

Pathway to Patient-Focused, Affordable Health Coverage

AMERICANS DESERVE HIGH-QUALITY, AFFORDABLE AND ACCESSIBLE HEALTHCARE. A SUSTAINABLE PATH FORWARD REQUIRES ADDRESSING THE REAL DRIVERS OF HIGHER COSTS AND MAKING HEALTHCARE SIMPLER.



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Executive Summary

At its best, the U.S. healthcare system provides timely access to high-quality, coordinated care for the American people. Through our blended system, Americans experience superior access to medical innovation, whether through advanced surgical techniques that promote rapid recovery or the timeliest access to pharmaceuticals that have made once-terminal illnesses manageable or even curable.

However, far too often, the healthcare system does not meet this standard of performance or meet the needs of the American people. Healthcare costs are increasingly unaffordable for people and are on a trajectory that is unsustainable for the country. The system is fragmented, far too complicated and held back by outdated, manual processes.

Role of Health Plans

Health plans enable timely access to routine care and protect patients from the devastating costs of serious illnesses and extremely costly innovations. Health plans are comprehensively regulated at both the federal and state levels and compete vigorously to keep coverage and care as affordable as possible.

Health insurance premiums directly reflect the high and rising underlying prices set by hospitals, drug manufacturers, physicians and other providers. Nearly 85 percent of Americans' commercial premium dollars go directly to covering the cost of hospital-based services, prescription drugs, physician fees and other medical services.

As one meaningful step toward addressing complexity, health plans are implementing commitments to streamline and simplify prior authorization for patients and providers, while maintaining important safeguards to advance evidence-based care, support affordability and protect patients from fraud, waste and abuse.

Further Regulating Health Plans Without Addressing Cost Drivers Will Not Work

Proposed policy changes focused solely on health plans will not lower healthcare costs, improve quality or simplify healthcare. Arbitrary premium reduction requirements or expanded benefit mandates untethered to lower medical costs will not make healthcare more affordable. Disrupting models that better integrate coverage and care will cause patient disruption and set back efforts to align incentives on patient outcomes and affordability. A public option administered by the federal government or state governments will shift costs, stifle competition and threaten the coverage most Americans want to keep.

Common-Sense Changes to Make Healthcare Work Better and Cost Less

AHIP believes the best way to make healthcare and coverage more affordable and accessible for everyone is for Congress to enact data-driven, patient-focused policies that build on successful market-based solutions and public-private partnerships. **The country must fundamentally address the underlying medical and prescription drug cost drivers that result in rising premiums, high cost-sharing and unsustainable total healthcare spending.**

To advance these goals, we provide recommendations in four areas:

- Make Coverage Affordable and Easier to Keep
- Make Health Insurance Simple to Use
- Address the Cost Drivers That Determine Premiums
- Advance Policies That Improve Health

AHIP and its member health plans are committed to partnering with the Committee to make healthcare more affordable and work better for everyone.

Healthcare Affordability Challenges

Healthcare costs too much. Two-thirds of Americans are worried about affording their healthcare, reporting it as the biggest financial worry for their families.¹ In a recent survey, when asked which household expenses they worry about affording, more Americans cited healthcare costs (30 percent) than food, housing or utilities.² That worry translates into real trade-offs: roughly one in three adults, about 82 million people, reported cutting back on something else in the past year to cover healthcare costs.³

Health plans are committed to affordability. Over 300 million Americans obtain health coverage through employer-provided plans, Medicare, Medicaid, the Individual Market or supplemental coverage. Health plans continue to seek opportunities to move the system from the flawed incentives of fee-for-service and collaborate with providers to move toward a system that puts patients at the center. Value-based arrangements that have achieved better patient outcomes, improved patient experience and lowered costs should be scaled across the system. Health plans have championed surprise billing protections for consumers in the *No Surprises Act*, sparing patients the financial shock of exorbitant out-of-network bills. Health plans negotiate lower in-network prices with hospitals, physicians and other providers — rates an individual consumer typically would not have access to on their own. Health plans cover preventive care including vaccines without cost-sharing, and health plans support policy changes to waive deductible requirements for chronic conditions. In all coverage markets, health plans also vigorously compete against each other on price. Premium price competition saves Americans \$80 billion annually.⁴

Healthcare in the U.S. today delivers more than it ever has. Patients in America today often have access to innovations and treatments that were unforeseen even 20 years ago. While many innovations have improved patient access and enabled shorter and less painful recoveries, they also contribute to steadily rising costs. For example, from 2012 to 2018, robot-assisted surgery grew from a niche technology to being used in 15 percent of general surgical procedures.⁵ Since checkpoint inhibitors became first-line treatment for metastatic melanoma, median overall survival for patients with the disease has more than doubled, from 8 months in 2010 to nearly 18 months in 2018, through therapies that are now routinely available.⁶

