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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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January 20, 2026

MEMORANDUM

To: Subcommittee on Health Members and Staff
From: Committee on Energy and Commerce Majority Staff
Re: Subcommittee on Health Hearing on January 22, 2026

I. INTRODUCTION

The Subcommittee on Health will hold a hearing on Thursday, January 22, 2026, at 9:45 a.m. (ET) in 2123 Rayburn House Office Building. The hearing is entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability."

II. WITNESSES

- **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
- **Ellen Allen**, Executive Director, West Virginians for Affordable Health Care

III. BACKGROUND

This hearing will continue the Committee's work to make health care more affordable for all Americans by hearing testimony from some of the nation's top health insurance executives. The purpose of the hearing is to discuss the root causes driving up health care costs and explore potential policies to bend the health care cost curve down.

A. National Health Care Spending

National health expenditures, as tracked by the Centers for Medicare and Medicaid Services (CMS), increased by 7.2 percent to $5.3 trillion in 2024, accounting for 18 percent of America's Gross Domestic Product in 2024:[1]

- Hospital expenditures grew 8.9 percent to $1.6 trillion in 2024—tripling the 3.2 percent growth rate in 2022 and representing 31 percent of total national health expenditures;[2]
- Physician and clinical expenditures grew 8.1 percent to $1.1 trillion in 2024—representing 21 percent of the total national health expenditures;[3]
- Prescription drug spending increased 7.9 percent to roughly $467 billion in 2024;[4] and
- In 2022, 41 percent of adults reported outstanding debt as a result of medical or dental bills.[5]

B. Commercial Insurance Spending

More than 214 million people were enrolled in private health insurance in 2024 in the U.S. Private health insurance spending in 2024 was $1.6 trillion, representing 31 percent of total health spending. Factors accounting for this growth in spending include growth in medical prices (accounting for 2.5 percent of the total increase) and the use and intensity of health care goods and services (accounting for 3.6 percentage points of the increase).[6]

In 2022, commercial payers, on average, reimbursed over two and a half times what Medicare reimburses 281 percent of the drug's average sales price (ASP), compared to 106 percent of ASP paid by Medicare.[7]

Recent Transparency in Coverage (TiC) data has illustrated commercial market reimbursement discrepancies for certain health care services based on provider sites of service. For example, in May 2023, facility fees for colonoscopies delivered within a hospital were found to be substantially higher—between 154 percent and 161 percent—than facility fees charged for the same services delivered at ambulatory surgery centers (ASC).[8]

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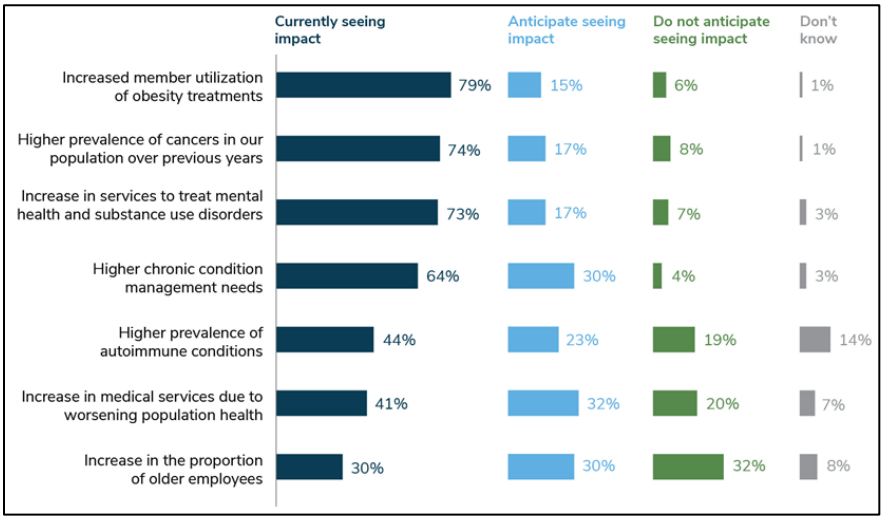
[1] Micah Hartman et al., *National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated*, HEALTH AFFAIRS (Feb. 2026), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2025.01683.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] Grace Sparks et al., *Americans' Challenges with Health Care Costs*, KFF (Dec. 11, 2025), https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/.
[6] *Supra*, note 2.
[7] Christopher M. Whaley et al., *Prices Paid to Hospitals by Private Health Plans*, RAND (Dec. 10, 2024), https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html.
[8] Yang Wang et al., *Facility Fees for Colonoscopy Procedures at Hospitals and Ambulatory Surgery Centers*, JAMA (Dec. 15, 2023), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812610?resultClick=1.

