms. DeGette. Please turn your mic on.

Mr. Griffith. Yeah, turn your mic on.

Mr. Hemsley. I apologize. Thank you.

While we think it is already a very competitive market, we are always open to competition.

Mr. Griffith. Yeah. The problem I have is -- you maybe heard in my opening -- is that we have issues in my district where we, in the ACA marketplace, only have one provider. So, you know, there is not as much competition.

Now, I will now ask -- and, Mr. Hemsley, you might want to listen as well, but I am going to

ask Mr. Cordani -- I am aware of the issues that you all have had when negotiating rates in my district in Virginia and in east Tennessee.

How do you reimburse larger systems versus smaller systems in these poor or underserved or rural areas?

Mr. Cordani. Mr. Chairman, when you say larger versus smaller "systems," hospital systems?

Mr. Griffith. Well, yeah. Exactly.

Mr. Cordani. Each hospital system negotiation is unique, so each hospital system has its own contractual relationship, and we try to get to the best balance of affordability and access.

We typically serve the employers in your home State, so we get the network or the access to the hospitals and the reimbursements to align. It is not higher reimbursement for larger and lower reimbursement for smaller. They are unique to each provider.

Mr. Griffith. So, when you have only one provider, particularly in the ACA marketplace, how does that impact the leverage that you have when negotiating with hospitals?

Mr. Cordani. In the broader sense, if I understand your question, more choice equals improved affordability, more competition equals improved affordability. So there is a consistent theme in any aspect of our business --

Mr. Griffith. And we have a unique situation in east Tennessee, Mrs. Harshbarger's district, and mine, where, because the hospitals were all at threat, both States and the Federal Government allowed Ballad Health to have a monopoly. I think it is the only way we could have saved our hospitals, but how does that impact your ability to negotiate with them?

Mr. Cordani. In general, the phenomenon you describe, Mr. Chairman, causes prices to go up on an accelerated basis. So less choice means more price inflation, whether it is through consolidation of hospitals or otherwise.

Mr. Griffith. All right.

Mr. Hemsley, the reason I asked you to pay attention is that we have a limited number of healthcare access in the region, and, recently, your subsidiary, Optum, bought the HMG, or the Holston Medical Group, which is one of the largest -- it is the largest provider in east Tennessee and provides in southwest Virginia as well. How does that impact the ability to have competition in the marketplace?

Mr. Hemsley. Well, Mr. Chairman, the motivation for that is to drive a value-based care system that has been described by me and others on the panel to actually get better care, more continuous care, and a better value to individuals.

So it really plays into an effort to make sure that there is good resources available, that value-based care can operate and optimize the experience for individuals.

Mr. Griffith. All right.

Mr. Hemsley. And physicians get paid very effectively under value-based care arrangements.

Mr. Griffith. All right. And I hate to move everybody along, but we are running out of time.

Again, Mr. Hemsley, based on your company's experience, did the Biden administration loosen enrollment validation requirements on the enhanced, temporary, COVID premium tax increases to such an extent that it led to widespread waste in the Federal ACA program, yes or no?

I am specifically talking about the shadow enrollees --

Mr. Hemsley. Oh.

Mr. Griffith. -- that you all don't even know who they are.

Mr. Hemsley. We do believe that there should be real oversight in terms of the ACA marketplace and all marketplace to --

Mr. Griffith. But the loosening up of the validation requirements led to this dilemma, did it not? "Yes" or "no," because I only have 9 seconds.

Mr. Hemsley. We believe there should be --

Mr. Griffith. So that is a "yes"?

Mr. Hemsley. -- discipline and oversight.

Mr. Griffith. You believe that led to an increased number of people who were being insured that aren't actually insured.

Mr. Hemsley. We believe there should be more --

Mr. Griffith. All right. I have to yield back and recognize the gentlelady from Colorado, Ms. DeGette, for her 5 minutes.

Ms. DeGette. Thank you, Mr. Chairman.

I want to talk a little bit about what it was like before the Affordable Care Act was implemented.

Before the ACA, 14.5 percent of Americans were uninsured. After the ACA, it was 8.6 percent. Because of insurance costs, it crept up a little bit, but then after the tax credits were implemented, it dropped back down to 8.2 percent.

Mr. Cordani, your company offers both ACA plans and administers employer-based health coverage, correct?

Mr. Cordani. That is correct.

Ms. DeGette. Now, prior to the ACA, private health insurance plans were not required to provide coverage for preexisting conditions like cancer or diabetes. Is that correct?

Mr. Cordani. We -- Madam Chair, we participate in the larger employer market --

Ms. DeGette. No, no. Before that -- before the ACA, the plans did not -- were not required to cover these things, preexisting conditions, right?

Mr. Cordani. In the small employer marketplace, correct. In the --

Ms. DeGette. Okay.

Mr. Cordani. -- large employer marketplace --

Ms. DeGette. Now --

Mr. Cordani. -- they were covered.

Ms. DeGette. -- even in employer-based insurance, there could be restrictions like waiting periods on coverage of preexisting conditions before the ACA. Is that correct?

Mr. Cordani. Congresswoman, in the small employer market --

Ms. DeGette. Correct.

Mr. Cordani. -- yes.

Ms. DeGette. And plans were permitted to have lifetime benefit limits, where if you became too expensive as a patient, they could throw you off the insurance. Is that right?

Mr. Cordani. Yes, it is.

Ms. DeGette. Okay.

Now, people might have had to pay also for preventative services to keep them healthy before the ACA had the essential benefits included. Is that correct?

Mr. Cordani. Again, in the small employer market; not in the large employer market.

Ms. DeGette. Okay.

Now, today, are your plans in the ACA marketplace or employer plans in large or small markets permitted to engage in any of these practices?

Mr. Cordani. Congresswoman, we cover approximately 1 percent --

Ms. DeGette. No, no. Are --

Mr. Cordani. -- of the ACA, and, no, they are not.

Ms. DeGette. I know what --

Mr. Cordani. No, they are not.

Ms. DeGette. I know what you do. Are people in the large or small markets permitted to say, "No, you have a preexisting condition; I am not going to cover you"? There are certain requirements in the ACA that everybody has to follow now so that everybody can have insurance.

Is that right?

Mr. Cordani. That is correct.

Ms. DeGette. Okay.

Mr. Cordani. The practices in the large employer market are now --

Ms. DeGette. I get you.

Mr. Cordani. -- in the small employer market.

Ms. DeGette. Now, the ACA has succeeded in many ways, but, clearly -- and we can agree on this on both sides of the aisle -- system-wide work is needed to bring down costs for everybody -- people on exchanges, people with employer-based insurance, people with Medicare, and more.

Enhanced premium assistance built upon what the ACA got right. Capping the cost of premiums in the individual marketplaces contributed to over 24 million people purchasing insurance on the exchanges last year, including Ms. Allen.

So, Mr. Markovich, I want to ask you: ACA premium support is calculated based on some of the lowest premiums in the market. Is that correct?

Mr. Markovich. Yes.

Ms. DeGette. Now, if one plan is more expensive, subsidies don't just automatically increase. Is that right?

Mr. Markovich. That is correct.

Ms. DeGette. Okay. And that means that plans have to compete on price, not just sit back and let the subsidies roll in. Is that right?

Mr. Markovich. Yes.

Ms. DeGette. Now, some of my colleagues have said this assistance to middle-class Americans is a handout to insurers.

Mr. Joyner, we had enhanced premium subsidies in place in 2024. Is that right?

Mr. Joyner. Correct.

Ms. DeGette. Now, at that same year, the health benefit segment of your business took a $984-million operating loss. Is that right?

Mr. Joyner. Correct.

Ms. DeGette. And so, I would say, if premium support is a handout, it is surely not a very good one. What premium support is, though, is help to the middle -- is help to help the middle class afford healthcare.

So I want to ask you, Ms. Allen, when people can't afford insurance, do you think it is worse for the person going without healthcare or worse for the insurance industry?

Ms. Allen. It is -- it can be catastrophic for the individual going without insurance or delaying the help they need.

Ms. DeGette. So I have 45 seconds left. Some of you know about my daughter Francesca. She is a Type 1 diabetic. And last summer -- and she is a young lawyer -- she had a job through her employer.

And she called me -- I was listening to you, Mr. Cordani, talk about the insulin prices.

But she called me up, and she said, "Mom, can I put my $1,500 quarterly diabetes equipment payment on your credit card? Because I am just having a little cash-flow problem this month." And I said, "$1,500 quarterly?" She had a $6,000 deductible on her insurance.

So we have to fix that. You have to fix that. And you all have to be -- are patients (ph) in fixing that. Because that ain't going to work for Francesca, and that is sure not going to work for Ms. Allen or anybody else.

I yield back.

Mr. Griffith. The gentlelady yields back.

By agreement, we are going to get one more set of questions in. I now recognize the Chairman of the full committee from Kentucky, Mr. Guthrie.

The Chair. Thank you, Mr. Chairman.

Thank everybody for being here today.

And I want to start with: Experts, including the Congressional Budget Office, estimated that the expiration of the temporary Obamacare enhanced COVID credit is projected to increase premiums by anywhere from 4 and 8 percent, depending on the market. Yet, in many areas, for 2026, insurers requested and were approved for premium increases of 30, 40, even 50 percent.

So, Ms. Boudreaux, you are in Kentucky. So the average Elevance Obamacare plan increased its premium by roughly 24 percent. Despite what Democrats would have the American people believe, the temporary COVID credit does little to actually lower underlying Obamacare premiums, and the American taxpayers are footing the bill.

So, Ms. Boudreaux, by your best estimation, even if the Democrats' temporary COVID credits were extended, would Obamacare plan bids in my State of Kentucky increase or decrease between 2026 and 2025?

Ms. Boudreaux. Well, thank you very much for the question, Congressman.

You know, as we shared, premiums reflect the underlying costs --

The Chair. So they would have increased, right? I only have 5 minutes, I am sorry. So they would have increased regardless of the extended credits, correct?

Ms. Boudreaux. The credits will give consumers --

The Chair. But they still increased.

Ms. Boudreaux. -- a break, but the overall costs are still driven by underlying root causes --

The Chair. Well, let's talk about the overall costs.

So I want to -- Obamacare costs are skyrocketing, and the American people are holding the bag. But, unfortunately, because the incentives have been so warped by the Democrats' policies, these affordability challenges are not just happening in Obamacare but across all of the healthcare markets.

And so, I want to focus on a particular incentive. And I would like to quickly go through a few questions for each of the CEOs, and I really need a quick yes-or-no answer.

Does the medical loss ratio, or MLR, put in place by the Obamacare -- does it cap the dollars that you can maintain at a percentage of the total amount of the premium payments your companies receive? Does the MLR cap what you can maintain based on the premium?

Is that a "yes" for everyone? It does.

Is it true that if the amount of your premiums go up, then the amount of dollars you can maintain, including profits, would actually increase? Yes or no?

Yes, it would go up.

Mr. Markovich. Yes.

The Chair. So, as premiums increase, wouldn't your companies' input costs, like hospital reimbursements, provider payments, and drug costs, increase?

So, the MLR policy also requires you to spend a set percentage of premiums on medical services. So, under the requirements of the MLR policy, the less that your companies contain the costs of healthcare, then the more your premiums increase, and that results in increasing your total profit potential.

So, then, the Obamacare MLR policy -- effectively, it is an incentive for your premiums to be higher, because you are penalized when you try to curtail health costs. Is that true, yes or no?

Mr. Markovich. No.

The Chair. Let's start with -- yeah, Mr. Hemsley? And we will go down.

Mr. Hemsley. This is a very competitive marketplace. We compete based upon price and premiums. So it is very competitive. And premiums really reflect the actual cost of healthcare services. So --

The Chair. So, again, I know I have got brief time, so we can let each one answer, please. I am sorry.

Mr. Hemsley. Yeah.

The Chair. Mr. Joyner?

Mr. Joyner. In our specific example, Congressman, we did not perform well in the exchange last year, so costs actually exceeded the premiums we collected. So, regardless of the MLR, we underperformed and actually gave back money to the government.

The Chair. Okay.

So, Ms. Boudreaux?

Ms. Boudreaux. The MLR -- we are in a highly regulated environment. We have to -- as you know, at least 80 percent of premiums, the majority go to medical costs. Our loss ratio in 2024 was 88.5 percent, and in 2025 we did not make money in the individual exchange.

The Chair. Mr. Cordani as well?

Mr. Cordani. Mr. Chairman, we lost money in the exchange all but 2 years since 2014. So that phenomenon has not affected us favorably.

The Chair. Mr. Markovich?

Mr. Markovich. We have capped our profit at 2 percent for the last 15 years, so this doesn't matter.

The Chair. So, when you get the -- you have an insurance business and you get limited on what you can recover, then it encourages you to vertically integrate so you can make profits other places. So, if the costs are reflective of your premiums, then if you can capture those costs that you are paying out, then it gives you the opportunity.

So, Mr. Hemsley, UnitedHealth Group has pursued aggressive vertical integration since the passage of Obamacare. And you have the largest health insurance plan, one of the largest PBMs, and one of the largest employer providers -- employer of providers, and there is not a sector in which you don't have a presence.

So, if competition helps healthcare, how do you explain the vertical integration? Does that

encourage competition and cheaper? How do you explain the vertical integration and competition?