Healthcare today is more intensive and more expensive. Since 2010, national health expenditures (NHE) have doubled, from \$2.6 trillion to \$5.3 trillion in 2024. Over that period, 60 percent of the growth in personal healthcare expenditures came from higher utilization, with the remaining 40 percent attributable to higher prices.⁷ That 60/40 relationship of utilization to prices is persistent: CMS reported that in 2024, 59 percent of NHE growth was due to increased use and intensity of healthcare services, while 41 percent was attributable to price growth.⁸ Imaging is an example of how spending growth reflects a mix between utilization and price: spending increased 36 percent from 2010 to 2021, while prices increased 23 percent. Spending growth was driven by a shift to more imaging overall and more use of advanced, high-intensity imaging.⁹

Reforms must protect patients and target cost drivers. Innovation is driving higher spending because many new therapies and technologies are both effective and very expensive and often lack competition. Prices that exceed value also drive higher spending while delivering no or limited additional clinical benefit for patients. Capping patient cost sharing without addressing the underlying cost of care shifts costs, rather than making healthcare more affordable overall. An affordability policy agenda must distinguish between which aspects of the system spur legitimate clinical innovation and which raise prices without materially benefiting patients.

AHIP's member health plans have data-driven insights into the causes of rising healthcare spending. These insights inform AHIP's recommendations on how to protect patients and lower total costs. This report describes the drivers of rising healthcare costs and how they have changed over the past decade. It describes how health plans are working to improve the system. Finally, it recommends reforms to make the healthcare system more patient-focused, affordable and sustainable and also cautions against unworkable policy proposals.

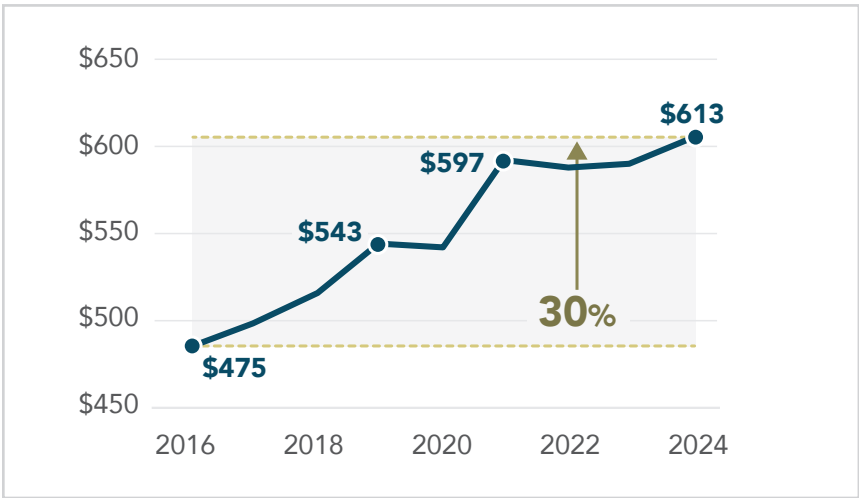
What Americans Pay for Healthcare

Nearly one in five dollars of U.S. economic output goes to healthcare, and Americans deserve to know where their money goes.¹⁰ Healthcare is 8 percent of Americans’ household spending on average,¹¹ but for families who receive a new cancer diagnosis or experience a medical emergency, costs can be much higher. U.S. healthcare spending pays for the most innovative therapies and one of the world’s shortest wait times for specialist care,¹² but it also pays the cost of the world’s highest drug prices, prices inflated by hospital consolidation and unnecessary care and fraudulent bills. Health plans tackle these costs on behalf of consumers, negotiating lower prices for drugs and hospitalizations while establishing guardrails to limit low-value, fraudulent or even harmful care.