C. Employer-Sponsored Insurance Spending

Health care costs in the employer-sponsored insurance market, which provides health coverage to around 178 million Americans, are expected to increase in plan year 2026 by 6.7 percent,[9] despite initial estimates expecting costs to increase by 9 percent before employer plan design changes to mitigate cost increases.[10] This is the highest year-over-year percentage increase in health care spending in the employer sponsored insurance marketplace in 15 years. Employers identified several factors contributing to escalating health care costs, including the following:

- Annual increases in prescription drug spending, which rose by 9.4 percent in 2025.
- An increase in high-cost claims, particularly those exceeding $100,000. Such claims are generally driven by highly complex medical conditions "such as cancer, NICU stays, cardiovascular disease, and advanced treatments like gene therapy."[11]
    - Five percent of all enrollees account for 56 percent of total health spending.
    - One percent of all enrollees are responsible for 28 percent of total health spending.
- An expected 11-12 percent increase in pharmacy costs looking ahead to 2026. In 2024, 24 percent of total health care spending went towards pharmacy expenses.[12]

Additional cost drivers identified by employers in the 2025 Business Group on Health Employer Health Care Strategy Survey include:[13]

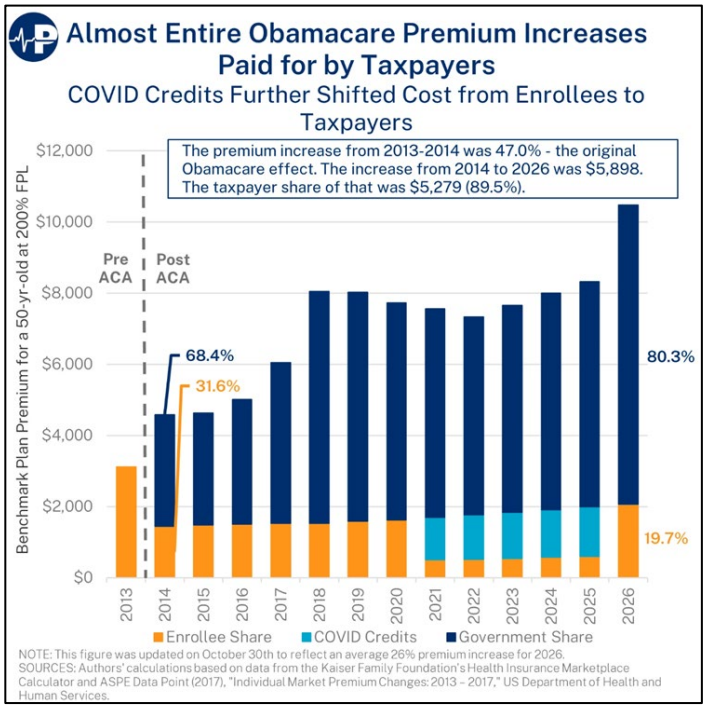


[9] Mercer, *Employers are challenged to keep healthcare affordable as costs soar: Survey results* (Nov. 17, 2025), https://www.mercer.com/en-us/insights/us-health-news/employers-are-challenged-to-keep-healthcare-affordable-as-costs-soar-survey-results/.
[10] Paige Minemyer, *Employers brace for a 9% cost increase in 2026: Business Group on Health survey,* FIERCE Healthcare (Aug. 19, 2025), https://www.fiercehealthcare.com/payers/employers-brace-9-cost-increase-2026-business-group-health-survey.
[11] Susan Mueller, MD, *High-cost claims: A growing concern for employer-sponsored health plans,* WTW (Sept. 12, 2025), https://www.wtwco.com/en-us/insights/2025/09/high-cost-claims-a-growing-concern-for-employer-sponsored-health-plans.
[12] Business Group on Health, *2026 Employer Health Care Strategy Survey: Executive Summary* (Aug. 19, 2025), https://www.businessgrouphealth.org/resources/2026-employer-health-care-strategy-survey-executive-summary.
[13] *Id.*

D. Individual Market Spending

The Patient Protection and Affordable Care Act (ACA) established health exchanges at the federal and state level, which sought to streamline the purchase of health insurance coverage for individuals and families not directly linked to employment. As of plan year 2025, there were over 24 million enrollments in ACA exchange health plans.[14]

From 2014 to 2020, which was the last year before implementation of the temporary enhanced premium tax credits by Democrats, the total average ACA premium increased from roughly $4,500 to $8,000, representing roughly a 10 percent year-over-year increase.[15] By comparison, for plan year 2026, health insurers increased gross ACA plan premiums on average by 26 percent. In states that rely on the federal marketplace, average gross plan premiums increased by an average of 30 percent.[16] The Congressional Budget Office (CBO) estimates that the expiration of the enhanced premium tax credit will increase gross benchmark premiums by between 4 percent and roughly 8 percent between 2026 and 2034.[17]



[14] Press Release, CTRS. FOR MEDICARE & MEDICAID SERVICES (CMS), *Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025* (Jan. 17, 2025), https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025.
[15] Mark Howell, *Almost Entire Obamacare Premium Increases Paid for By Taxpayers,* Paragon Health Institute (Sept. 22, 2025), https://paragoninstitute.org/paragon-pic/almost-entire-obamacare-premium-increases-paid-for-by-taxpayers/.
[16] Cynthia Cox, *ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay*, KFF (Oct. 28, 2025), https://www kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/.
[17] Letter from Phillip L. Swagel, Director, Congressional Budget Office to the Honorable Ron Wyden, the Honorable Jeanne Shaheen, the Honorable Richard Neal, and the Honorable Lauren Underwood (Dec. 5, 2024), https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf.