Mr. Hemsley. It really is a very substantial value dynamic in terms of bringing a better care experience and more value to the healthcare environment in total, by better coordination of care across those spectrums, by better use of data, by more engagement in critical areas in healthcare, including how drugs are made available and integrated into therapies --

The Chair. Thanks. My time has expired, so I apologize.

And I will yield back to the chair.

Mr. Griffith. I thank the gentleman for yielding back.

I now will declare the committee in recess. We will begin as soon as we get a relative number back. And Ranking Member Pallone will be up in the queue. He is up in the batting order when we get back.

Thank you.

[Recess.]

RPTR HNATT

EDTR ROSEN

[11:26 a.m.]

Mr. Griffith. All right. I am going to call the subcommittee to order. We are back in session. And I now recognize the ranking member of the full committee, Mr. Pallone, for his 5 minutes of questioning.

And I am taking a minute or two so we get a couple more Members in here before he finishes. All right. Mr. Pallone, you are recognized.

Mr. Pallone. Thank you, Mr. Chairman. I wanted to turn to Ms. Allen. Just last week, President Trump put out his so-called Great American Healthcare Plan where he says we shouldn't fund ACA enhanced premium tax credits, and we should just give cash to people to put in tax-exempt health savings accounts.

So, Ms. Allen, your testimony speaks to the more than $25,000 in out-of-pocket healthcare costs you are facing this year, and that is even with becoming Medicare eligible in September.

In the face of losing the ACA enhanced premium tax credits, would having access to a health savings account put a dent in your healthcare costs? Let's even say that the health savings account was preloaded with a couple of thousand dollars, which seems to be what the President is talking about. How does that compare to the reality of the healthcare costs that you are facing?

Ms. Allen. Thank you for the question. You know, frankly, that is insulting. A $2,000 deposit into a health savings account for someone whose premium is $2,000 a month does not go a long way, so it wouldn't be very helpful at all.

Mr. Pallone. My point is that the President, and I think the Republicans are now facing the reality, they have these ideas, you know, which they even -- some of them past on the floor a couple weeks ago, the President talks about it, but they are not really addressing the root causes of rising healthcare. And the only people that I know who, you know, you know, talk about this, you know,

willing to do a high deductible, we hear like could be $7,000, $8,000 a year, and then, you know, you get a couple of thousand in a health savings account, are people that are wealthy, because you can't -- it seems to me you can't, you know, put money into -- first of all, you can't even put money into a health savings account unless you have some excess money to spare, right? And so this idea of, you know, highlighting a health savings account as an answer, it just isn't -- it only benefits the wealthy, in my opinion, because the majority of Americans can't afford, you know, their medical bills, much less pre-fund a tax advantage account for thousands of dollars. It doesn't do anything for them. And I really think that if you want to address the affordability crisis now, the only answer is extending the ACA enhanced premium tax credits.

But let me go back to, I don't know if we have time for everyone, but I wanted to ask some of the CEOs, I will start, I guess, with Mr. Markovich, to the companies who provide coverage on the ACA marketplace and ask for the plans you offer, what are you -- what are people telling you about the coverage? What are you hearing from them? I will start with you, Mr. Markovich.

Mr. Markovich. Well, what we are seeing is that for certain people in certain categories, their premiums are going up quite substantially as a result of the expiration of the tax credits.

I was speaking to a member in California last week, he is 61 years old, he is a proprietor of a small business, he has been a 10-year member under the ACA covering himself, his wife and his two daughters, and his premiums were going to go from $1,600 a month to almost $5,000 a month. He simply couldn't afford it, and he ultimately ended up putting his wife and two daughters on a bronze plan, a much less rich plan, and he is literally going uncovered and just trying to hang on until he is eligible for Medicare. So for people in that category, higher income, 400 percent of poverty level, and that age bracket, it has been some significant increases.

Mr. Pallone. And the same thing is happening in my home State, right? In other words, you have people whose premiums have doubled, tripled, because of the Republicans' inaction on the premium tax credits. And the problem is if you go from silver to bronze, you know, you often have

less coverage, or you have a higher deductible, or higher copays.

And, you know, I just -- when the Republicans say, Oh, that is okay, it just doesn't work for the average person. And the idea of having these health savings accounts to make up the difference is completely out of reach for people who are middle income. That is my experience.

I know I can't go down the whole list here. My time has run out. Thank you, Mr. Chairman.

Mr. Griffith. The gentleman yields back. I now recognize the gentlelady, vice-chair of the subcommittee, Mrs. Harshbarger from east Tennessee.

Mrs. Harshbarger. Thank you, Mr. Chairman. And thank you to the witnesses for being here today.

Today, we are here because American families are being crushed by healthcare costs. And the failures of Obamacare and insurance companies sit at the very center of that system.

Premiums are up, deductibles are up, choice is down, and, meanwhile, the insurance profits, consolidation and executive compensation continue to rise.

This is not a failure of doctors or patients. It is a failure of a system that rewards bureaucracy over care, opacity over transparency, and market power over competition.

So first I want to touch on the issue of consolidation and vertical integration. And as a pharmacist, both in my practice and from healthcare providers across the country that contact me, there is a real concern when a single corporation controls coverage, pricing, dispensing, and care decisions, when that level of vertical integration exists, competition erodes, and patients end up paying more. That is just the bottom line.

There is a chart to the right of me, and what we see, this is what it looks like in real practice, the same corporate family decides what is covered; they set the drug prices, and the rebates through its PBM; it controls the pharmacy counter; it owns the doctors, and the clinics, and they make referrals; and it increasingly controls the data and analytics that drive the utilization decisions, ladies

and gentlemen. That is not competition. That is control. And that isn't just participating in the market. It is writing the rules of the market.

So we are going to start with some questions. First, Mr. Hemsley, and then I will go to Mr. Joyner. What prevents your companies from steering patients to their own pharmacies and clinics, prioritizing your own PBMs, or designing benefit structures that disadvantage competitors? And if your answer is simply going to be existing law or existing regulations, you need to pinpoint specific guardrails that affirmatively stop those practices. Mr. Hemsley.

Mr. Hemsley. Well, thank you, Representative, for the --

Mrs. Harshbarger. And I have got a short amount of time, so you need to be quick, sir.

Mr. Hemsley. I think there are a number of factors. The objective here is to actually provide a better value and a better experience to the consumer, and there are many regulations and business practices that ensure that --

Mrs. Harshbarger. Okay. Well, you can submit that in writing to me, your answer, sir.

Mr. Griffith. And if you could pull the mic a little closer. Pull the mic a little closer to your mouth so we can hear you.

Mrs. Harshbarger. Mr. Joyner, same question.

Mr. Joyner. At this point, we see the combination of businesses that we are in is helping solve and/or address the challenges in healthcare. I mean, I think people would suggest that technology doesn't work, there is a fragmented and disjointed experience, so by putting these businesses together, we believe we are solving for, you know, one, the fragmentation --

Mrs. Harshbarger. If you are in a rural healthcare setting like my district, or Representative Morgan Griffith's district, listen, you have independent pharmacies who are under water. They can't get reimbursed properly. They lose money on every prescription. You have physician practices that cannot get it together. They go bankrupt because of the vertical integration within these entities. So you can also submit in writing your answer to that, sir. Yeah.

Mr. Hemsley, you know, I am used to following the money, especially when patients are told something is about affordability. And AARP presents itself as an independent nonprofit speaking for seniors, but its own financial filings show that UnitedHealth paid AARP over $9 billion in a single deal, far more than AARP brings in from membership dues, and more than four times its annual operating revenue.

They also earned royalties tied directly to insurance premiums, meaning, more seniors pay, the more they pay, the more AARP makes. Yet that same organization lobbies Congress on affordability, and pushes policies that benefit large insurers like yours.

So before we accept AARP as an independent voice for seniors, we need some straight answers about who this relationship is really serving.

So I have two questions: Why does UnitedHealth pay AARP roughly $9 billion, and what does UnitedHealth get in return, and what percentage of AARP's total revenue comes from UnitedHealth today?

Mr. Hemsley. Thank you for the question, Representative. We have had a long-standing relationship with AARP, more than 20 years, and we serve their Members --

Mrs. Harshbarger. Well, you are not answering my question, sir.

Mr. Hemsley. Well, and we extended that for an indefinite time.

Mrs. Harshbarger. Well, I am out of time, so you can submit your answer in writing. Thank you, sir, and I yield back.

Mr. Griffith. Thank you very much. The gentlelady yields back. I now recognize the gentleman from California, Dr. Ruiz.

Mr. Ruiz. Thank you very much. I am an emergency medicine physician, I work in the emergency department and have treated many patients, and also many uninsured patients.

I just want to cut to the chase and get to the effects of a growing population that are uninsured on to the healthcare system.

Ms. Boudreaux, you said in your testimony that hospital pricing is a part of increasing costs. Mr. Markovich, what does a growing population in the millions of uninsured patients do to a hospital for uncompensated care.

Mr. Markovich. Well, the dynamic is that people then -- by law, hospitals have to accept patients that come to the emergency room irrespective of whether they have insurance or not. And then typically what happens is they don't get reimbursed, or they get reimbursed very little for that care, and then they are generally increasing, or looking to find that revenue from other sources. And so it has --

Mr. Ruiz. What sources do they --

Mr. Markovich. They come back to the plans and negotiate higher reimbursement.

Mr. Ruiz. So they negotiate higher reimbursements from the plan, and what does the plan then do in preparation for that?

Mr. Markovich. Well, I mean, we do our best to keep the rates as low as --

Mr. Ruiz. You do your best, but --

Mr. Markovich. But, I mean, there are just many circumstances in which in order to serve a population, to provide access, you have to have these hospitals in the network and you end up raising your prices.

Mr. Ruiz. So in other words, you raise the prices for premiums is what you just said.

Mr. Markovich. Yes.

Mr. Ruiz. And what happens to the individual who is uninsured? They no longer seek care, they can't afford the care, what happens to them and their health outcomes?

Mr. Markovich. There has been studies on this. Their life expectancy tends to be lower. They tend to delay healthcare.

Mr. Ruiz. So they die early, you are saying.

Mr. Markovich. They die earlier, and they generally aren't in as good of health.

Mr. Ruiz. So they are sicker. And when they get sick, where do they go? Do they see a primary care doctor, or where is their safety net. Do they go -- the uninsured.

Mr. Markovich. Excuse me, Congressman. They go to the emergency room.

Mr. Ruiz. They go to the emergency department. The emergency department is one of the higher costs, places to get care, or is it lower costs to get care?

Mr. Markovich. Higher.

Mr. Ruiz. Higher costs. So they go to the hospital, higher costs, they are sicker, the hospital gets uncompensated care, they are negotiating higher prices so they can keep their doors open, and so you are increasing premiums. Okay.

Now, I just want to make this point clear because the Republicans just passed the big ugly law, right, that cuts Medicaid up to $1 trillion that is going to leave 15 million people uninsured. But they said, No, it is not going to affect anybody. We are only going to try to get, try to get those that are scamming the system by creating overburdened administrative requirements. But we have argued all along that doing that is going to raise costs for everybody. And we just made the link that the uninsured population becomes uncompensated care, strains hospitals, they have to keep their doors open, they are going to put pressure on all of you during negotiations, and you will increase premiums. Do you agree, Cordani? Mr. Cordon?

Mr. Cordani. Congressman, the phenomenon you described is correct.

Mr. Ruiz. Do you agree, Ms. Boudreaux?

Ms. Boudreaux. The phenomenon that you described is important, but I think --

Mr. Ruiz. Do you agree, Mr. Joyner?

Mr. Joyner. I agree.

Mr. Ruiz. Do you agree, Mr. Hemsley?

Mr. Hemsley. I agree.

Mr. Ruiz. Every single health insurance people here is stating that because of the 15 million

uncompensated care produced by the Republican big ugly law, that everybody else's premium is going up, and this uncompensated care is going to cost hospitals $400 billion. Okay.

In addition to that, this big ugly law reduced revenues to hospitals by over $600 billion. So costs are going up by $450 billion, and the revenue has gone down by $600 -- over more than $600 billion. It is about a net loss of over a trillion dollars for just hospitals alone, in addition to the nearly $1 trillion cuts to Medicaid.

The big issue here is the healthcare crisis that Republicans have created that is in -- cut Medicaid in order to give billions in tax cuts to billionaires, and it is raising premiums across the board for all of those who have your insurance. And I yield back.

Mr. Griffith. The gentleman yields back. I now recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing. It is a very critical hearing.

Insurance companies play a significant role in our healthcare system, as everyone knows, and it is our duty as lawmakers to ensure that our families and constituents can access the care they need.

I often hear from constituents who experience delays or denials for specialty drugs for conditions like hemophilia, rheumatoid arthritis, or cancer. Patients cannot deal with burdensome processes to re-up their medications, especially when missing a dose could be life threatening, or they cannot afford to pay thousands of dollars out-of-pocket.

So first question is for Mr. Hemsley. How can we fix this broken system where patients often feel like they either pay out-of-pocket, if they can, or jump through hoops to access medication? Mr. Hemsley, please.

Mr. Hemsley. Well, thank you for the question. I think it is a very thoughtful question. I think that we should be advancing, there are protections in the market that when people change

their planned coverage, that there should be continuation of care.