Rising healthcare costs

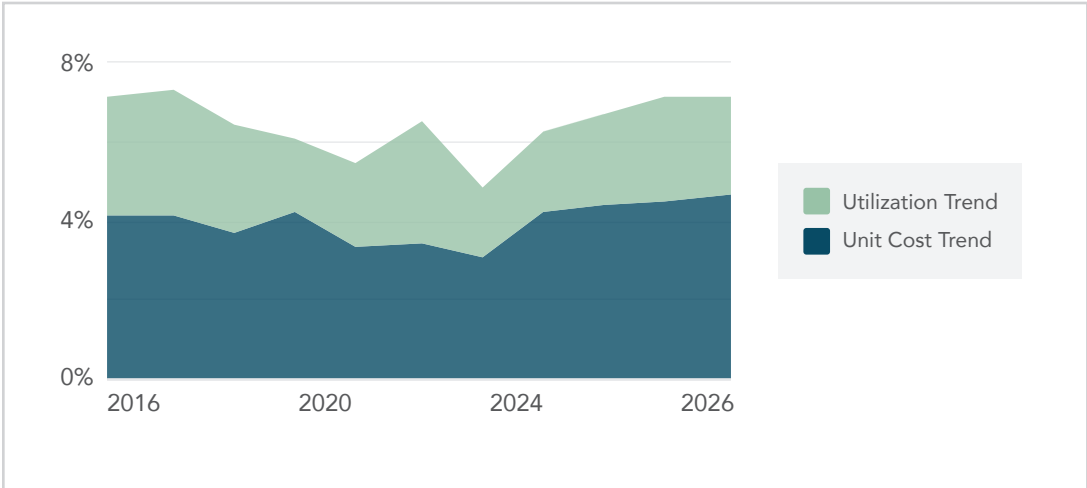
Healthcare costs are rising due to more care utilization and higher prices. Data from the Individual Market shows these trends. From 2016 to 2024, average monthly claims cost increased 29 percent, from \$475 to \$613 (Figure 1).¹³ Throughout this period, price growth drove approximately 60 percent of total cost increases, while utilization drove the remaining 40 percent (Figure 2).¹⁴ Outpatient care drove the bulk of this claims increase, increasing 45 percent over the period (Figure 3).¹⁵

Figure 1: Average Monthly Claims Cost Increased by 30% from 2016 to 2024 in the Individual Market



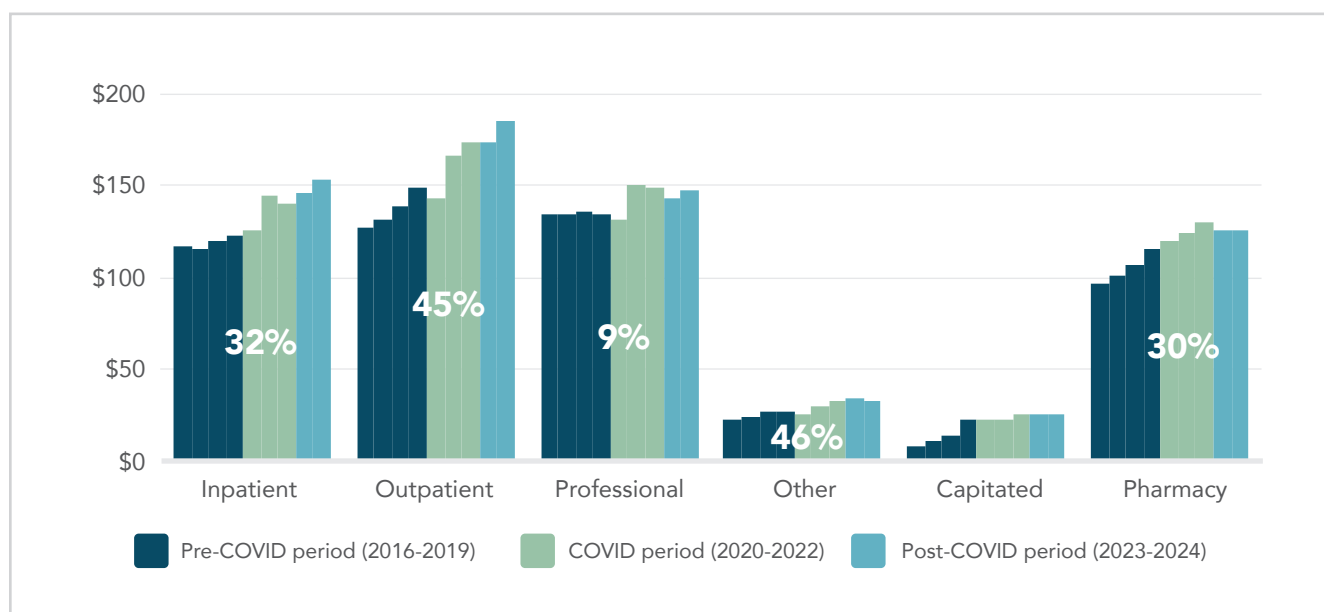
Average monthly claims cost is the national average of risk-adjusted allowed claims in the Individual Marketplace.

Figure 2: Price Growth Drives 60% of Total Claims Growth in the Individual Market



National average of unit cost and utilization trends projected by health plans in the Individual Marketplace when filing their rates. Unit cost trend captures changes in the average cost of a service, including changes in provider reimbursement, pharmaceutical prices and the mix of services. Utilization trend captures changes in the number or frequency of services used per member.