E. Regulatory Landscape

The ACA introduced a litany of federal coverage and plan design mandates for private market health insurance plans, particularly within the small group and nongroup markets. These mandates included, but are not limited to, the following:[18]

1. **Medical Loss Ratio**:[19] The ACA established a federal medical loss ratio (MLR) in the individual, large group, and small group markets. The MLR requires health plans to spend at least 80 percent of collected premium revenue on medical and quality improvement expenses in the small group and nongroup markets and is set at 85 percent in the large group market. The remaining share of premium collections, which are 20 percent in small group and nongroup, and 15 percent in large group, may be used for administrative expenses and profits.
    a. If an insurer fails to meet the MLR threshold, they may have to pay back excess profits to their beneficiaries and/or plan sponsors in the form of rebate checks.
    b. The MLR has been identified as a potential core driver of health premium inflation.[20] The MLR effectively capped profit margins and administrative costs for U.S. health insurers, which turned the U.S. health insurance marketplace into a "cost-plus" business, incentivizing insurers to grow patient and employer premium collections in place of improving efficiencies as the only way for an insurer to increase profits.
    c. The MLR also has been identified as potentially increasing incentives for health plans to pursue horizontal and vertical integration.
        i. The MLR created a system in which insurers were incentivized to acquire, affiliate with, or spin off provider organizations, pharmacy benefit management companies, group purchasing organizations (GPO), and other "service" businesses not beholden to the MLR mandate. This allows plans to skirt MLR requirements by vertically integrating such that their medical payout thresholds can be achieved by paying themselves through their owned or affiliated provider and service businesses.[21]
        ii. The MLR disproportionately impacts smaller insurers. A health plan's MLR is, in part, determined by the relative size of the health plan—larger health plans with bigger beneficiary pools leverage economies of scale and allow for premium dollars to be managed and spent more efficiently. That

[18] 42 U.S.C. § 18001-18122; *see also* Kaye Pestaina et al., *The Regulation of Private Health Insurance*, KFF (Oct. 8, 2025), https://www kff.org/patient-consumer-protections/health-policy-101-the-regulation-of-private-health-insurance/?entry=table-of-contents-introduction.
[19] Laura A. Wreschnig, CONG. RSCH. SERV. (CRS), R42735, Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress (Jan. 29, 2015).
[20] Randolph W. Pate et al., *The Unintended Consequences Of The ACA's Medical Loss Ratio Requirement*, Health Affairs (Oct. 15, 2025), https://www.healthaffairs.org/content/forefront/unintended-consequences-aca-s-medical-loss-ratio-requirement.
[21] Grant Rigney, *Gaming the Medical Loss Ratio: How health insurers turn consumer protections into corporate windfalls*, The Foundation for Research on Economic Opportunity (Dec. 16, 2025), https://freopp.org/oppblog/gaming-the-medical-loss-ratio-how-health-insurers-turn-consumer-protections-into-corporate-windfalls/.

means smaller plans may have a harder time meeting MLR thresholds should their smaller patient pools' health care costs increase, whereas larger plans may be more insulated from health care cost increases.[22]

2. **Coverage Mandates**: The ACA established a core set of national "essential health benefit" categories, built in flexibility for states to add additional essential health benefits, and mandated coverage of preventive services at no cost sharing to the patient.
    a. In the small group and nongroup marketplace, qualifying health plans must include coverage for ten essential health benefit categories, including the following: ambulatory patient services; emergency services; hospitalizations; pregnancy, maternity, and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; and pediatric services including oral and vision care.[23]
        i. States also maintain flexibilities to add additional essential health benefit coverage requirements.[24] For example, qualifying health plans in California must provide coverage for nearly 40 state-mandated essential health benefits, whereas Colorado mandates gender affirming care as an essential health benefit, and Oregon mandates acupuncture as an essential health benefit.[25]
        ii. In order for a state to add essential health benefits to its qualifying health plans, the state must "defray" any additional costs, either to the health plan or the beneficiary, if adding the benefit would increase federal spending on ACA subsidies. In 2024, CMS loosened states' defrayal requirements, with CMS tacitly acknowledging that their regulatory changes would likely increase health plan costs and federal spending on ACA subsidies.[26]

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[22] Avik Roy, *Obamacare's MLR 'Bomb' Will Create Private Insurance Monopolies and Drive Premiums Skyward. Hallelujah!*, Forbes (Dec. 6, 2011), https://www forbes.com/sites/theapothecary/2011/12/06/obamacares-mlr-bomb-will-create-private-insurance-monopolies-and-drive-premiums-skyward-hallelujah/.
[23] *What Marketplace health insurance plans cover*, Health benefits & coverage, Health Insurance Marketplace, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/#:~:text=All%20plans%20offered%20in%20the,aren't%20essential%20health%20benefits (last accessed on Jan. 16, 2026).
[24] CMS, Data Resources, *Information on Essential Health Benefits (EHB) Benchmark Plans* (Jan. 14, 2025), https://www.cms.gov/marketplace/resources/data/essential-health-benefits#:~:text=For%20the%202020%20plan%20year%20and%20beyond%2C%20CMS%20approved%20changes,%2Dbenchmark%20plan%20(ZIP).
[25] CMS, *California – State Required Benefits*, https://downloads.cms.gov/cciio/State%20Required%20Benefits_CA.pdf (last accessed Jan. 16, 2026); *see also* Stacey Pogue et al., *Enhancing Essential Health Benefits: How States Are Updating Benchmark Plans to Improve Coverage*, The Commonwealth Fund (Nov. 14, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans#:~:text=So%20far%2C%2011%20states%20and,and%20updating%20this%20federal%20protection..
[26] Final rule, 89 Fed. Reg. 26218 (June 4, 2024) (*Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program* final rule, which was published on April 15, 2024, and took effect on June 4, 2024).