In the prior authorization, disciplines in the space can also be strengthened and improved and made in a real-time basis so that there isn't delay in care.

Mr. Bilirakis. Okay. A follow-up here, from the perspective of an insurance plan, would you rather, again, for Mr. Hemsley, would you rather spend a dollar to pay for a patient's prescription that may prevent an adverse health event, or would you rather spend it on paying a hospital bill after an adverse health event takes place?

MR. Hemsley. A very well-framed question. Thank you, Representative. We are very much oriented to preventative care and proactive care and avoidance of more serious and acute experiences in higher-cost settings.

Mr. Bilirakis. Okay. So the answer is you would rather --

Mr. Hemsley. Preventative care.

Mr. Bilirakis. -- pay the prescription as opposed to having somebody -- I mean, quality of life is so important, too. I mean, you can't put a price on a person's life, that is for sure.

Mr. Hemsley. Absolutely.

Mr. Bilirakis. So as co-chair of the Congressional Rare Disease Caucus, I spent years promoting policies that help bring innovative cures to market, and rare disease companies have made remarkable progress delivering these cures. I think most of you would agree with that.

We know that earlier intervention with new treatments, like gene therapy, can give patients a second shot at life. That is priceless. And save money in the long run, of course.

Cell and gene therapies could reduce total disease costs and productivity by up to 30 percent for certain serious conditions in the U.S., potentially translating to billions in savings, where you can't put a price on a person's life, or quality of life, in my opinion.

However, we often hear that these drugs are denied by insurance companies due to policy

exclusions, or cost concerns, despite their overwhelming benefits.

So second question is for Mr. Cordani. How does Cigna approach coverage decisions for high costs, but high-impact treatments, like gene therapies, what types of innovative payment models does your company deploy to deliver these innovative treatments to your members at an accessible price?

Mr. Cordani. Congressman, thank you for the question. Two parts to my answer. One is, the coverage policies are determined typically employer-by-employer that we serve. We serve large employers. We will advise them based on the clinical evidence, and the vast majority of the coverage that we are able to provide for our large employers are comprehensive coverage.

Back to innovative programs. If you take some of the most expensive gene therapies, there are several that are in excess of $1 million per dose, we were the first offer program that actually took all the affordability risk away from the employer through our Embark Program by simply charging $1 per member per month because no one was able to predict when that event was going to transpire, but we needed to have access for the benefit of our employers.

That is an example of an innovative program that removes the uncertainty for the employer, while ensuring that access exists if the unique need for one of those $1, $2 or $3 million pharmaceuticals are necessary.

But getting to comprehensive coverage is typically working with the employers and advising them on the most comprehensive coverage possible.

Mr. Bilirakis. Okay. Thank you very much, and I yield back, Mr. Chairman.

Mr. Griffith. The gentleman yields back. I now recognize the gentlelady from Michigan, Mrs. Dingell, for her 5 minutes.

Mrs. Dingell. Thank you, Mr. Chair. And thank you, Ranking Member DeGette, for holding this important and very timely hearing.

It is coming at a pivotal moment. Millions of Americans across the Nation have seen their

healthcare premiums skyrocket because of both the expiration of the Affordable Care tax credits last month, the only thing that made a lot of people able to afford it, but also, because of the passage, I will behave today, and just call it the big brutal bill.

Insurers sent out renewal notices a couple months ago notifying consumers that their premiums were going to skyrocket in 2026, yet all of you are posting record profits, approving millions of dollars' worth of CEO compensation packages, executive bonuses, and paying your shareholders.

Let me tell you something: People are really struggling. I hear these stories every single day. The moms are the worst. They are not able to get their kids their medicine. Even parents with asthma, their children have asthma, can't afford the inhalers.

Make no mistake that we are seeing a ripple effect. My colleague next to me just talked about some of them that are going on. The American people deserve better.

I want to start with Ms. Allen. I want to thank you for being here today, and for your willingness to be one of the faces sharing your personal story. It is important for everybody in this country, but especially the executives at this table to understand directly from real people living with the consequences of both what happens here in Congress, and what happens in the insurance companies.

Like nearly 200 million Americans, Ms. Allen is living with a chronic health condition that makes consistent and affordable coverage important.

Ms. Allen, I know you had no choice but to buy the bronze plan under the Affordable Care marketplace. You wanted to buy the silver, but you couldn't afford it. Can you explain what that means in real terms?

Ms. Allen. Thank you for the question so very much. Yes, I was hoping to purchase the silver plan just to reduce my total out-of-pocket costs. I mean, 40 percent co-insurance, the out-of-pocket costs, I know I would face $10,000 potentially, and actually likely.

So that is money that I actually took out of a savings account to pay my healthcare costs. And I am closer to retirement, right, than not, so that is not helping me secure my economic viability in my retirement years.

Mrs. Dingell. I am going to ask you one more question and then move to the others. But your Affordable Care plan that you have, how many -- it has worked, right? How many claims have been denied?

Ms. Allen. You know, I have had essentially no claims denied with my plan. I have been very happy with my plan, particularly with the tax credits.

Mrs. Dingell. Until this year, correct?

Ms. Allen. Until this year. I think I have had one specialty eye drop medication denied, which eventually I was able to secure.

Mrs. Dingell. Now I would like to turn to Mr. Hemsley who is the CEO of the country's largest insurer. A CBS News analysis of about 1.3 billion Federal health insurance claims across 3 years shows that in 2024, insurers denied 19 percent of in-network claims, about 1 in 5. UnitedHealthcare in particular denied as many as 1/3rd of its Federal claims in the preceding 2 years, all while raking in record profits of $400 billion.

Patients were battling terminal illnesses are spending the last days and months of their lives with loved ones on the phones battling with their insurance company, and essential treatments are being denied.

Mr. Hemsley, should sick patients who don't want to leave their families with bills have to spend hours on end fighting to get their treatments approved?

Mr. Hemsley. Congressman, thank you for the question. It is very important that people don't go through that kind of complexity and that --

Mrs. Dingell. Then how are you simplifying it because I don't have a lot of time.

Mr. Hemsley. I would love to comment on that. Really only about less than 2 percent of all

the interactions that we receive are under a prior authorization review, and the vast majority of those are administrative. And at the end of the day, 99 percent of all the care is covered.

We should be doing more to expedite and make the prior authorization processes quick, real time, accurate, crisp, and not interfere with care.

Mrs. Dingell. So are you telling me the fact that 1/3rd is denied is not true?

Mr. Hemsley. It is not consistent with our experience at all.

Mrs. Dingell. I have more questions for the record. Thank you, Mr. Chair, and I will yield back.

Mr. Griffith. The gentlelady yields back. I now recognize Mr. Carter of Georgia for his 5 minutes of questioning.

Mr. Carter of Georgia. Thank you, Mr. Chairman. Between 2014 and 2024, the seven largest for-profit health insurers, including United, CVS, Cigna and Elevance, raked in over $10 trillion in revenue. $10 trillion. And $543 billion in profits.

In fact, since the passage of the Unaffordable Care Act, the stock prices of these health insurers has increased by over 1,000 percent. 1,000 percent.

Premiums are rising, and patients struggle to afford care. Insurance executive compensation continues to increase at the expense of patients. Americans now owe -- and hear me and hear me clearly -- Americans now owe $220 billion in medical debt. $220 billion. To put it simply, the system is failing the people it's meant to serve, and that is the patients.

Mr. Joyner, Mr. Joyner, in 2024, CVS Health spent a staggering $41 million in compensation to you and your colleague Karen Lynch. This is enough to cover the premiums for thousands of American families. How do you justify getting paid that much when so many of your patients struggle to afford skyrocketing premiums? $41 million, Mr. Joyner.

Mr. Joyner. That was -- Congressman, thanks for the question.

Mr. Carter of Georgia. Don't thank me for the question. Just answer them, please.

Mr. Joyner. That was not my compensation that you referenced. This past year, my compensation was $17 million.

Mr. Carter of Georgia. It was $17 million. Pardon me.

Mr. Joyner. Of which $1.1 was my base salary. The rest is long-term incentives. And the bonus --

Mr. Carter of Georgia. I just met with some pharmacists out there who want to say you are welcome, they helped you pay that -- they helped pay your salary.

Mr. Joyner. And I think it is important to note, based off the performance of the year, I did return my bonus back to the Employer Relief Fund. So the employees that were going through challenging and difficult times got the benefit of my bonus last year.

Mr. Carter of Georgia. CVS employees?

Mr. Joyner. Yes, sir.

Mr. Carter of Georgia. Going through the difficult -- what about the patients who are trying to pay their premiums going through difficult times? Let me ask you, Mr. Hemsley, yes or no, don't thank me for the question, just yes or no. Have you ever personally looked a patient in the eye and explained why your company denied them a medication their doctor said that was needed? Have you ever personally looked a patient in the eye and told them that?

Mr. Hemsley. I have looked patients in the eyes many times. I don't recall whether it is regarding a prior authorization, but it is --

Mr. Carter of Georgia. Well, Mr. Hemsley, let me tell you, I practiced pharmacy for 40 years, I am the one who had to look the patient in the eye. I am the one who had to tell them that on your behalf. It is not fun.

Mr. Hemsley, I want to tell you a story about Andrea Kelly. She is a single mother from Kentucky who was diagnosed with stage two breast cancer and has endured years of chemotherapy, surgery and radiation just to stay alive, and she wants to stay alive because she has got a

seven-year-old daughter.

Despite being stable on the medications for a year, UnitedHealthcare is now denying Andrea her Lupron injection and Veozah medication. According to her doctor, these denials are actively increasing, as you would imagine, and you understand, they are actively increasing Andrea's risk of cancer recurrence. This is not about convenience or cost. This is about whether her cancer comes back.

To quote Andrea, and I quote, "I am a single mom and would do anything to live as long as I can for my daughter who is now seven. I need access to my medication so that I can live for my child," end quote.

It was me, I was the one who went to the counter, I was the one who had to tell them that. Not you. Not you, Mr. Joyner. Not any of you on this panel, but me, the pharmacist. I was the one who had to tell them that.

Mr. Hemsley, knowing that your company's denial raises Andrea's risk of cancer recurrence, why is UnitedHealthcare overriding her doctors and denying their medication? Do you have any idea?

Mr. Hemsley. I don't know that particular circumstances.

Mr. Carter of Georgia. Can you help me out here because I want to help her out. What can I tell her? What can I tell Andrea that she can tell her 7-year-old daughter?

Mr. Hemsley. I would love to learn more about that and see if we can't help solve that problem.

Mr. Carter of Georgia. Let me ask you this, Mr. Hemsley. President Trump is proposing a bold new healthcare plan, and I applaud him for that, one that puts patients in control. Thank God somebody finally realizes instead of sending the money, my colleagues, instead of sending money to insurance companies, send it to the patients, let them create a competitive marketplace. The President is proposing this. He wants to put patients in control, expand choice, and ensure

transparent pricing.

Can we count on you, Mr. Hemsley, to support President Trump's great healthcare plan?

Mr. Hemsley. Representative, we will be open to any kind of bipartisan solution, and I think the President's thoughts contribute to the conversation, good ideas to be considered --

Mr. Carter of Georgia. I certainly hope so because for 40 years I am the one. I am the one. Thank you, Mr. Chairman. I yield back.

Mr. Griffith. The gentleman yields back. I now recognize the gentlelady from California, Ms. Barragan, for her 5 minutes of questioning.

Ms. Barragan. Thank you, Mr. Chairman. I want to just ask the witnesses, all of you here, except the witness on the end, all of you get a stock option or a stock benefit for your compensation. Is that correct, Mr. Hemsley?

Mr. Hemsley. Yes, Representative.

Ms. Barragan. And Mr. Joyner?

Mr. Joyner. Yes.

Ms. Barragan. Ms. Boudreaux.

Ms. Boudreaux. I do as well, tied to long-term incentives.

Ms. Barragan. Okay. And --

Mr. Cordani. Yes, I do.

Mr. Markovich. No, we don't have any ownership or stocks. We are a non-profit. There is no ownership.

Ms. Barragan. Okay. You get performance bonuses instead?

Mr. Markovich. Correct.

Ms. Barragan. Okay. So those of you who have stock, your company has to do better or good for you to maintain that value in that stock. Is that right? Nobody disagrees with that, right?

[No response.]

Ms. Barragan. You are all in the business of making a profit, right? Nobody disagrees with that?

[No response.]

Ms. Barragan. Okay. Mr. Hemsley, you got a $60 million one-time equity award. That is a lot of money. For my constituents, when I said we were having this hearing today, I said, What would you ask? They said we want to know why they are making so much and why we can't afford our healthcare, or why we stretch every penny and dime to buy healthcare just to have the claim denied when I actually need it. And that is what is wrong. That is what is wrong in this system.

Mr. Hemsley, you were just asked about the denial rates. I have a chart. I have a chart right here of the denial rates. I don't know if you can see it, but UnitedHealthcare Group, according to the Kaiser Family Foundation study, says your in-network denial rate is 33 percent. That is 33 percent. You just told me colleague that wasn't accurate. Are you saying the report is inaccurate, or are you just not aware of what your denial rates are?

Mr. Hemsley. Representative, I think we are aware of our denial rates. I don't know what the context of what you are showing me.