Figure 3: Outpatient Costs Grew 45% from 2016 to 2024 in the Individual Market, Outpacing All Other Spending

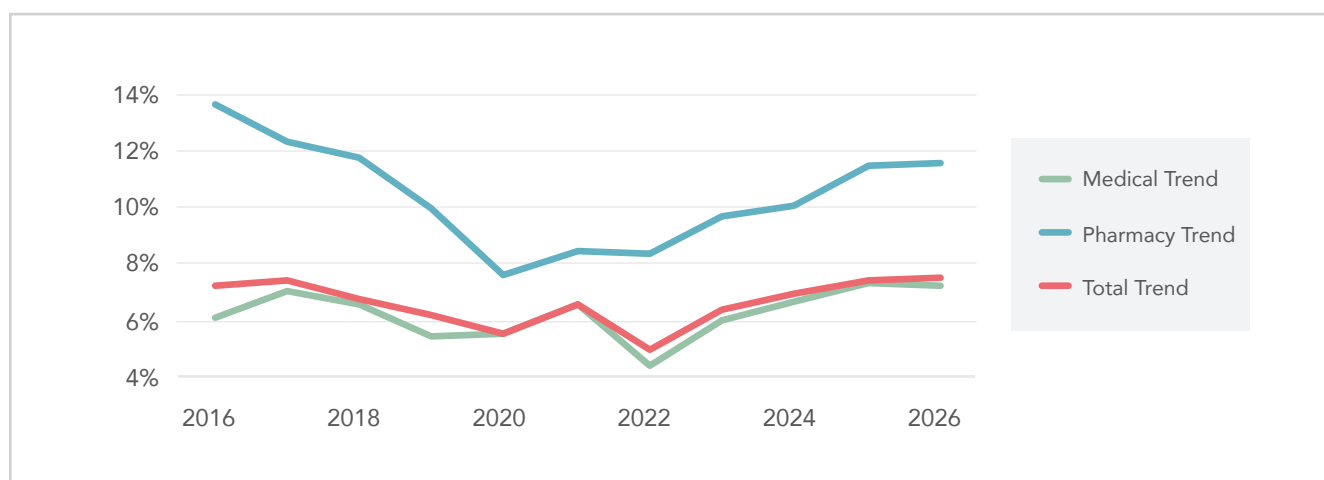


Costs are the observed average per-member per-month claims cost in the Individual Marketplace. Color blocks represent the pre-COVID period (2016-2019), COVID period (2020-2022) and post-COVID period (2023-2024).

Both healthcare utilization and healthcare prices are growing faster today than they were before COVID. Across markets, CMS reports medical price growth in 2024 increased healthcare spending by 2.5 percent, compared to an annual average of 1.4 percent from 2014-2019. Similarly, utilization growth increased total spending by 3.6 percent in 2024, compared to 2.7 percent on average pre-COVID.¹⁶

In the commercial market, these trends are more pronounced. In the pre-COVID period, health plans' use of networks¹⁷ and formularies¹⁸ contributed to a decreasing trend in healthcare costs, with projected annual cost growth falling from 7.2 percent in 2016 to 5.5 percent in 2020 – falling 0.4 percentage points per year.¹⁹ Following substantial provider market consolidation,²⁰ healthcare costs are now increasing at a faster rate, growing from 4.9 percent in 2022 to 7.5 percent in 2026 – an average of 0.6 percentage points per year (Figure 4).²¹ Prescription drug trend shows an even more pronounced change, with trend falling by an average of 1.5 percentage points per year from 2016 through 2020 but increasing by an average of 0.8 percentage points per year from 2022-2026 (Table 1).²²

Figure 4: Cost Trend Growth Was Falling Pre-COVID but Is Growing Now



National average projected medical and pharmacy trends reported by health plans in their Individual Marketplace rate filings.