b. The ACA empowered the U.S. Preventive Services Task Force (USPSTF) with authority to determine health plan coverage for certain preventive services with no patient cost sharing.[27]
    i. Experts have argued that the USPSTF, which was initially created in 1984 as a government advisor to assess the utility of preventive health measures, was never designed to wield the force of law and assess sweeping coverage mandates across insurance markets.[28]
    ii. The USPSTF aims to update its guidelines every five years, but it often takes over five years to update their recommendations. For example, USPSTF most recently updated colorectal screening guidelines in 2021, and, to date, they have yet to initiate the next update. USPSTF recommendations, once initiated, often take years to be finalized.
    iii. New preventive screening breakthroughs and modalities that do not receive coverage designations from USPSTF often languish.[22]
    iv. The USPSTF notably does not consider the costs of preventive services when determining coverage mandates.[29]

3. **Guaranteed Issue, Risk Pooling and Rating Restrictions**: The ACA prohibited health plans from "underwriting" certain individuals, prohibited certain individuals from enrolling in coverage based on underlying medical conditions, restricted the social and medical factors that plans account for when pricing health plan offerings to beneficiaries, limiting them to demographic data and smoking prevalence, and required health plans to maintain a single beneficiary risk pool.
    a. Prior to the implementation of the ACA, health plans were afforded more flexibility in offering and pricing health plans that were more specifically reflective of an individual's expected health care costs. Health plans were also more freely able to deny health coverage for expected high-cost beneficiaries based on underlying health conditions, for example.[30]
    b. The ACA mandated coverage for individuals regardless of underlying health conditions and largely prohibited plans from underwriting plans at the individual level, effectively increasing health care access and affordability for the

[27] 42 U.S.C. § 18001-18122; *see also* Laurie Sobel et al., *ACA Preventive Services Are Back at the Supreme Court: Kennedy v. Braidwood*, KFF (Jul. 17, 2025), https://www.kff.org/womens-health-policy/aca-preventive-services-supreme-court-kennedy-braidwood/#:~:text=The%20ACA%20and%20Preventive%20Services,periodic%20updates%20of%20existing%20recommendations.
[28] Scott Gottlieb, *The Bleeding Edge of Rationing*, American Enterprise Institute (Nov. 3, 2011), https://www.aei.org/research-products/report/the-bleeding-edge-of-rationing/.
[29] U.S. PREVENTIVE SERVICES TASK FORCE, Task Force Resources, *USPSTF and Cost Considerations* (Apr. 2021), https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/task-force-resources/uspstf-and-cost-considerations.
[30] *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*, American Academy of Actuaries (May 2017), https://actuary.org/how-changes-to-health-insurance-market-rules-would-affect-risk-adjustment/.

unhealthiest Americans but also driving up health care costs for healthier Americans.[31]

F. Administrative Costs

Administrative costs in the U.S. health care system account for roughly 25 percent of total health expenditures annually from 1999 through 2019. If the current trend holds, administrative costs will be roughly $2.2 trillion in 2035.[32]

Exhibit 1: The industry will spend over $2 trillion on administrative functions in 2035

Administrative costs by activity, 2035, $US trillion, % of total

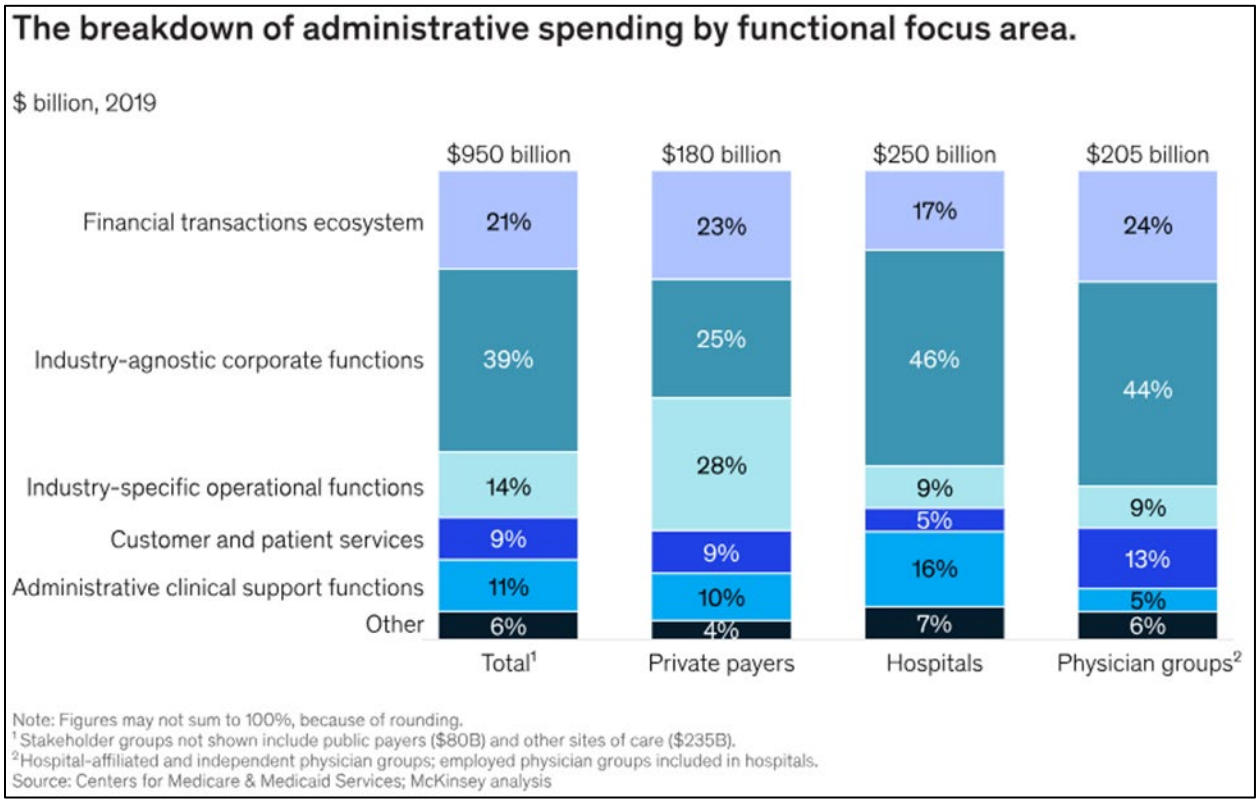
Cost category	Activities within cost category
General and administrative	Back-office administration functions, including human resources, legal, finance, and information technology
Payment exchange	Claims, revenue cycle management, billing, quality reporting
Customer service	Member, patient, and customer support
Utilization management	Prior authorization, payer case management
Credentialing/licensing	Licensing and credentialing, provider management
Other	Government administration, sales and marketing, non-clinical IT, clinical support administration