Ms. Barragan. Okay. So you are not aware of the study. Okay. Well, what do you think your denial rate is?

Ms. DeGette. Excuse me. Can you pull the mic closer?

Ms. Barragan. What do you think the percentage is?

Mr. Griffith. Yeah, we are having a hard time hearing. If you could put your mic closer and we will give you an extra 5 seconds.

Mr. Hemsley. Sorry.

Ms. Barragan. What do you think your denial a rate is.

Mr. Hemsley. Less than two percent.

Ms. Barragan. Yeah, that is wildly off from any numbers that I have seen.

I want to enter into the record an LA Times article published in February of 2025 that tells the story of Colleen Henderson and her three-year-old toddler who, of course, is insured by UnitedHealthcare. They fought your company for 5 years to pay for specialty care to treat their three-year-old daughter's rare condition. She had a tumor in her bladder. A tumor in her bladder. The family ended up with $1 million in medical debt, and was forced to declare bankruptcy because UnitedHealthcare said treatments recommended by the doctors were unnecessary.

Do you understand why the American people are not a fan of UnitedHealthcare and big healthcare companies, Mr. Hemsley?

Mr. Hemsley. I think that is a tragic situation. I don't know the details of it, but I am very sympathetic to situations like that.

Ms. Barragan. Well, what are you going to do to make sure that more families are not going into medical debt, and that their kids can get the care they need, because you know the alternative is the kid is going to die.

Ms. Hemsley. Well, I am glad you brought that up because I think one of the reasons that motivated me to return to this company is because I think we could be a force for solutions like that, and that we are -- our mission aligns to that, and my purpose is to improve the performance of this enterprise to solve those kinds of solutions.

Ms. Barragan. Well, I hope that we see improvements, and I am going to be tracking that progress to see if it actually happens.

The other thing that is really quite fascinating is that we find that most people will not appeal these denials. Most people don't have the time or the effort. I live in a district which working-class families, they can barely find the time to show up to two jobs to pay their bills. Do you think they are going to have the time and the effort to appeal a claim?

We have seen that less than one percent of claims are appealed, but when they are, insurance reverse their decision 44 percent of the time. That is almost half.

Why do your patients have to fight your company to get their claims covered?

Mr. Hemsley. Representative, again, I appreciate the subject. It is important. They shouldn't have to fight. We should make this much easier and intuitive, and we use technology for that purpose. We have a number of initiatives in market right now to try to make it --

Ms. Barragan. Mr. Hemsley, the way you are talking about this is not sympathetic. It is not compassionate. I appreciate the topic. These are people's lives. These are children's lives. This is where people -- you said that you want to help people when they are sick. You know what doesn't help, when they get a bill, when they have to go into medical debt for $1 million of debt. That doesn't help people when they are sick. I hope that you all are going to do better.

Mr. Griffith. The gentlelady yields back. And the gentlelady referenced a document. If she could make sure that we have a copy of that, and without objection, it is so ordered to be entered into the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. I now recognize the gentleman from Pennsylvania, Dr. Joyce, for his 5 minutes of questioning.

Mr. Joyce. Thank you, Mr. Chairman. According to CMS data from 2024 on total healthcare expenditures, spending reached a new high of over $5 trillion. Notably in this report, hospital costs, which now make up 30 percent of that $5 trillion, are the steepest rising costs being paid by the American patient. One of the reasons driving this has been the trend of hospital consolidation leading to regional monopolies dominating markets. I hope that this is a topic that this committee will explore in future hearings.

For our insurers on the panel, please raise your hand if you agree with the following statement: Highly consolidated provider markets make it harder to contract at competitive rates for the services on behalf of your customers.

[No verbal response.]

Mr. Joyce. I see that Mr. Hemsley, Mr. Joyner, Ms. Boudreaux, Mr. Cordani, and Mr. Markovich have all raised their hands. Thank you.

Since the passage of the ACA, we have seen costs across all markets continue to increase. One of the key issues driving this is the medical loss ratio, or the MLR, that requires plans to spend either 80 or 85 percent of their premium dollars on healthcare expenses.

The MLR created multiple perverse incentives for insurance companies to dramatically consolidate both vertically and horizontally.

The companies that you lead today are not just involved in insurance. You own PBMs, you own specialty pharmacies, you own retail pharmacies, you own GPOs, you own physician groups and practices. In some cases, you own hospitals, and you own drug manufacturing companies, and at least one of you owns a bank. This has led to alleged cases of self-dealing as your companies work to circumvent the MLM requirements.

I would like to add for the record a STAT News article from November of last year entitled, "UnitedHealth Pays Optum Physicians 17 Percent More Than Outside Providers." Under MLM rules, it is now in the insurer's interest to purchase as many health services that count towards that 80 or 85 percent medical spend requirement to ensure that Americans' premium dollars merely are just changing hands within your company's corporate structure.

Since provider profits are not capped under the MLR in the same way that planned profits are, there is absolutely no incentive to keep prices low. In fact, it is in your interest to keep driving them even higher, resulting in bigger payments that can make your own corporate-owned providers bigger profits that you can obtain legally skirting the MLR requirements.

As a doctor, which there are many of us on this committee, we took the Hippocratic oath, an oath that says above all, do no harm, but it is painfully evident that the promise that we took is not reflected in the blatant gaming of the MLR, because you are clearly putting corporate profits ahead of patients, and ultimately each and every one of you are hurting those patients.

Transparency in this area is critical for us to truly understand what is driving cost increases. And I would ask that by the end of February, in writing, to please provide to this committee the names, the size of the business areas of each subsidiary that your company own that you have spent premium dollars that would qualify as a medical or quality-improvement expense under the MLR.

Can you please also provide the percentage of your dollars spent in each individual or commercial or Medicare Advantage market that went to the subsidiaries that you own?

And can you provide a breakout of how your negotiated rates compare for services delivered by your affiliates versus a nonaffiliate provider? Please raise your hand to indicate that you will provide the committee with that information by end February.

[No verbal response.]

Mr. Joyce. Seeing that all of the insurers, Mr. Hemsley, Mr. Joyner, Ms. Boudreaux, Mr. Cordani, and Mr. Markovich have all raised their hands.

In addition, the growing physician employment that each of you operate, that is one problem. But you also own some of the largest pharmacies in our country, and this has led to a crisis among smaller and rural pharmacies, especially in my district in south central and southwestern Pennsylvania, closing and leaving entire communities unserved.

I would also like you to provide in writing a comparison of total cost and spend for routine dispensing fees when you pay a community pharmacy in your network against what you pay a pharmacy that you own. Please raise your hand to indicate that you will provide this committee that information by the end of February.

Mr. Joyner. Congressman, we don't all own --

Mr. Joyce. I see all health insurers have raised their hands. I will follow up with questions for the record detailing these requests, and I ask that you stand by that commitment that you just made to answer these questions for my patients and for my constituents. Thank you, Mr. Chairman, and I yield back.

Mr. Griffith. The gentleman yields back. The gentleman referenced a document he wanted to be placed in the record. If you can make sure we have a copy of that, and without objection it will be so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Further, I would request that since you asked for specific information by the end of February, if you would put that in writing so that it can be presented to the members who are insurance company executives.

Mr. Joyce. Yes, Mr. Chairman.

Mr. Griffith. I appreciate that. Thank you very much.

I now recognize the gentlelady from Washington, Dr. Schrier, for her 5 minutes of questions.

Ms. Schrier. Thank you, Mr. Chairman. Thank you to our witnesses today. Thank you to Dr. Joyce for his comments. I wholeheartedly agree.

I would like to talk about Medicare Advantage today, specifically with regard to prior authorizations. Just to set the stage, I am a pediatrician and took care of kids in my community for almost 20 years before coming to Congress.

I also have had Type 1 diabetes for over 40 years, so I get what it is like to be a patient who is dealing with difficulties with insurance companies.

And now, I am a Member of Congress and I hear a lot from my constituents, and I am here to go to bat for them.

So just, I am sure it is not a news flash for you, but just so you know, people are pretty pissed off at their insurance companies because they are paying more every single year, and they feel like they are not getting the value for it, and, like, you are not living up to your end of the bargain.

I mean, their insurance companies, your companies, are charging more, paying less, and then delaying, or even denying care due to abusive demands for prior authorizations. And I hear the same, by the way, from hospitals, from physicians, they are telling me that they are forced to hire more people to deal with your paperwork than nurses, and that is just plain wrong.

Particularly when it comes to Medicare Advantage, not only do you delay that care with prior

authorization demands, but you sometimes flat out deny claims after the services are already rendered.

And here is an example. One of my constituents had a stroke, required hospitalization. This patient had a UnitedHealth Medicare Advantage plan, and UnitedHealth refused to pay for that hospitalization because United decided that it was medically unnecessary overwriting the doctor's own medical decision.

And so, now we have got this senior who is in the hospital, can't go home, stuck with a huge bill, and that is just unconscionable.

And it is shameful that you are doing this to people on Medicare Advantage. I mean, they paid into the system for their whole lives, they are paying premiums now, they are counting on you to look after them, and I just want you to think about how many elderly patients who suffered a stroke can then go home and deal with sitting on hold with customer service and submitting letters in the appeals process. And it took over a year, by the way, for UnitedHealth to finally pay.

Mr. Hemsley, if a patient's physician has determined that their patient should be in the hospital after a stroke, why would UnitedHealth decline that care?

MR. Hemsley. I am not familiar. I appreciate the question, and very sympathetic to the situation that you described, you described it before. I am not -- I don't have specific knowledge --

Ms. Schrier. You don't really need specifics, like senior, suffered a stroke, doctor said this guy is not safe to go home and United overruled.

Mr. Hemsley. They should get all the care that is appropriate for them, yes.

Ms. Schrier. Thank you for saying that, and I will communicate to that to my constituents and go to bat for them. I will tell you that paying a bill is the last thing patients should worry about after having a stroke, and doing this because a multi-billion dollar company doesn't think that it is necessary for them to get their care.

I mean, this is why so many people hate their insurance companies. They pay a lot of

money, they expect peace of mind, and then the insurance company leaves them high and dry.

A lot of you run Medicare Advantage plans, but UnitedHealth is the poster child for Medicare Advantage abuse. I mean, we all know about padding diagnoses so you can make patients seem sicker and riskier, and then overcharge the government for their care.

But today's focus really is on prior authorizations and denials, which you demand more than other insurance companies that take care of Medicare Advantage patients. And most patients, they just shrug their shoulders. They give up. But the ones who do appeal, 80 percent of them get their appeals covered.

If these denials are ultimately overturned, why are you doing these pre-authorizations and denials?

Mr. Hemsley. Well, I appreciate the question, Representative. We have been methodically reducing the area of prior authorization and expediting that process. We are not trying to do any other --

Ms. Schrier. I am with 15 seconds. I am going to hold you to that, and I will follow up with you about what you are doing now. But I have to tell you that to the rest of us, this looks like your business model. It looks like you bet on wearing patients down, on them not appealing, and then they either decide to just eat the costs, or they die before they get the care they need. And my constituents are sick of it, and we are sick of it, doctors are sick of it, and people deserve better. So we need Medicare Advantage reform now. Thank you.

Mr. Griffith. The gentlelady yields back. I now recognize the gentlelady from Iowa, Dr. Miller-Meeks.

Ms. Miller-Meeks. Thank you, Mr. Chairman. And I want to thank our witnesses for testifying before this subcommittee today.

There are many topics, such as prior authorization, which we just heard about, and denial of claims, which the majority of which are later approved without modification, that I would like to

discuss with our witnesses today. But unfortunately, or fortunately for you all, I only have 5 minutes, so I am just going to jump in.

As a physician and veteran and a former director of public health, I strongly support innovation in healthcare delivery, but every dollar wasted on inefficiency, waste, denial of claims, or unnecessary billing, is a dollar not spent on patient care.

That is why Senator Grassley's recent report detailing UnitedHealth Group's conduct in the senior's health insurance advantage plans, commonly known as Medicare Advantage, that report is very troubling. I have had many doctors within the State, and I myself have experienced what is happening when patients go -- or patients come back after having visited at home.

Medicare Advantage was created to improve outcomes and coordinate care for seniors, not to incentivize gaming the system.

Do any of your companies decide a claim for a level of care without documentation or justification for the level of service or test or imaging? The answer to that is no. You require documentation.

The independent Federal oversight reports from HHS-OIG have identified that conditions, including congestive heart failure, were among diagnoses often added via in-home assessments are chart reviews and Medicare Advantage.

So if you would deny a claim from a provider without documentation, why is it that you feel at liberty to submit a claim to CMS for a diagnosis based on a home visit? Congestive heart failure is not a paperwork diagnosis. It is a serious life-altering condition. And when it is added to a patient's record without active management, without their routine provider and doctor knowing that they have the condition, that is creating higher payment without accountability, and it is a danger to patients and providers.

Now I am going to turn our attention to a lesser known player in the healthcare system that I believe American people should be made aware of, PBMs, and PBM GPOs. The largest PBMs, CVS

Caremark, Express Scripts, and Optum have created rebate contracting entities, or PBM group purchasing organizations, which are adding to the complex and opaque nature of the medicine supply chain.

My first PBM reform bill on transparency was in 2019 as an Iowa State Senator. PBMs claim these entities provide them and their clients with greater bargaining power to lower costs, but recent investigations by Members of Congress, industry experts, State attorneys general, and Federal oversight agencies suggest the opposite may be true.