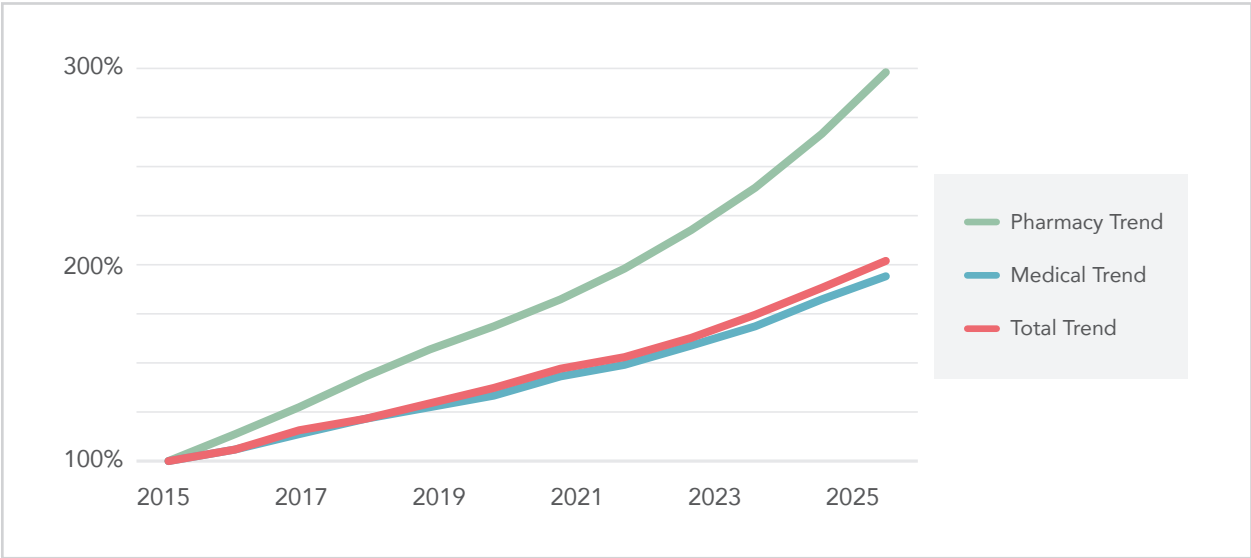
Table 1: Pre-COVID, Growth in Cost Trends Was Slowing; Now, Cost Trends Are Growing Faster

		Pre-COVID (2016 - 2020)	Post-COVID (2022 - 2026)
Cumulative Increase in Cost Trend	Medical Trend Increase	26.9%	30.2%
	Pharmacy Trend Increase	48.7%	50.3%
	Total Trend Increase	28.6%	31.4%
Average Annual Change in Cost Trend	Medical Trend Annual Change	-0.1%	0.7%
	Pharmacy Trend Annual Change	-1.5%	0.8%
	Total Trend Annual Change	-0.4%	0.6%

National average projected medical and pharmacy trends reported by health plans in their Individual Marketplace rate filings. Over each period, trend continued to increase, but the rate of increase was slowing in the pre-COVID period. This can be seen in the falling trend lines (Figure 4).

The cumulative effects of these changes are pronounced. Projected total claims costs have doubled since 2015, and pharmacy claims have tripled (Figure 5).²³

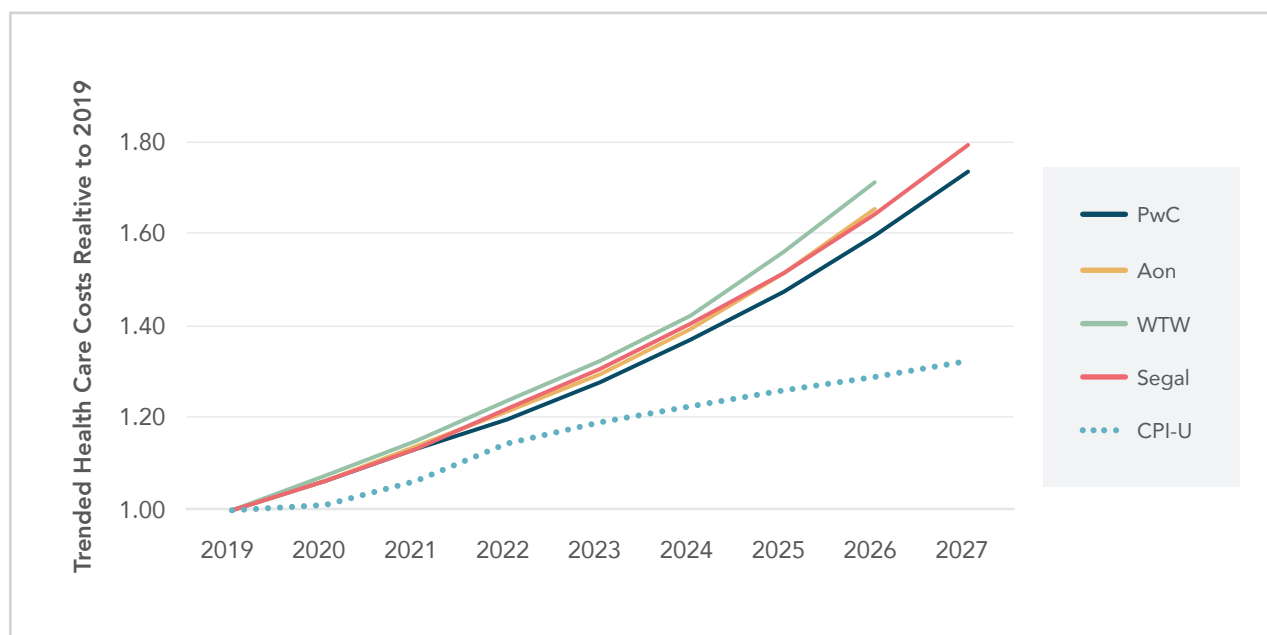
Figure 5: Projected Claims Costs Have Doubled Since 2015 While Projected Pharmacy Claims Have Tripled



Cumulative projected claims growth from national average trends reported by health plans in their Individual Marketplace rate filings.