Completing bureaucratic tasks, such as charting and paperwork, are the leading contributor to physician burnout, as 62 percent of providers have identified administrative work as their top source of burnout.[33] The National Center for Health Workforce Analytics (NCHWA) projects an overall shortage of over 140,000 physicians in the U.S., including a shortage of over

[31] *Cost of the Future Newly Insured under the Affordable Care Act (ACA)*, Society of Actuaries (Mar. 2013), https://www.soa.org/globalassets/assets/files/research/projects/research-cost-aca-report.pdf.
[32] Charlie Hoban et al., *Administrative Costs Are Too High — Healthcare Can Fix That*, Oliver Wyman, https://www.oliverwyman.com/our-expertise/insights/2025/jan/how-to-reduce-administrative-costs-healthcare.html.
[33] Ron Southwick, *Nearly half of doctors report burnout, but there is some progress, survey finds*, Chief Healthcare Executive (Jan. 25, 2024), https://www.chiefhealthcareexecutive.com/view/nearly-half-of-doctors-report-burnout-but-there-is-some-progress-survey-finds.

70,000 primary care physicians in 2038 should the current trends persist.[34] Primary care access has been linked to lower health care costs among patient populations.[35]

In 2019, $950 billion was spent on administrative functions across various health care stakeholders, representing 25 percent of total national health expenditures. Private payers accounted for 19 percent of the total administrative spend, hospitals accounted for 26 percent, physician groups accounted for 22 percent, public payers accounted for 9 percent, and other sites of care (e.g. dental offices, home health, nursing care facilities) accounted for 24 percent:[36]



G. Prior Authorization

Prior Authorization is a "utilization management" mechanism leveraged in managed care that requires patients and providers to obtain their insurer's approval for a given medical procedure or medicine before the insurer will pay for that service or drug. According to the American Medical Association, physicians complete 43 prior authorization requests per week on

[34] HEALTH RESOURCES AND SERVICES ADMINISTRATION, Data and Research, *Health Workforce Projections* (Dec. 2025), https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand.

[35] Jian Gao et al., *The Effect of Primary Care Visits on Total Patient Care Cost: Evidence From the Veterans Health Administration*, JOURNAL OF PRIMARY CARE AND COMMUNITY HEALTH (Dec. 23, 2022), https://journals.sagepub.com/doi/10.1177/21501319221141792.

[36] Nikhil R. Sahni, *Administrative simplification: How to save a quarter-trillion dollars in US healthcare*, McKinsey & Company (Oct. 20, 2021), https://www.mckinsey.com/industries/healthcare/our-insights/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare#/.

average, resulting in an average of 12 hours per week.[37] The mean annual projected costs per primary care physicians for completing prior authorization requests range from $2,161 to $3,430.[38]

The 2023 Medicare Advantage data also showed that insurers partially or fully denied 3.2 million prior authorization requests, reflecting 6.4 percent of total health care claims for the year. Patients appealed roughly 11.7 percent of prior authorization denials and 81.7 percent of those appeals resulted in the denial being partially or fully overturned.[39]

Data has shown that prior authorization can play a role in reducing health care premiums and out of pocket costs for patients. A 2023 Milliman study commissioned by the Blue Cross Blue Shield Association found that eliminating prior authorization in the commercial market could increase patient premiums by 4.8 percent, ranging from $43 to $63 billion annually, and increase patient cost sharing by 2.6 percent.[40]

In August 2025, 48 health insurance plans reached a deal with the Trump Administration to reform prior authorization for medical claims, committing to work towards modernizing and streamlining the process.[41] Their commitments included standardizing electronic prior authorizations, reducing the scope of claims subject to prior authorization, reviewing 80 percent of electronic prior authorization approvals in real-time, and ensuring that non-approved prior authorization requests would be reviewed by medical professionals.