We have a graph up here. Let's start with the left. The drug maker, who pays rebates directly to the PBMs and PBM GPOs to ensure their drugs were included on their health plan formularies, meaning the drugs are covered by insurance. Then their PBMs, and their PBM GPO subsidiaries collect the rebates, which they promise to pass through their patients and health plans.

Can any of you tell me what percentage of rebates are passed through to the patient who is paying a higher drug cost because the rebates are added to the price of the drug? Is it zero? You don't even know that you are not giving these patients back a rebate for paying higher drug prices.

Next, the PBMs pass supposedly the rebates to the health plans. However, the health plans are told 100 percent of the rebates negotiated by its PBM are then returned to the plan as savings. They often aren't told anything about the PBM GPOs subsidiaries, which collect a whole different set of fees from the drug maker in exchange for formulary management.

So a health plan might be getting 100 percent of the rebates the PBM received, but the plan has no idea if the rebate got everything the GPO earned, or how much money the GPO may have kept.

It begs the question, are PBM GPOs just a cover for the big three to say in a contract that they pass through 100 percent of the rebates they get, and also a way to keep anyone else from being able to fully access brand drugs.

Mr. Joyner, on average in the commercial market, what percentage of manufacturer rebates

and fees negotiated through your PBM are retained by your GPO, or are they going to other subsidiaries, or offshore?

Mr. Joyner. Congresswoman, we pass through 99.9 percent of the rebates to our customers, and feel really strongly about the strength of our purchasing arm. In fact, if you look at the branded products that were rebate --

Ms. Miller-Meeks. I am going to reclaim my time. Mr. Cordani, how many of -- your GPO are sent out as headquartered, why is it headquartered outside the United States, and do you pay taxes on fees in America?

Mr. Cordani. Our GPO is headquartered in Switzerland. We are a global company, so we leverage our global infrastructure for that GPO --

Ms. Miller-Meeks. Thank you. Before I yield my time, why isn't this a violation of Stark? As a physician, I cannot do what you all have done with PBMs. With that, I yield.

Mr. Griffith. The gentlelady yields. I now recognize the gentlelady from Massachusetts, Ms. Trahan, for 5 minutes of questioning.

Ms. Trahan. Thank you, Mr. Chair. Like all of my colleagues, I hear from people across my district who are exhausted by having to make impossible financial decisions about their healthcare while a handful of massive corporations post record profits, and their top executives take home record pay.

Your Republicans have destabilized hospitals and families with their biggest healthcare cut in American history in their failure to extend the ACA tax credits with no alternative plan to bring costs down.

At the same time, the private insurance market itself has become deeply consolidated, and that consolidation is a major reason costs remain so high.

You have sitting before us the executives from four companies, that together, control about 50 percent of the commercial insurance market. Not exactly a depiction of a healthy competitive

system. It is a system of haves and have nots, where market power is concentrated, competition is weakened, independent providers are squeezed out, and families are forced to pay more.

The lack of real checks and balances is bad for patients, it is bad for innovation, and it is bad for affordability.

And to show what this level of consolidation looks like in maybe a more familiar context because your business is deeply complicated, let's just step outside of healthcare for a moment. Imagine if in the auto market, one dominant company didn't just sell car insurance, but they also owned the dealerships, controlled all the repair shops, and ran the claim systems. Meaning, one company would be selling the cars, steering the repairs, and setting the price at every step.

Independent shops would struggle to survive, consumer choice would shrink, innovation would be stifled, and basic economics tells us that prices would rise, not fall. Yet in healthcare, we have allowed insurance to buy up doctors, pharmacies, and critical infrastructure, and build exactly this kind of vertically integrated ecosystem.

If one car company sold the insurance, owned the dealerships, controlled the repair shops, and ran the claim system, regulators would immediately worry about steering, self-dealing and higher prices.

So I will just kind of throw it out into the ether: Can anyone on this panel explain why consumers should believe healthcare is the one industry where this kind of corporate structure lowers costs instead of raising them? You know, I pose this question, it is a tough one, and it is obviously volunteered, because peer-reviewed research consistently shows that provider consolidation drives higher prices, especially for commercially insured patients. And those higher prices show up as higher premiums, higher deductibles, higher out-of-pocket costs, and higher overall spending.

When an insurer owns the provider it pays, it can set internal reimbursement rates instead of negotiating in a competitive market, and that kind of consolidation has been shown to raise prices for

the same services.

Now, UnitedHealthcare is the country's largest private insurer, and owns roughly 90,000 doctors through Optum. Meaning, a growing share of premium dollars are circulating inside the same company instead of lowering premiums, or providing rebates to patients.

Mr. Hemsley, as my colleague from Pennsylvania mentioned, UnitedHealth determines the reimbursement rates paid to Optum-owned physician groups, and those rates that you set are inside the same corporate family, hidden from regulators, hidden from competitors, patients, us.

So, Mr. Hemsley, when United owns the insurer, the doctors, the pharmacy benefit managers, and the care delivery system end-to-end, where exactly is the competitive pressure supposed to come from to keep prices down?

Mr. Hemsley. Thank you for the question, and I think it is an important area to clarify. The structure of that is in response to the marketplace to actually drive more value and drive costs down by the integrating and allowing these elements of healthcare services to actually serve the consumer better. There is a great deal of oversight and regulation on the establishment of pricing within an organization like ours. All the sponsors of benefits evaluate and can look at those prices.

Ms. Trahan. So respectfully, the claim that competitive pressure is keeping pricing down, or that regulation is keeping down, is undermined by the fact that the Department of Justice is actively investigating UnitedHealth over how its physicians and insurance divisions interact, including interviewing former Optum doctors.

And the bottom line is this: When the same companies control the insurance, the doctor, and delivery of care, competition just breaks down and families pay more. What is clear right now is that this system is working very well for corporate profits, but this committee has a responsibility to fix a system that today isn't working for patients. Thank you. I yield back.

Mr. Griffith. The gentlelady yields back. I now recognize the gentleman from California, Mr. Obernolte, for his 5 minutes of questioning.

Mr. Obernolte. So we are having a discussion today about why health insurance costs so much and how we can better allocate rate payer dollars to healthcare costs.

Mr. Markovich, I was pretty astonished last year when I heard that Blue Shield had contributed half a million dollars to a committee supporting the passage of Prop 50 in California. Prop 50, as everyone in this room knows, was an effort to shift five congressional seats from Republican control to Democratic control. It is a pretty transparent partisan undertaking that passed.

Reasonable minds can disagree whether or not that is something that should have been supported. I, myself, feel like mid-cycle redistricting erodes voter's trust in our elections and our democracy. I opposed doing it in Texas. I opposed doing it in California. Reasonable minds can have a discussion about that, but I was just astonished that a health insurance company would wade into a political debate in such an enormous way. Why on earth did you do that?

Mr. Joyner. Well, respectfully, Congressman, we didn't do that. What we did -- we have a long history of Blue Shield of California contributing to candidates from both parties at the Federal and State level, including Governor Schwarzenegger, Brown, and Newsom, and we try to support candidates that we think will be thoughtful about healthcare policy.

And this contribution to a fund that did not have a specified purpose is something we committed to as a part of that. After that contribution had happened, the Governor then purposed those funds for Proposition 50, and our plan did not take a position on it.

Mr. Obernolte. Okay. To be clear, though, these were two different checks for a quarter million dollars each to a ballot measure committee, not a candidate, I mean, we understand supporting candidates, but this was to support a ballot measure. So if not Prop 50, what ballot measure did you think you were supporting?

Mr. Joyner. Well, we didn't know, neither we nor the other healthcare companies --

RPTR SEFRANEK

EDTR HOFSTAD

[12:27 p.m.]

Mr. Obernolte. You wrote a half-a-million-dollar check not knowing what ballot measure you were supporting?

Mr. Markovich. We and other companies, including other healthcare companies, all contributed to this account, and it is not uncommon, particularly in California, with lots of propositions, where candidates would prefer contributions to these types of accounts as opposed to direct contributions to their campaign support.

Mr. Obernolte. Well, now knowing what you know, do you regret having made that contribution? I mean, this was the only -- Prop 50 was the only proposition that this committee supported.

Mr. Markovich. Well, we did not support or oppose Proposition 50. We didn't take a position on that.

So, you know, it is a decision we consciously made going in, as did others, and just didn't have control over where it went afterwards.

Mr. Obernolte. All right. Well, let me -- you, in your testimony, said that you think that our healthcare system needs some tough love. Respectfully, I would like to offer you some.

When a health insurance companies weighs in to such an obviously political topic like that, it not only erodes your ability to work with folks on the other side of an issue, but also erodes consumers' trust in the system as a whole. So please don't do that again.

Mr. Hemsley, I represent a very rural section of California, and one of the biggest problems we have is access to healthcare. So we are grateful to have critical access hospitals that are in most of the communities that I represent.

But we are having an increasing problem with Medicare Advantage plans, like the ones that

you provide, where the critical access hospitals are no longer recognized as being in network, and my constituents are forced to drive long distances to get the healthcare they need.

Now, I understand that keeping costs down is something that is often in tension with contracting with these hospitals. But let me also suggest that when people have to drive hours and hours to get access to basic healthcare, some of them just won't do it, and that denial of healthcare turns out to have much larger costs in the long term for our entire system.

What can we do to improve that, and why are those decisions being made?

Microphone, please.

Mr. Hemsley. Thank you for the question, Congressman.

There is meaningful pressure in the Medicare Advantage space, given the funding actions taken in the previous administration that has put a great deal of pressure in terms of what can be served.

We are very interested and dedicated to the rural health care and adequacy there. I will look into the situation that you describe.

But we are also advancing initiatives to see if we can get rural care resources paid more effectively and more currently. So we have four pilots in the market that are expediting payment -- trying to cut the payment timeframes in half. And --

Mr. Obernolte. So, I am sorry, we are out of time here. But these critical access hospitals are going to close if this trend continues. That is not good for you, and it is not good for the constituents that rely on it.

Mr. Hemsley. We appreciate that --

Mr. Obernolte. I yield back.

Mr. Griffith. The gentleman yields back.

And we are in a dilemma. All of our witnesses have to be at another hearing in just a little bit. So, unfortunately, we are going to have to roll back the question time for members to 3

minutes subsequent to the questioning by Ms. Ocasio-Cortez, who is now recognized for 5 minutes.

Ms. Ocasio-Cortez. Thank you so much, Mr. Chairman.

And apologies if we have to move quickly here due to the time. Thank you to all of our witnesses for coming here today.

Mr. Joyner, you are the CEO of CVS Health, correct?

Mr. Joyner. Correct.

Ms. Ocasio-Cortez. And I actually don't know how many Americans know this, but CVS Health owns Aetna, the health insurance company, correct?

Mr. Joyner. Correct.

Ms. Ocasio-Cortez. And CVS, which owns Aetna, also owns Oak Street Health medical clinics, correct?

Mr. Joyner. Yes, it does.

Ms. Ocasio-Cortez. And, in addition to that, they own, of course, CVS pharmacies. And CVS Health also owns CVS Caremark, the pharmacy benefit manager, which helps negotiate some of these rebates and prescription prices, correct?

Mr. Joyner. That is correct.

Ms. Ocasio-Cortez. And CVS Caremark processes nearly 30 percent of all prescriptions in a given year. And so, in other words, CVS Caremark helps determine the prices that patients pay for a third of all prescriptions in the U.S.

In fact, I was following one of CVS's recent -- or, one of CVS's investor calls, where they really laid out quite clearly what this means if you are a patient. This is what is known as a "captive" strategy. And CVS, in the investor call, used the example themselves of a patient known as "Kate."

Kate has an Aetna health insurance plan, right here, which is owned by CVS Health. She then goes to a CVS pharmacy. She is connected to an Oak Street Health medical clinic. She sees a doctor at Oak Street Health, who prescribes her medication. And then she goes to fill that

prescription at a CVS pharmacy.

So the price Kate pays for that medication is dictated by Aetna, CVS Caremark, and they also own the drug manufacturer Cordavis.

Mr. Joyner, this is quite a bit of market concentration, wouldn't you agree?

Mr. Joyner. No, I wouldn't agree that it is market concentration. I would suggest it is a model that works really well for the consumer.

Ms. Ocasio-Cortez. Yeah. I think it works very well for CVS. I think -- in fact, you all said on the call that a fully -- you all call it a "fully engaged member"; that is great marketing there -- a fully engaged member unlocks sizable value for payers and CVS Health.

So the health insurance gets a cut, the pharmacy benefit manager gets a cut, the drug manufacturer gets a cut, and the patient gets screwed.

I think the Federal Trade Commission has also found that healthcare conglomerates like CVS Health charge more for medications filled at their pharmacies. We are talking about thousand-percent markups on medications for cancer and HIV.

And, you know, I think this is actually an interesting point of common ground that I may have with some of our Republican colleagues here in this hearing, because, whether you are a blue-blooded capitalist or a card-carrying Democratic Socialist, I think corporate monopolies are a problem. And this vertical integration is destroying people's ability to access care.

You know, I don't think -- we are seeing this across the board. And if they can self-deal -- you know, I saw something that was interesting from the opening statement of Mr. Hemsley from UnitedHealth talking about how much United spends -- was it 85 percent on care, Mr. Hemsley?