These same trends show up in employer-provided coverage. By 2027, commercial claims cost is projected to be 70 percent higher than it was in 2019 – twice the cumulative rate of inflation (Figure 6).²⁴

Figure 6: Projected Commercial Claims Costs Grew 70% Since 2019, Twice the Rate of Inflation



Average of cumulative projected trend growth from leading commercial health insurance market consulting firms compared to CPI-U.

Chronic disease drives spending higher

The U.S. Centers for Disease Control and Prevention estimate 76 percent of American adults have at least one chronic disease and over half of American adults have more than one chronic disease.²⁵ Recent studies also demonstrate adolescents were 15-20 percent more likely to have chronic disease in 2023 than in 2011.²⁶ Such high levels of disease—many of which are preventable—create significant challenges, including:

- Diminished quality of life: Chronic conditions lead to reduced physical functioning and worse mental health.²⁷
- Lost productivity: Poor health costs U.S. workers and employers \$575 billion and 1.5 billion days of lost productivity per year.²⁸
- Healthcare system strain: Chronic disease exacerbates healthcare workforce shortages that are expected to worsen, compromising access for all Americans.²⁹
- Increased healthcare spending: 90 percent³⁰ of the \$5.3 trillion annual healthcare expenditures³¹ are attributed to managing and treating chronic disease.
- Reduced life expectancy: Five of the top 10 leading causes of death are associated with or caused by potentially preventable and treatable chronic diseases.³²

Without addressing the risk factors and drivers of chronic disease, such as poor nutrition, insufficient physical activity, substance use, underinvestment in preventive care and medication non-adherence, the financial impact of treating the chronic disease epidemic will continue to increase the overall cost of healthcare.

Total healthcare spending is rising faster now than in the past, driven by both higher prices *and* higher utilization.

Prescription drugs

One quarter of every commercial market dollar spent on healthcare goes to prescription drugs.³³ Pharmaceutical innovations can improve health and change lives. Medicines that cure Hepatitis C, halt cancer progression and make HIV a manageable chronic disease are examples of legitimate innovations that have meaningfully benefited patients. At the same time, Americans regularly pay far too much for prescription drugs. Americans pay the highest drug prices in the world, and yet patients wait the longest for generic competition due to anticompetitive tactics utilized by brand drugmakers, such as over-patenting and pay-for-delay deals.

Nine cents of every dollar spent on prescription drugs goes to research and development of new treatments, but **11 cents** goes to brand manufacturers' sales, advertising and administrative costs.³⁴ Drug ad campaigns are ubiquitous in America but largely prohibited in the rest of the world. The U.S. is one of only two countries that allow drug manufacturers to advertise directly to consumers (the other is New Zealand). These marketing campaigns omit what matters most to consumers: the prices. The Congressional Budget Office found eliminating direct-to-consumer (DTC) advertising would reduce spending on brand name drugs.³⁵ Even greater savings are possible from eliminating the tax deduction drug companies get for these ads — the top ten drug companies get over \$1.5 billion annually in tax write-offs for their non-stop ad campaigns targeting consumers and doctors.³⁶

Abuse of the drug patent system by drugmakers prevents competition and keeps U.S. drug prices too high. Anticompetitive patent tactics such as patent thickets, pay-for-delay and product hopping contribute to \$40 billion in unnecessary drug spending annually.³⁷ When brand drug manufacturers employ these anticompetitive tactics, prescription drug spending is inflated, the overall cost of care goes up and patient access is harmed.

Hospital inpatient, outpatient and emergency room care

Forty-one cents of every commercial market dollar spent on healthcare goes to some form of hospital care. Outpatient hospital costs (e.g., going to a hospital for an MRI or visiting a specialist in a hospital outpatient department) account for nearly 20 percent of Americans' commercial premiums.³⁸

Hospitals provide essential, often lifesaving care. Yet patients face high hospital costs. The average hospital stay was about \$16,700 in 2022, according to federal data.³⁹ Too often, one large hospital or health system can dominate an entire geographic region, limiting health plans' ability to negotiate lower prices for patients.