A 2024 analysis by the Council for Affordable Quality Healthcare found that 35 percent of medical plans have full electronic prior-authorization processes, with the remaining prior authorization requests being processed either partially electronically or completely manually via phone, mail, fax, email.[42]

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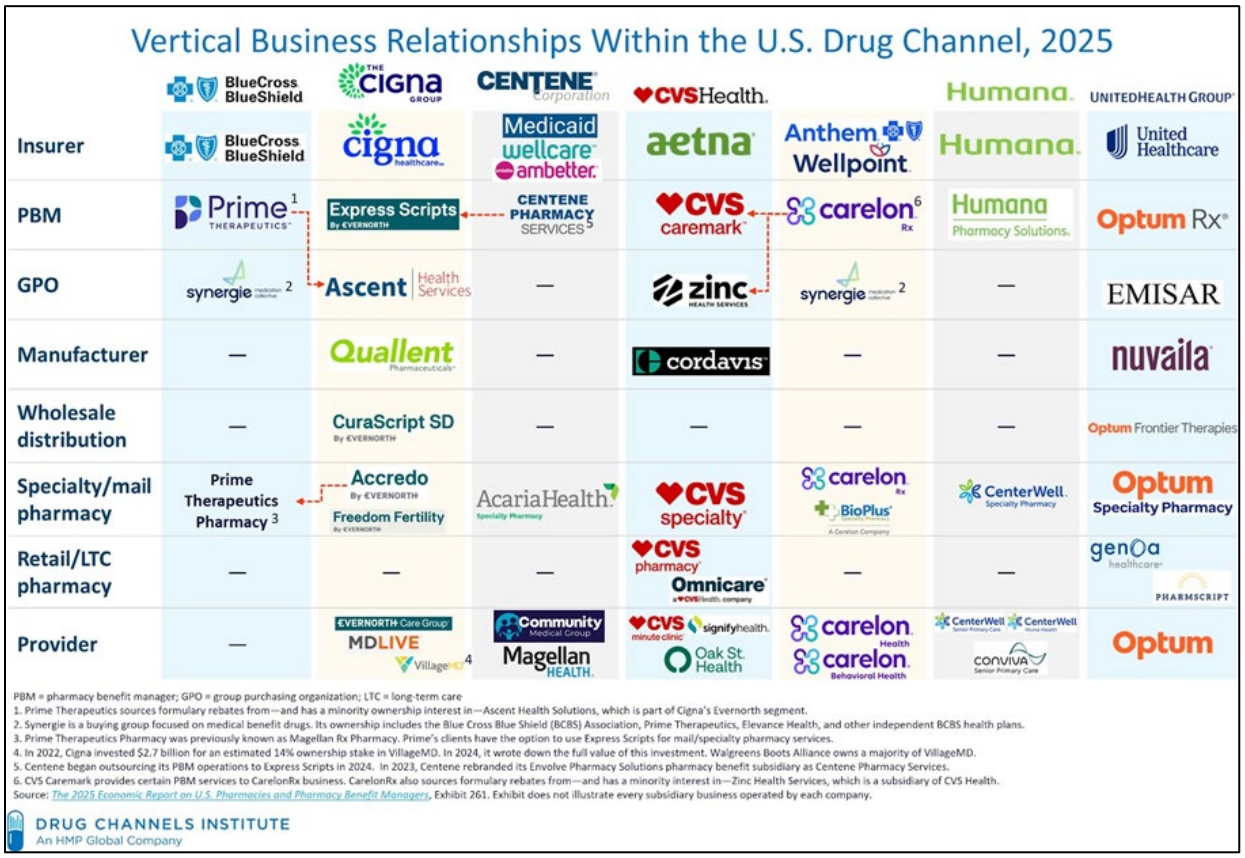
[37] Tanya Albert Henry, *Exhausted by prior auth, many patients abandon care: AMA survey*, American Medical Association (Jul. 18, 2024), https://www.ama-assn.org/practice-management/prior-authorization/exhausted-prior-auth-many-patients-abandon-care-ama-survey.
[38] Christopher P. Morley, PhD et al., *The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies*, THE JOURNAL OF THE AMERICAN BOARD OF FAMILY MEDICINE (Aug. 22, 2012), https://www.jabfm.org/content/jabfp/26/1/93.full.pdf.
[39] Jeannie Fuglesten Biniek et al., *Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023*, KFF (Jan. 28, 2025), https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/.
[40] Busch & Muller, *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*, Milliman (Mar. 30, 2023), https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf.
[41] Press Release, AHIP, *Health Plans Take Action to Simplify Prior Authorization* (Jun. 23, 2025), https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization.
[42] Jackson Hammond, *Prior Authorization: AHIP's Commitments*, RealClearHealth (Dec. 18, 2025), https://www.realclearhealth.com/2025/12/18/prior_authorization_ahips_commitments_1154257 html#_ftnref10.