Mr. Hemsley. Approaching 90 percent.

Ms. Ocasio-Cortez. Approaching 90 percent. But the ACA forces you all to spend a decent amount of that on subsidies on care.

But when you own the care, when the insurer owns the pharmacy, owns the PBM, owns the drug manufacturer, you also own the healthcare cost. You own a big chunk of the healthcare cost.

And so, you know, 100 years ago, we had this type of market concentration in our banks, and we did something about it when it crashed the economy, and we passed the Glass-Steagall Act. We should be considering that in our healthcare system.

And if we believe in competition, I think we should put our votes and our legislation in alignment with that and consider breaking up this industry in order to allow the competition that prevents this kind of vertical integration and abuse of power.

And, with that, I yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Oregon, Mr. Bentz, for his 3 minutes of questioning. Sorry.

Mr. Bentz. That is fine, Mr. Chair. Thank you.

Thank all of you for being here.

I am going to follow Dr. Joyce in asking that each of you produce certain documents. But I am really interested in the float. And that, of course, is what leads to people calling insurers banks doing a side business as healthcare. Because, of course, you charge the premium, you collect the money, you put the money in the bank, it earns interest, and then you pay it out.

And so the float is of extraordinary interest to those of us that support HSAs, because a health savings account means that, instead of paying the premium to you, the theory is, the person with the account earns the money.

Starting with you, Mr. Hemsley, is that true? If HSAs were put into place, would the patients actually be earning the money instead of the insurance company?

Your microphone.

Mr. Hemsley. Sorry. Thank you for the question, Representative. I don't know if I

understand the question, but we maintain --

Mr. Bentz. No, then let's go back.

Mr. Hemsley. Yeah.

Mr. Bentz. It is simple enough.

Mr. Hemsley. Uh-huh.

Mr. Bentz. If HSAs were put in place and people could put their money into the has and have it earn interest from them instead of paying it to you as a premium, and they would wait until, I guess, they had the problem or the deductible to pay, would they be earning the money instead of you? That is the question.

Mr. Hemsley. They earn interest rates in their has accounts.

Mr. Bentz. Maybe a better way of asking this is shifting over to how much money an insurance company makes by denying a claim.

So what I was doing up here as I was waiting for my turn to ask these questions, I was trying to determine how much money insurance companies would make while they delayed in making a payment on a claim that ultimately is approved. And I found it here. But in order to put it in proper perspective, one has to know how big the company is and what the total denied claims amount to.

So I was looking at you because, unfortunately, you are first, for you. The total denied pool is 19 percent, a 19-percent denial rate, which amounted to about $50 billion of your total income. How much interest did you earn on that?

And I am going to ask -- you don't have to answer now. I am going to ask that each one of you, though, answer that for me and for the committee. So please respond in writing, how much money is made during the period of time that the delay is occurring on claims that are ultimately approved? That is what I want to see.

And maybe -- because it is obvious, the argument, that if you deny a claim, you get to earn

money on the denied amount that you don't pay until you finally do have to pay it out.

Now, you can argue about all the stuff you have gone through, and I was going through some of that here. In this case, I recognize those justifications. I want to see the amount. And that is what we are going to start with.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Bentz. With that, Mr. Chair, I will yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Massachusetts, Mr. Auchincloss, for his 3 minutes of questioning.

Mr. Auchincloss. This week, it looks like the House of Representatives is going to pass PBM reform finally, which is good news for patients. But it seems to me that the big three health insurance corporations, knowing that PBM reform is around the corner, needed a different way to retain profits while still, on paper, complying with new requirements and the coming requirements of PBM reform, and so they formed these group purchasing organizations overseas, in Ireland and Switzerland in particular, that have since been exhaustively investigated.

And I will enter into the record, Chair, that investigation.

Mr. Griffith. Date of the article?

Mr. Auchincloss. January 6th.

Mr. Griffith. Without objection -- of this year?

Mr. Auchincloss. Yes.

Mr. Griffith. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Auchincloss. Now, this investigation found many, many things, but of note, particularly for UnitedHealth GPO Emisar, that although it had no website, no email, no phone number available at the time of the investigation, it was described as "negotiating rebate agreements with pharmaceutical manufacturers" and was also bringing in tens of millions of dollars per employee.

So what is going on over there?

Mr. Hemsley, how many people does Emisar employ?

Ms. DeGette. You need to turn on your mic.

Mr. Auchincloss. Mic, please.

Mr. Griffith. Turn on your mic.

Mr. Auchincloss. Microphone, please.

Mr. Hemsley. I am sorry.

I don't have a specific answer, but several thousand.

Mr. Auchincloss. Several thousand.

And is the number of covered lives that Emisar covers different than the number of covered lives your PBM, Optum Rx, serves?

Mr. Hemsley. I don't have the exact number, but I believe they serve other health plans and have a different --

Mr. Auchincloss. That number is important, though, sir, because if your GPO is not serving more covered lives, how is it possibly aggregating purchasing power any more than the existing PBM?

We are going to follow up with questions on the record, because these GPOs are an attempt to circumvent congressional authority over PBM reform, and they are ultimately going to be a source of profit, to the detriment of patients' co-pays.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Auchincloss. Mr. Hemsley, I want to pivot, actually, from policy to the personal, though.

You and your company and your colleagues suffered a horrendous loss last year, and the reaction on social media to the murder of Brian Thompson was a shameful moment for this country, particularly for his sons, who don't deserve that.

Would you like to state into the congressional record, which will last forever, unlike those social media posts, what kind of man Mr. Thompson was?

Mr. Hemsley. Yeah. Thank you for the -- for that opportunity.

I think we can all disagree on many things, but I think one thing we can agree on is that violence or the threat of violence is not appropriate in any circumstances.

Brian Thompson was a force for good. He was a creative and effective man in terms of trying to address many of the challenges that have been presented today. And we miss him dearly, and I appreciate the opportunity to recognize him.

And he left two very fine men behind as his children, and a wife and a family. And I think that, as we bring things down to what is real in many of the conversations today, I appreciate you recognizing and giving an opportunity for that.

Mr. Auchincloss. And may his memory --

Mr. Griffith. The gentleman yields back.

Mr. Auchincloss. I yield.

Mr. Griffith. I now recognize the gentleman from Ohio, Mr. Balderson, for his 3 minutes of questioning.

Mr. Balderson. I got that memo, Mr. Chairman. Thank you very much.

Thank you all for being here.

And since we are on 3 minutes, my first question is going to go to Ms. Boudreaux.

Thank you for being here, ma'am.

CMS internal data shows that, in 2021, the average percentage of enrollments in the ACA market without any medical claims was 19 percent. That percentage jumped to 35 percent in 2024. I believe this was largely due to the enhanced COVID premium tax credits.

Under the Biden administration, congressional Democrats approved billions of taxpayer dollars that went to your company with very little oversight. This lack of transparency in oversight led to rampant fraud and waste.

What I find interesting is that the waste over the past several years seems to have been a much bigger issue in the Federal exchange than the State-based exchanges.

Yes or no, Ms. Boudreaux, did your company see evidence of increased waste, fraud, and abuse since congressional Democrats enacted the temporary COVID credits?

Ms. Boudreaux. Thank you for the question, Congressman.

What we saw -- again, we have real concerns, similar to you. We share the concern about fraud, waste, and abuse. And our enrollment comes directly from the Federal and State exchanges, and it was -- you know, the enrollment there, we think, was about 15 percent, not the 30 percent you were showing.

Mr. Balderson. Okay.

And why was this waste more pronounced at the Federal exchange than the State-based exchanges?

Ms. Boudreaux. Again, we saw -- as we looked at that, we worked very closely with the State exchanges, but we did see some consistency between the Federal and State.

But, again, we are incredibly focused and share your concern about fraud, waste, and abuse and support many of the guardrails in the marketplace program around authentication of enrollment, doing that in a much more significant way. And we also support continuous enrollment, because we think that allows for a healthy population.

Mr. Balderson. Okay.

What are you seeing in the marketplace that makes stronger protections necessary?

Ms. Boudreaux. So there are a couple of opportunities, we believe.

One is verifying eligibility, ensuring that those who are eligible for the premium subsidies. We can do that with two-factor eligibility.

Again, only having special enrollment periods, really limiting those. Because, again, what makes a stable exchange marketplace is continuous coverage, policies that support that.

We also believe that coverage and being able to have preventative services over the long haul really supports individuals in the exchange and helps us to manage healthcare costs.

Mr. Balderson. Do you support legislation to strengthen the patient validation protocols?

Ms. Boudreaux. Unfortunately, sir, I am not sure I know exactly what that legislation is. I am happy --

Mr. Balderson. Well, we haven't done anything yet. I am just asking if you would support that. So, okay.

Thank you very much.

I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentleman from Louisiana, Mr. Carter, for his 3 minutes of questioning.

Mr. Carter of Louisiana. Thank you, Mr. Chairman.

We have heard in the lead-up to this hearing again and again that my colleagues, if nothing more than in their action, have indicated that it is okay for 24 million Americans to see their healthcare premiums increase by two or three or even four times.

The defense to this is -- and I will quote one of my colleagues -- is saying, "Those 24 million people are just 7 percent of Americans."

I suspect if you are one of the 24 million people experiencing skyrocketing healthcare cost, even financial ruin, that rhetoric doesn't really resonate with you.

The people in my home district of Louisiana are, in many cases, hardest hit.

Mr. Hemsley, can you share with me -- there is an issue with this notion of step therapy, where a patient is forced to use a medication that may be a generic or may be something else that is used similarly, even though their physician has indicated they don't think that that is the best medicine for them.

Should a licensed physician who knows the patient be trusted over an insurance algorithm when determining the most appropriate treatment instead of forcing patients through a step therapy requirement that delays care and oftentimes increases suffering and even cost?

Mr. Hemsley. No, I think there are appropriate times for step therapy, but in the situation you describe I would not.

Mr. Carter of Louisiana. And Mr. Joyner?

Mr. Joyner. Yeah, I agree. Step therapy is an opportunity for one to introduce a savings opportunity for the consumer and member as well, so --

Mr. Carter of Louisiana. But, respectfully, oftentimes it is not a savings; it is a nuisance.

Because the physician is saying, "This doesn't work for my patient." The patient goes to the pharmacy and is told, "You can't get this because the insurance company won't approve it because you haven't tried this." And the patient says, "But I have tried it. It doesn't work. There are horrible side effects." But now I have paid a 30-, 60-day, 90-day co-pay for it, and they won't let me do it again.

Isn't that unfair to a patient whose doctor, not an algorithm, but whose doctor has stated that this medicine doesn't work?

Mr. Joyner. Yeah --

Mr. Carter of Louisiana. These are the kind of things that we hear from our constituents, who are caught in the middle, trying to get a medication to assist them with their ailment, but only being caught up in the confines or the clutches of bureaucracy within healthcare.

Mr. Joyner. Yep. We completely agree with you, Congressman. In fact, if they have tried and failed, that is exactly where we want to engage and where we want to work with the provider on the appropriate therapy.

Mr. Carter of Louisiana. So is it fair, from all of the companies -- I have 7 seconds -- fair, from all the companies, that you agree that this is an issue and that you will commit to working with us to be that buffer for the patient so they are not caught up in a forced step therapy when the medicines don't work, to overrule their physicians, but to listen to them?

Is that a "yes"?

Thank you.

I yield.

Mr. Griffith. I am seeing yeses from everybody, and I appreciate those questions.

And I now look to recognize the gentleman from Ohio, Mr. Rulli, for his 3 minutes of questioning.

Mr. Rulli. Thank you, Mr. Chair.

And I want to take a moment and I want to thank Congressman -- I am not sure if I can say his name -- for calling out with Brian Thompson. He has always been in our prayers. And I think lowering the temperature and bringing things to a normal society is where we need to go, and there are definitely problems, and we are going to work on them.

So, with that said, House Republicans, by passing the Big Beautiful Bill and Lower Health Care Premiums for All Americans Act, have made it clear that they are serious about lowering healthcare costs and expanding choice and improving the quality of care for all Americans.

At a time when Americans are facing the highest healthcare costs in years, it is important, more than ever, to continue to bring down these costs.

Passage of the ACA left Ohioans with less healthcare insurance and options and skyrocketing premiums.

So I want to take a different approach. When I was in the Ohio Senate, I had this question for years, and I am going to bring it to you right now. To all the witnesses, do you believe that competition and free market leads to affordability?

And what I mean by this is, under the ACA, patients are not allowed to shop their premiums across State lines. Patients who live near State borders cannot shop their plan for the best possible price on these plans. In my opinion, that could bring down the cost.

What changes can Congress make to potentially allow interstate competition and increase the variety of plan options that patients can choose from?

Anyone on the panel is welcome to answer.

Mr. Hemsley. We would endorse all kinds of ideas and be open-minded about anything that could get bipartisan support for increasing access, reducing cost, making healthcare more affordable. If that was on -- if that idea was part of that, we could be for it.

Mr. Markovich. As a general principle, competition is good. What can get troubling or challenging for health plans is, there are a lot of State regulations around health insurance. And so, if they are different from one plan to another because they are based in a different State, that can create just a challenging environment to have apples-to-apples comparisons in terms of shopping for customers.