Research consistently finds healthcare provider consolidation is a primary driver of the high cost of healthcare in the U.S. Prices increase between 20 percent and 50 percent⁴⁰ following the merger of two neighboring hospitals while research on quality finds no improvement; mortality and readmissions unchanged, and patient experience modestly worse.⁴¹ These mergers also reach workers' paychecks: when two local hospitals merge and prices go up, payrolls fall 4 percent for every 10 percent increase in prices.⁴²

Some health systems leverage their significant market shares by requiring health plans to contract with all affiliated facilities, which inhibits health plans' ability to give patients choices of alternative sites of care with lower-cost and higher-quality care. These anticompetitive contract terms, in the form of 'anti-steering,' 'anti-tiering,' and similar contract provisions, protect inflated provider prices — costs that all Americans pay through higher premiums and out-of-pocket costs.

Doctor visits and non-hospital care

Nineteen cents of every commercial market dollar spent on healthcare goes to doctor visits and other non-hospital care.

Community practitioners and family physicians are often patients' most frequent connection to healthcare. Urgent care centers and ambulatory surgery centers enable patients to receive many services in high-quality, more cost-effective and far more convenient settings while also saving patients time and preserving hospital resources for more intensive needs. Encouraging more non-hospital, community-based care can deliver more accessible and targeted patient care at a lower cost without sacrificing quality.

When some private equity (PE) firms enter the business of healthcare and prioritize extraction of short-term profits over patient care, costs go up for everyone. Today, some private equity firms are consolidating physician practices and refusing to negotiate prices with health plans, instead choosing to abuse the arbitration processes intended to protect patients from surprise bills from out-of-network providers.

Capital investment in healthcare can provide substantial benefits if it reflects a sustained commitment to serving patients and to system improvement. However, when PE and other investment firms make healthcare about exploiting loopholes and extracting short-term

profits, consumers absorb the cost. PE's stake in healthcare has grown to more than \$1 trillion over the past decade and continues to remain at elevated levels.⁴³ At minimum, PE healthcare investments should be transparent so regulators can monitor the patient impact of these investments.

A pressing and immediate example of PE's impact on healthcare is through the *No Surprises Act*. This bipartisan reform was intended to protect patients from the financial burden of expensive surprise medical bills and reduce the cost of care for employers and working families. The law established an Independent Dispute Resolution (IDR) process as a binding arbitration system to settle out-of-network payment disputes. However, this system has been exploited in ways that undermine the law's goals. Rather than functioning as a genuine arbitration mechanism for good-faith billing disputes, the IDR process has become a profit center for PE-backed physician staffing firms, third-party billing intermediaries and other entities whose business model depends on extracting inflated payments from the system. PE firms back at least five Independent Dispute Resolution entities (IDREs), with at least one firm investing in both a disputing provider group and a certified IDRE – a direct conflict of interest.⁴⁴

These actors flood the process with massive volumes of low-value, often duplicative claims – not because the underlying disputes are meritorious, but because the economics of the IDR process reward volume over validity. When even a fraction of inflated demands is awarded, the return on investment is substantial, creating a self-reinforcing cycle that drives up costs for health plans and, ultimately, for employers and consumers who bear those costs through higher premiums. Employers and health plans are reporting that IDR awards and costs are increasing premiums, often by multiple percentage points.⁴⁵

The Congressional Budget Office warns IDR will drive higher prices over time.⁴⁶ The IDR process has resulted in \$22.4 billion in total costs from 2022 to 2025, driven by a high volume of disputes and awards that dwarf expected in-network rates.⁴⁷ Policymakers should take decisive action to address this clear example of PE-backed providers gaming patient protections against surprise billing and driving up costs for everyone.

