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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Health Subcommittee

of the

United States House of Representatives

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

January 22, 2026

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

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

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

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

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

CURRENT LANDSCAPE

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

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

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

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

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

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

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

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

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

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

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

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

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[3] UHG Report - Final

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

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

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

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

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

Prior Authorization and Coverage Denials

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

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

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

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

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

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

Negative Impacts on Patient Care

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

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

Payment Delays for Approved Care

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

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

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

Use of Third-Party Vendors

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

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

Increased Burnout Due to Administrative Burdens

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

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

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

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

Benefit Design Implications

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

SPENDING ON HOSPITAL CARE

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

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

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

RECOMMENDED SOLUTIONS

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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