But, overall, if you can increase choice and increase competition, that is a good thing.

Mr. Rulli. Do you think that by us excreting this from the ACA, that would help? Or do you think, like, a freestanding bill to address this, where we could have interstate competition?

Mr. Markovich. Congressman, I'd be happy to work with you on it. I don't -- I am not trying to -- I know the time is limited. It is a fairly complex question, to make sure that you are doing what you are intending to do, which is increase competition and consumer choice, without creating an environment in which it is misleading for consumers because what they are buying from one plan versus another is very different in terms of their coverage. And that could be an

unintended consequence if it is not shaped the right way.

Mr. Rulli. I would love those conversations, if possible.

Thank you.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady of Texas, Mrs. Fletcher, for her 3 minutes of questioning.

Mrs. Fletcher. Thank you, Chairman Griffith.

And thank you to all of our witnesses for being here today.

I think we can all agree that we should be working to lower healthcare costs for all Americans. And I have heard from many of my constituents in Houston about the same problems that my colleagues have talked about today -- in particular, prior authorization, which leads to delays in care, and about the incredible burden of the back-and-forth between providers. I represent so many physicians who come to me and tell me they are not able to give their patients the care that they need because of the amount of time that they spend and their staff spend on the phone fighting with insurance companies. These are huge issues that we absolutely have to address.

I also think, with the limited time that we have, Congress hasn't helped yet either this year. Instead, this Congress has voted to decimate our healthcare system and raise costs for all Americans by cutting Medicaid funding and eliminating the enhanced premium tax credits that we have been talking about under the Affordable Care Act.

Mr. Carter just touched on this, and Chairman Guthrie made an important point earlier, that not everybody participates in an ACA plan. But I think what we haven't heard as much of today is that this entire system is an ecosystem. And so all of the costs, the cuts to Medicaid, the cuts to the ACA premium tax credits, removing people from the risk pool, will mean that everybody else's costs are going to go up.

That is a core principle of insurance, right? You get more people into the pool -- this is the idea of the ACA -- get more people in, you can bring costs down.

So I think that that is something that we need to understand here as we are making policy going forward.

And because, gosh, this is really limited time, I just want to go straight to: The Republicans have proposed, I think, two new things today. One of them is that they are suggesting putting money into HSAs.

So I want to ask each of the insurance industry witnesses here: Yes or no, can HSAs be used by individuals to pay their health insurance premiums?

I will start with you, Mr. Hemsley.

Can you turn on your microphone, please?

Mr. Hemsley. If that was part of a bipartisan solution --

Mrs. Fletcher. But, today, can you use has funds to pay for your premium?

Mr. Hemsley. No.

Mrs. Fletcher. Okay.

Mr. Joyner?

Mr. Joyner. No.

Mrs. Fletcher. Ms. Boudreaux?

Ms. Boudreaux. There is no single solution. HSAs would need to be expanded. But we do think there is an opportunity.

Mrs. Fletcher. Thank you, Ms. Boudreaux.

Mr. Cordani?

Mr. Cordani. Structurally, no, but employers are able to use HSAs to complement catastrophic coverages, effectively, and perhaps we could learn from the employer market.

Mrs. Fletcher. Mr. Markovich?

Mr. Markovich. Under current law, no.

Mrs. Fletcher. Okay. And that is the key. Under current law, this isn't a solution, to just

use the HSAs.

The other question I have in general -- well, we have 15 seconds, so I am just going to submit some more questions for the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Fletcher. But I thank you for your testimony today.

And I will yield back.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from New York, Mr. Langworthy, for his 3 minutes of questions.

Mr. Langworthy. Thank you very much, Mr. Chairman.

And I will kind of cut right to the chase. I mean, this is my first term on the Energy and Commerce Committee, and I have had an awful lot of healthcare meetings, and some of you have been by the office. But I ask every stakeholder that comes, why is healthcare increasing so drastically compared to other facets of the economy? Who is at fault?

And the amount of finger-pointing -- you know, if the hospitals are there, it is the insurance companies; or if it is the insurance companies, it is because of pharma; if it is pharma, it is because of the insurance companies.

And we need to get to the bottom of why premiums have exploded on Americans over the last 10 years and more drastically in the last 2, and what is driving these costs.

And what I think is important for us to be aware of is, what is each of your dedication to the bottom line with the -- the bottom-line cost to the taxpayer, to the consumer? Because, I mean, we are obviously shoveling trillions of dollars at the healthcare system in America, yet prices are exploding.

Now, some of my colleagues want the government just to pay for this for everyone, and that is what they think is the best ultimate solution. You heard several mention that. I believe in the American healthcare system that is a free-market system because I think it leads the way in innovation to get us the best outcome.

So, Mr. Hemsley, what is UnitedHealthcare specifically, not generally, doing right now to

lower premiums for its customers?

Mr. Hemsley. Thank you, Representative, for the question.

We are intensely focused on managing costs --

Mr. Langworthy. You need to keep these answers short. I mean, is there a specific action you are --

Mr. Hemsley. Managing costs, coordinating care, using data and insights and value-based care as the key to change the whole direction of healthcare towards a value-based outcome system and less towards a volume-based system.

Mr. Langworthy. Okay.

Mr. Joyner, what is CVS specifically, not generally, doing to lower premiums for its customers?

Mr. Joyner. Yeah. Today, we believe the single biggest issue is the health status of the population. They are aging, consuming more healthcare resources. So our focus is on wellness, prevention, keeping people out of the hospital, keeping people on low-cost therapies that we believe will ultimately manage the overall health cost, and, like UnitedHealthcare, focusing on an outcomes-based model with the provider. So we are working collaboratively and introducing technology to help bring the consumer into the process.

Mr. Langworthy. Ms. Boudreaux?

Ms. Boudreaux. Thank you.

Congressman, we have two core strategies in our company: one, reduced overall healthcare costs, and simplify the system.

I would offer three practical things.

One is, as we have shared, improve and streamline the prior-authorization process to take complexity out of the system for members and care providers.

Second, investing in fraud, waste, and abuse to take on necessary costs and make the premiums go to the right things.

And the last thing, as I share with my colleagues, continuing to invest and paying for value in outcomes to make people healthier.

Mr. Langworthy. Okay.

My time has expired, and so I will yield back, and if the rest could respond in writing, I would appreciate it.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. The gentleman has yielded back.

I now recognize Mr. Veasey from Texas for his 5 minutes -- or, 3 minutes. Excuse me.

Mr. Veasey. Thank you, sir.

I want to talk about vaccines, particularly because I think that Republicans and the Secretary, Secretary Kennedy, is undermining vaccines in this country.

My home State of Texas, we are at the epicenter of the historic measles outbreaks, where we have seen 2,000 Americans and 2 Texas kids that have been killed unnecessarily. And measles, which were previously eradicated, is one of the most deadly diseases, but there is a safe and effective vaccine for that, and I think that we all know that.

Meanwhile, 15 children have died during this flu season, and 90 percent of them were unvaccinated.

So it is not theoretical. For decades, insurers have covered vaccines based on the recommendations of independent medical experts. Those recommendations have literally saved the lives of 1 million Americans since 1994.

And, despite this fact, Secretary Kennedy has injected this pseudoscience into Federal vaccine policy and weakened the childhood immunization schedule. The Secretary says he wants to make America healthy again, but all he is doing is bringing measles back again. His actions have abandoned decades of hard scientific evidence and put children's lives directly at risk.

And so I want to ask this. And I would just like to go down the line to each one of you, and we will start here, on my right here. Yes or no, as a CEO, do you commit to covering ACIP insured vaccines on the immunization schedule prior to Secretary Kennedy's reckless changes for plan year 2026? And for what reason is your decision making that?

If everybody could just go down the line, yes or no, do you plan on --

Mr. Hemsley. So our --

Mr. Veasey. And we don't have a lot of time. If you could just give a "yes" or "no."

Mr. Hemsley. Our coverages are comprehensive and supported by the same authorities you reference, and then we allow the consumer to make a choice as to how they want to proceed. So we provide comprehensive coverage. And that is between the doctor and the --

Mr. Veasey. So you are still going to be covering?

Mr. Hemsley. Yes, we are.

Mr. Veasey. Okay.

Mr. Joyner. Congressman, no change to our policy. We are continuing.

Ms. Boudreaux. Congressman, we cover vaccines. We haven't changed our policy. Our vaccines -- we do it as required by law, but we also look at ACIP as well as clinical societies, and that is how we make our decisions.

Mr. Cordani. Our comprehensive coverage remains intact, and it is largely zero-dollar cost to our customers in the employer market.

Mr. Markovich. Yes. It is the consensus of the medical community that they are safe and effective, and so we continue to cover them.

Mr. Veasey. Thank you.

Well, first of all, let me just say thank you. We really appreciate that you are following the science behind all of this. And I am glad that we can agree that children's lives are more important than politics.

And, again, not only are you following the science, I mean, you are following common sense. This stuff has been researched and it has been a part of American life and has made us safer for a reason. So thank you for your commitment.

I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Florida, Mrs. Cammack, for her 3 minutes.

Mrs. Cammack. Thank you, Mr. Chairman.

You know, over and over, I hear the same question from people back home: Why in the heck am I paying for insurance if it actually doesn't cover anything?

And this is across all plans and companies. So, to be clear, I am not just talking about the ObamaCare, which has dominated much of the conversation today. Only, you know, 20 million people are covered there. But what I am talking about are the 160 million Americans who get their coverage through employer-sponsored insurance. And that is where so many of the affordability challenges are showing up every single day.

And these families are rarely talked about. They haven't been talked about much today. And so I want to address their concerns that they have sent to me across social media, emails, text messages -- thousands and thousands of messages we have collected over the last 72 hours.

And there is a very troubling theme: One, they think that you guys showing up here today will change nothing. So, on behalf of the thousands and thousands -- hell -- millions of Americans, please take this hearing as a moment in time when you need to change direction.

I am going to make this very simple for people watching back home. I am going to ask a series of questions, and if this statement applies to your company, please raise your hand.

So, if your executive compensation at your company, including yours, is primarily tied to financial performance, like revenue, margins, earnings, or stock price, please raise your hand.

Don't be shy.

Okay. I see three out of five. Okay.

Raise your hand if your compensation is directly tied to patient health outcomes, such as preventing harm from delays, reducing inappropriate denials, or ensuring access to care; the majority of your compensation is tied directly to patient outcome.

I am going to submit for the record right now a request that you in writing give us the fine print of your contracts, displaying where patient outcome is directly tied to your executive

compensation.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Cammack. Raise your hand if an executive at your company takes a financial penalty when a patient is harmed due to an insurer-caused delay or wrongful denial.

Okay. No hands. So no one at the company bears any responsibility for denial of care or patient outcomes.

Raise your hand if an overturned denial or appeal negatively impacts executive compensation at your company.

Not one.

That right there is the problem. When denials and delays and appeals, which happen every single day, occur, the patient and their families are the ones that get hurt, not your bottom line.

I also heard very briefly from our colleague that HSAs currently cannot pay premiums for plans. Good news is that there is legislation called the ACCESS Act, which would allow for HSAs to expand and use that subsidy to pay for those premiums. So I look forward to working with her on this legislation.

I see my time has expired. With that, I yield.

Mr. Griffith. And the gentlelady yields back.

And I now recognize the gentlelady from Illinois, Ms. Kelly, for her 3 minutes of questioning.

Ms. Kelly. Thank you, Chair Griffith and Ranking Member DeGette, for holding today's hearing.

There is a healthcare affordability crisis in this country under President Trump. Republican-led cuts to Medicaid will drive the uninsured rate up by roughly 50 percent over the next decade. At the same time, their refusal to extend ACA tax credits will more than double monthly premiums for millions of Americans.

You have heard all this already.

The result is simple: People will delay care or go without entirely because they cannot

afford coverage, as our witnesses said.

These are people's lives we are talking about. As some of the largest health insurance administrators in the Nation, you have real influence over Federal policy and industry outcomes. The ask has been clear, and your responses have not met the moment.

For all CEOs: Back in November, one of my constituents, Mercedes Wells, had a traumatic birth in her car after being discharged from the hospital while in active labor. In response, I announced a new maternal health bill, the WELLS Act. I also sent letters to many of you asking about your commitment to maternal health.

We have a maternal health crisis in this country, and evidence shows that doulas lead to better healthcare for pregnant women.

So I ask all of you: Raise your hand if your company has a standard policy to explicitly cover doulas for their services during and after pregnancy for the majority of your plans.

All but one. Thank you.

Mr. Hemsley, earlier, you admitted to my colleague that your company uses technology in a number of initiatives.

Over the last 5 years, there has been an alarming increase in reports of inappropriate AI prior-authorization denials by your company. One study in 2024 found that these AI denials had a 90-percent error rate. If a healthcare provider had this bad of an error rate, they would lose their license and be in jail.

Does United use AI or algorithmic tools to adjudicate claims or pretreatment estimates? And what governance and independent auditing do you use to prevent systemic underpayment or inappropriate denials?

Mr. Hemsley. Yes. Thank you for the question.

We use AI solely for administrative purposes. We do not use it for clinical applications at all.

Ms. Kelly. So it has nothing to do with denials?

Mr. Hemsley. Only from an administrative -- gathering documents, things like that. Only administrative.