H. Vertical Integration

Following the passage of the ACA, "in the second half of the 2010s," health insurers accelerated vertical integration with other organizations across the U.S. health care sector, including but not limited to providers, hospitals, pharmacies, and pharmacy benefit managers: [43]



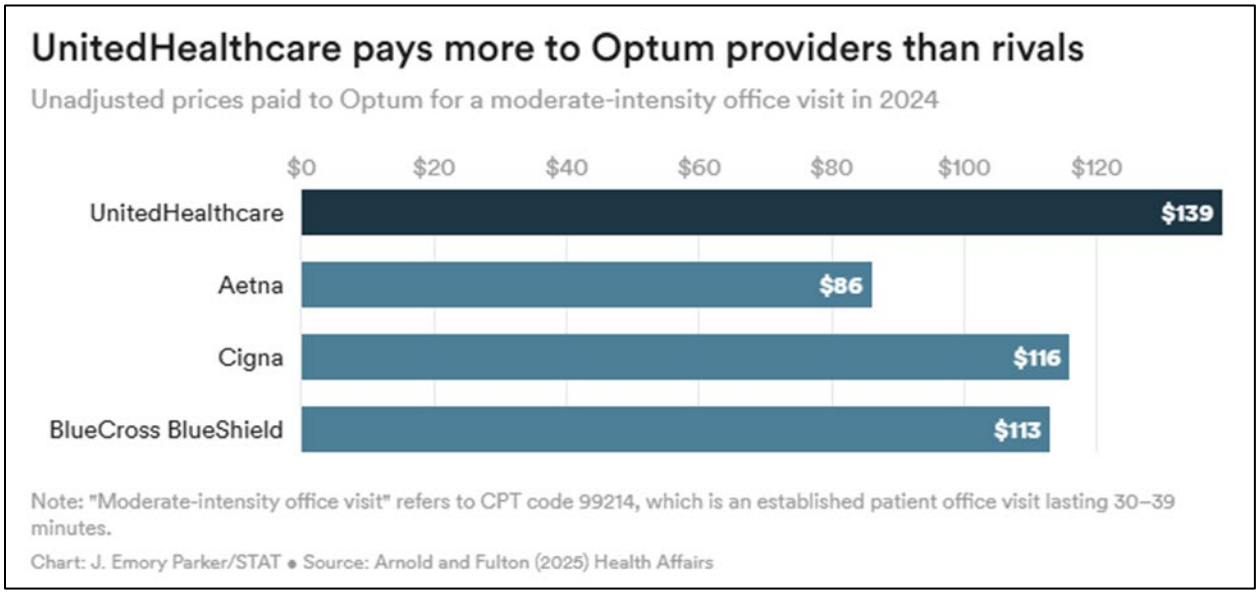
Data have shown that plan affiliated providers, including physician practices and pharmacies, are often reimbursed at higher rates than unaffiliated provider organizations.

a. Notably, the Federal Trade Commission (FTC) found that the three largest pharmacy benefit managers (PBM), OptumRx (owned by UnitedHealth Group), Express Scripts (owned by the Cigna Group) and CVS Caremark (owned by CVS Health), reimbursed affiliated pharmacies for specialty generic drugs at higher rates (ratios greater than 100 percent) than unaffiliated pharmacies.
   i. According to the FTC, "[o]perating income generated by the Big PBMs' affiliated pharmacies from dispensing the top 10 specialty generic drugs alone accounted

[43] Natasha Murphy, *Trends and Consequences in Health Insurer Consolidation*, Center for American Progress (Dec. 4, 2024), https://www.americanprogress.org/article/trends-and-consequences-in-health-insurer-consolidation/; *see also* Adam J. Fein, PhD, *Mapping the Vertical Integration of Insurers, PBMs, Specialty Pharmacies, and Providers: DCI's 2025 Update and Competitive Outlook*, Drug Channels (Apr. 9, 2025), https://www.drugchannels.net/2025/04/mapping-vertical-integration-of.html.

for nearly 11 percent of parent healthcare conglomerates' relevant business segment operating income in 2021." [44]

b. UnitedHealth Group employs or affiliates with approximately 90,000 providers, representing roughly 10 percent of all physicians in the United States.[45]
c. In November 2025, a study conducted by Brown University's Center for Advancing Health Policy through Research (CAHPR) showed that UnitedHealthcare pays their own Optum physician practices roughly 17 percent more than non-Optum practices.[46] In areas where UnitedHealthcare has at least 25 percent market power, United pays Optum practices 61 percent more than non-Optum practices:

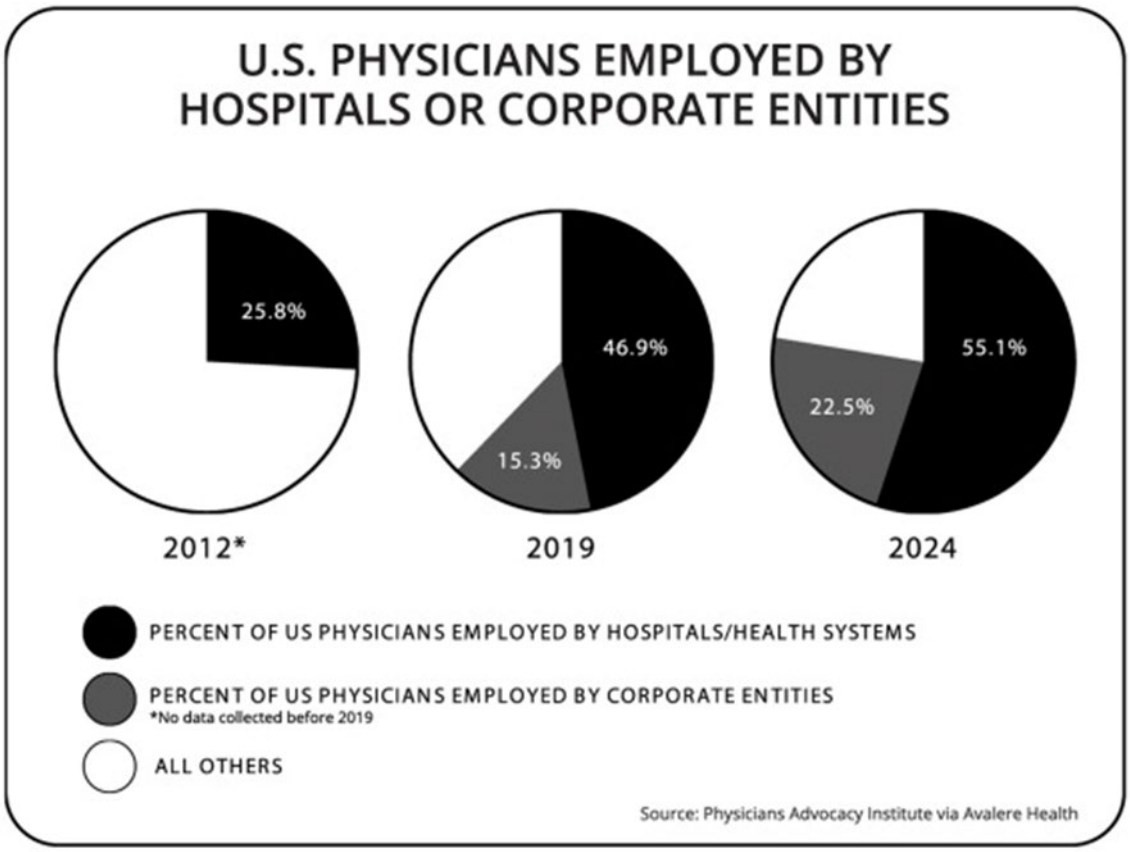


i. UnitedHealth disputed this study on the basis that the study only cited 705 cases where UnitedHealthcare paid Optum providers, representing less than 1 percent of the total study sample.
ii. Matthew Fiedler, a senior fellow at Brookings, commented on the study, "United is paying [Optum] practices more because it is a way to hide money from the medical loss ratio regulations without actually parting with those dollars."[47]
iii. Martin Gaynor, a former special advisor to the DOJ's antitrust division, stated, "[w]hen United, and they're not the only insurer who has done this, owns all kinds of firms, doctor practices prominent among them, then they're in a position to simply shift money over to these practices. On paper, they're complying with

[44] FEDERAL TRADE COMMISSION, Second Interim Staff Report, *Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers,* at 15 (Jan. 2025), https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf#page=18.
[45] Bob Herman, *UnitedHealth Group now employs or is affiliated with 10% of all physicians in the U.S.*, STAT (Nov. 29, 2023), https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/.
[46] Juan Siliezar, *UnitedHealthcare pays more to its own physician practices than others, study finds,* Brown University School of Public Health (Nov. 10, 2025), https://sph.brown.edu/news/2025-11-10/unitedhealthcare-optum-payments.
[47] Tara Bannow, *UnitedHealth pays its own physician groups 17% more than outside ones, study shows*, STAT (Nov. 3, 2025), https://www.statnews.com/2025/11/03/unitedhealth-pays-its-optum-physicians-17-percent-more/.

> the medical loss ratio. It makes it look like they're not earning a lot of profit. But of course that's just a shell game."[48]

The acceleration of vertical integration was not limited strictly to health plans during this period, as the percentage of U.S. physicians employed by hospitals and health systems increased significantly from 2012 to 2024.[49] Research has shown that private health insurers negotiate and reimburse higher prices in localities where there is less provider competition, with one study finding that private market prices for certain services were typically three times more in highly concentrated, low provider competition counties than low concentration counties.[50]



Vertical integration has also shown to affect Medicare referral patterns and spending as well. Hospital and health system ownership of physician practices was associated with increases in hospital-based imaging and laboratory tests and a decrease in nonhospital based imaging and laboratory tests. As Medicare reimburses hospital-based services at a higher rate, the site-of-

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[48] Tara Bannow, *UnitedHealth pays its own physician groups 17% more than outside ones, study shows*, STAT (Nov. 3, 2025), https://www.statnews.com/2025/11/03/unitedhealth-pays-its-optum-physicians-17-percent-more/.
[49] Rachel Ekaireb, MD et al., *Vertical integration and market consolidation in healthcare: Policy drivers and impact on physicians and patient care*, SEMINARS IN COLON AND RECTAL SURGERY (Sept. 7, 2024), https://www.sciencedirect.com/science/article/pii/S104314892400037X.
[50] Laurence C. Baker, PhD et al., *Physician Practice Competition and Prices Paid by Private Insurers for Office Visits*, JAMA (Oct. 29, 2014), https://jamanetwork.com/journals/jama/fullarticle/1917436#google_vignette.

service shift towards the hospital setting for hospital and health system-owned provider practices represented a combined $73.1 million increase in Medicare spending between 2013 and 2016.[51]

IV. STAFF CONTACTS

If you have questions regarding this hearing, please contact the Majority Staff of the Committee at (202) 225-3641.

[51] Christopher M. Whaley et al., *Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration*, HEALTH AFFAIRS (May 2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01006.