Ms. Kelly. Will you pledge that each determination will be reviewed or -- I don't know how you do it -- by an outside, neutral, practicing physician who is licensed in the same specialty as the care in question?

Mr. Hemsley. I am not sure I understand what you are asking.

Ms. Kelly. I guess I am questioning why people are denied, and you are saying it is not by AI. So who determines how people are denied?

Mr. Hemsley. Clinical policies, broadly accepted and promulgated by the care community, the academies and colleges --

Ms. Kelly. So not physicians in the field, or yes?

Mr. Hemsley. Physicians oversee our clinical reviews.

Mr. Griffith. Ms. Kelly.

Ms. Kelly. I am sorry.

Mr. Griffith. That is all right. If we didn't have a time limit, I would let you go.

I recognize the gentleman from Texas, Mr. Crenshaw, for 3 minutes.

Mr. Crenshaw. Thank you, Mr. Chairman.

You know, since the Affordable Care Act passed, premiums have increased 129 percent. That is 90 percent more than inflation. In the 10 years before the ACA passed, premiums rose at about 5 percent per year, 69 percent total, which roughly tracked inflation.

Something broke the system, and that something is ObamaCare. So what happened?

Now, the Democrats who passed the ACA deserve blame. They deserve a lot of blame. They imposed rigid mandates and regulations that made it nearly impossible to offer flexible, affordable, tailored insurance plans. That crushed competition.

Much of this is government's fault, but not all of it. In your testimonies, many of you claim

vertical consolidation is a major driver of rising costs like it is outside your control. But is it?

Because here is the thing: Many of you here today are participants in that consolidation. We have insurers that own physician groups, PBMs, hospitals, pharmacies -- every rung of the healthcare ladder. And the result? Competition is basically nonexistent. Many counties have one or two ACA plans, options, if that.

Your companies have narrowed networks so severely that patients are forced into the very consolidated systems that you now complain about. And the government did not force you to do that.

So, look, Congress has a responsibility here to fix a broken system, to fix incentives, restore patient control and choice and competition. But you have a responsibility to also act in good faith.

Premiums are way up. Profits are way up. Claim denials are way up, which was just addressed. One in five claims denied. It is an all-time high this year. Why? That is a rhetorical question, because I don't have enough time.

But I do want to ask one simple question. Wouldn't it make a lot more sense to subsidize low-income patients -- which is the point of the ACA, right? -- subsidize low-income patients directly through a health savings account that they own instead of subsidizing you, the insurance companies?

Who can answer that one? Anybody? Does anybody agree with that, that concept? Subsidize patients through a health savings account instead of subsidizing insurance companies?

Mr. Markovich. Congressman --

Mr. Crenshaw. Not even our patient advocate?

Sorry. Go ahead.

Mr. Markovich. I don't want to -- did you want to -- okay.

I am -- I and we are very open to having mechanisms where money goes directly to --

Mr. Crenshaw. Okay, I got one "maybe." Anybody else?

Mr. Hemsley. We would be supportive of anything that puts the consumer more in control.

Mr. Crenshaw. I got another "maybe."

Mr. Hemsley. And --

Mr. Crenshaw. Sorry. There is no time.

Mr. Hemsley. -- funding makes no difference. It is the costs.

Mr. Crenshaw. Got it.

Patient advocates even?

Mr. Allen. Respectfully, I think that could undermine the healthcare system --

Mr. Crenshaw. Interesting. Okay. "No."

So let me ask you again another question, just Econ 101. Does competition re- -- competition requires real choice, right? This is an Econ 101 question. Competition lowers prices, doesn't it?

Competition will exist if patients control the money and then can go on the market and actually make you compete with each other.

Mr. Griffith. Mr. Crenshaw, would you submit that for the record, please?

Mr. Crenshaw. I will.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Crenshaw. Jeez, that was fast.

Mr. Griffith. Yeah, I know.

The gentleman yields back.

I now recognize the gentleman from Ohio, Mr. Landsman, for his 3 minutes.

Mr. Landsman. Thank you, Mr. Chair and the ranking member, all of you for being here.

In my lifetime, a lot has happened, but the biggest thing, in my mind, is the extreme concentration of wealth and power. I think most of the issues that we face in this country can be connected back to this concentration of wealth and power at the top.

And nowhere is that more true than in healthcare. CEO pay across the board is up a thousand percent since I was born. Workers are, you know, up 25 percent. They can't keep up. And as it relates to healthcare, you have one of three Americans who are struggling with medical debt. One in three Americans had to pass on a needed procedure because they couldn't afford it.

And in the One Big Beautiful Bill, after decades of all of this money going up, they voted on the largest transfer of wealth in American history from low-income, working folks to the super-wealthy, spending trillions of dollars on tax cuts for the super-wealthy, and they cut a trillion dollars in healthcare.

So folks are sitting here wondering, you know, how is this possible? How do I, as a hardworking American, continue to be screwed over like this?

Now, looking at the profits: United, over the last couple years, it is on average around $20 billion; CVS, around $6 billion; Elevance, around $6 billion; Cigna, around $6 billion. You all know this is an issue. It is why UnitedHealth said, we are going to invest these ACA profits back into our customers.

If shareholders said tomorrow, let's do this, let's do more of this, this was a good idea, let's invest more of our profits back into our patients, what would you tackle first?

So you have got $15 billion, $14 billion, this year in profits. Let's say you just want to keep a couple; shareholders said, the rest of it is going back into our patients. Would it be medical debt? Would you focus on denying less claims? Would you cover more people?

I am just curious -- and we will start with Mr. Hemsley -- what would you invest in first?

Mr. Hemsley. Thank you for the question, and I think it is very thoughtful.

And the same things we are investing in now: the advancement of a movement towards value-based care to get off the volume; better systems and technology to take the complexity and make the system more simple.

I think those things would profoundly change the underlying costs and the consumer and care provider experience.

Mr. Landsman. I only have 12 -- but I would love to hear from everyone else, but I only have 10 seconds. I want to be respectful, because you guys have to go to another meeting.

We have a lot of work to do. Congress has to fix this. They have to fix the healthcare system so that we can invest more in patients. I think this is an opportunity for you all -- and you are hearing it -- to do the same.

Thank you. I yield back.

Mr. Griffith. The gentleman yields back.

I now recognize the gentlelady from Indiana, Mrs. Houchin, for her 3 minutes.

Mrs. Houchin. Thank you, Mr. Chairman.

And thanks to the witnesses.

Today's hearing provides us an opportunity to look beyond the premiums and examine what is happening behind the scenes, how insurers structure administrative fees, how payment practices affect employers and providers, and whether current incentives are aligned with affordability for patients or profits for insurance companies.

There are so many perverse incentives created by the ACA, I honestly can hardly blame you

for trying to find ways to increase profits. But vertical integration, I think, is something that we absolutely have to take a look at, and I am glad this committee is doing that.

As insurers have become more vertically integrated and increasingly relying on administrative entities like group purchasing organizations -- and a reminder: Vertical integration is the insurance companies owning the providers, owning the hospitals, owning the pharmacies, owning the PBMs, and now affiliating with group purchasing organizations.

GPOs were created by the largest PBMs and have added yet another layer of complexity to the prescription-drug supply chain, making it even more opaque. Two of the three largest PBMs have established their GPOs overseas, which you have confirmed, while continuing to claim that rebates and fees are being negotiated on behalf of U.S. plan sponsors and patients.

Evidence suggests, in practice, some of these entities may be retaining rebates in the commercial market and charging additional fees that are not passed on to employers or reflected in lower out-of-pocket costs at the pharmacy counter. And with vertical integration, it makes the true profit margins easier to hide.

In fact, a recent investigative report published by Hunterbrook looked into PBM GPOs and found that, while there were fewer than 150 employees across all three of them, PBM-owned GPOs somehow generated more than $50 million in revenue per employee. Not even Nvidia generated that level of per-employee revenue.

So my question is, how are PBM GPOs so incredibly profitable?

Anyone can answer.

How is it so profitable to have a GPO? How are they profiting $50 million in revenue per employee on the backs of American patients?

No answers. Okay.

I have also heard from a number of physicians who have reported concerns about the No Surprises Act and the implementation of that often delaying awarded amounts.

And I want to focus quickly on Elevance Health.

Ms. Boudreaux, compliance -- do you track compliance internally on those arbitration awards? And how many of those are remaining unpaid or partially unpaid more than 30 days after a favorable decision?

Ms. Boudreaux. So, Congresswoman, thank you for the opportunity to talk about the No Surprises Act.

We are very supportive of the No Surprises Act, always have been. There is a problem, though, in the arbitration system, where private equity and EC-backed entities are flooding the system. The CBO recommended that 17,000, roughly, would be this year. We have received, across the system, almost 2.2 million arbitrations.

And because of the style of arbitration, where it is basically baseball-style, we are seeing awards at 429 to 450 percent.

And if you would just give me one second, I think making this real for people is so important.

You know, in this situation, Los Angeles is one of the areas we are seeing the highest arbitration awards. CMS for spinal surgery will pay $1,500. Commercial insurance will pay $1,900 --

Mr. Griffith. And, ma'am --

Ms. Boudreaux. -- offering $2,000 --

Mr. Griffith. -- we are pushing up against your time. We know you have another hearing.

Ms. Boudreaux. Thank you. I will just finish with --

Mr. Griffith. So please do a full explanation in your written response to Mrs. Houchin.

Mrs. Houchin. And, Mr. Chairman, I have a number of questions that I will provide to the record.

Mr. Griffith. Absolutely.

[The information follows:]

******** COMMITTEE INSERT ********

Mrs. Houchin. Thank you for the time.

Mr. Griffith. The gentlelady yields back.

I now recognize the gentleman from Michigan, Mr. James, for up to 3 minutes.

Mr. James. Thank you, Mr. Chairman.

We were promised affordable care. What Americans got was unaffordable premiums, sky-high deductibles, and bureaucrats standing between patients and their doctors, all while American people get sicker.

I said back in 2018 that ObamaCare was a flawed, broken system, and I was called a fearmonger.

So let's stop arguing about intentions and talk about results. Under this system, families are punished if they stay healthy and they are financially devastated if they get sick. That is not healthcare; that is sickcare.

Since the Affordable Care Act passed, wages are up 26 percent, but deductibles are up 160 percent. Premiums are up nearly 80 percent. The average family now pays around $24,000 a year for health insurance -- more than many families pay for their mortgage. Some are paying $30,000, $40,000 and still rationing care. That is not a safety net; that is a hangman's noose.

So let's start with a very simple question for some very smart people here. Raise your hand if you believe that healthcare today is affordable for the average American.

No hands. So we have agreement.

I believe it is unaffordable because nobody knows what they are paying for. The only way we can have affordability in this country is if we have accountability. And we, you all must be accountable to the American people. President Trump made this clear in his Great Healthcare Plan: You must post your prices so patients can see them.

So I will ask you again plainly: Yes or no, if you are buying a plane ticket, do you know how

much it costs?

Yes, you know how much it costs. So why in healthcare do we hide our prices? You only hide things if you don't want people to know what you are doing.

Will you commit -- will you commit to publishing clear, complete rates, side-by-side coverage comparisons, that employers and families can actually understand in the same places that you place your bills?

I see one head nodding.

Mr. Markovich. Actually, we are already doing that.

Mr. James. Already doing it?

Mr. Markovich. Yeah.

Mr. Hemsley. Already doing that.

Mr. James. It is not having the desired results. We need to do better. We need to stand behind the transparency data with the same seriousness that you expect patients to pay you back.

The American people were promised affordable care. What you have given them is higher costs and worse health outcomes. After more than a decade, Americans are a heck of a lot sicker and a heck of a lot more insured at the exact same time. How does that happen?

Your incentive structures must change. You must be held accountable, and you must change course. The American people are done with it. I am done with it.

And I am speaking to all my colleagues on this committee. We have to hold these companies accountable, and the best way to do this is through transparency. My bipartisan and bicameral Patients Deserve Price Tags bill does exactly that. Please, give the American people your support.

Thank you, Mr. Chairman. I yield.

Mr. Griffith. The gentleman yields back.

That concludes the questioning section of this hearing.

I ask unanimous consent to insert in the record documents included on the staff hearing document list and those that were brought up during the meeting.

Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. I now recognize the ranking member for 30 seconds for a point of personal privilege.

Ms. DeGette. Thank you, Mr. Chairman.

I just want to thank everybody for coming here, and I want to thank you in advance for being part of our bipartisan solution. We appreciate it.

Our members worked hard for this hearing, and they wanted to ask their full 5 minutes of questions. So I would just ask everybody -- we had to truncate the end of it because of your schedule. So I would just ask everybody, when you get these questions from members on both sides of the aisle, please give us in-depth responses quickly, because it will help us as we work to develop bipartisan legislation.

Thank you, Mr. Chairman. I yield back.

Mr. Griffith. Thank you, Ranking Member DeGette.

I would like to thank all of our witnesses again for being here today.

Members may have additional written questions for you. I guarantee they will. And I will remind members, they have 10 business days to submit questions for the record, and I ask the witnesses to respond to the questions fully and promptly.

Members should submit their questions by the close of business on Thursday, February 5.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Griffith. Without objection, the subcommittee is adjourned.

[Whereupon, at 1:23 p.m., the subcommittee was adjourned.]