Health plans' role in lowering costs

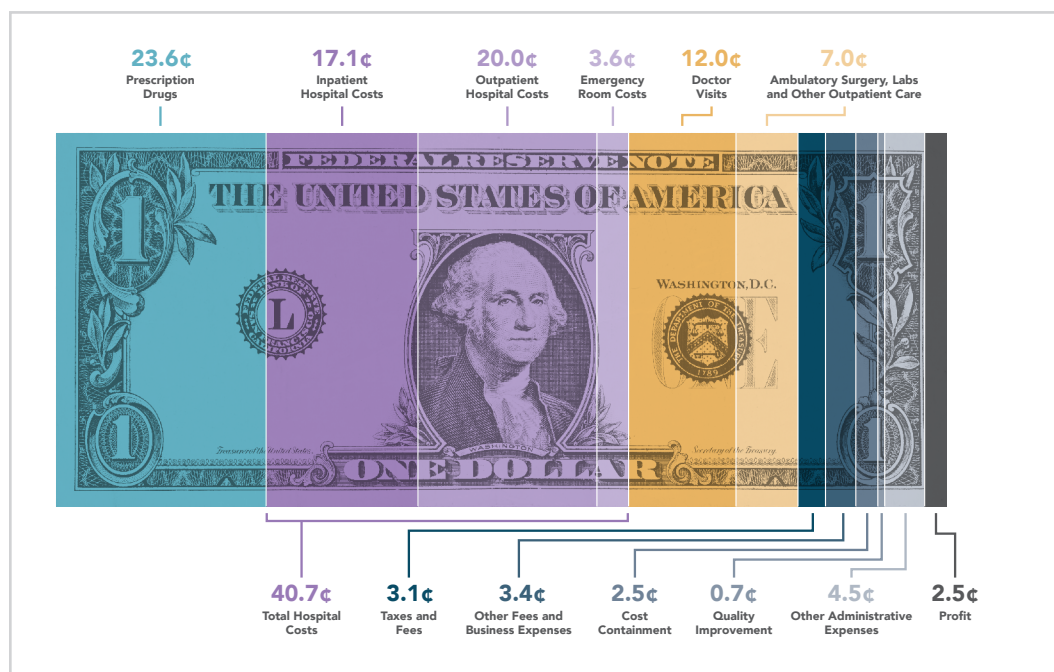
Health plans play a vital role in the healthcare system: enabling patient access to care and lowering the cost of care. While health plans use market-based tools such as negotiation to reduce costs, in many cases they are also dependent on the prices set by brand drugmakers, consolidated hospitals and certain physician groups. Nearly 85 percent of Americans' commercial premium dollars go directly to covering the costs described above. When prices for these treatments and services go up, the premium consumers pay for their coverage must rise to keep pace.

"Ultimately, the increase in premiums is being driven by growth in health care spending, not a higher percentage of markups."

– Yale Health Care Affordability Lab

The AHIP Healthcare Dollar shows commercial health plans allocate 4.5 cents of every dollar to general administrative expenses and that 2.5 cents of every dollar is retained as profit (Figure 7).⁴⁸ Over time, health plans have increased the proportion of premiums paid for hospital care, drugs and physician visits. An analysis by the Yale Health Care Affordability Lab showed that between 2011 and 2024, the portion of premiums paid as claims increased from 81% to 85%.⁴⁹ Those researchers go further: "Ultimately, the increase in premiums is being driven by growth in health care spending, not a higher percentage of markups." Other independent voices agree. KFF describes health plans' role this way: "But, the fact of the matter is, it's high underlying health care costs – for hospital care, physician and clinical services, retail prescription drugs and other health expenditures – that are the biggest driver of increasing insurance premiums. Insurers pass those costs along or risk declining profits and ultimately insolvency."⁵⁰

Figure 7: Where Does Your Healthcare Dollar Go?



Health plans are highly regulated

When providing health insurance, health plans must publicly account for each dollar received and then spent, with limits in place to ensure consumer premiums are used appropriately. Under federal law, health plan profits and administrative costs are capped through medical loss ratio (MLR) requirements. No other part of the healthcare system is subject to such a cap. In the individual and small group markets, the MLR requires health plans to spend at least 80 percent of premiums on claims and quality improvement. The threshold for large group plans is 85 percent. If health plans do not meet this target, they must return amounts above the threshold to the consumer as rebates. Medicare Advantage plans and Part D plans also have an 85 percent MLR requirement, with the requirement to return excess amounts to the government. In Medicaid, states are required to set rates for Medicaid plans that meet at least an 85 percent MLR threshold, and most states require remittances from plans that fail to meet the threshold.

Even with this threshold in place, due to competitive market dynamics, health plans routinely demonstrate average MLRs that are much higher than required. The average individual MLR was 7.4 percentage points above the 80 percent required standard in 2024, and the average large and small group MLRs were 6.3 and 8.3 percentage points above their 85 percent and 80 percent required standards, respectively.⁵¹ Medicare Advantage plans averaged a 90 percent MLR and Part D plans a 95 percent MLR in 2023, far above the required 85 percent standard.⁵² MLRs in Medicaid were over 90 percent.⁵³ These outcomes are consistent with a competitive market. Further, both state and federal regulators have oversight of the rates health plans file in these markets, requiring plans to justify their proposed rates under actuarial standards. States may also require changes to these rates. Simply put, MLR requirements would allow even higher premiums than seen today, as market competition among health plans has kept premiums below the MLR maximums.

MLR is an important consumer protection. Consumers benefit even more from a competitive health insurance marketplace in which health plans innovate to lower premiums and offer benefits that Americans want. Consumers and employers are enormously responsive to differences in premiums among health plans. Without a competitive premium, a health plan may be unable to enroll enough consumers to offer a stable, actuarially sound product. In the Individual Market, researchers have estimated a plan that increased premiums 10 percent higher than its competitors would see 17 percent lower enrollment;⁵⁴ other researchers found a 5 percent premium increase relative to competitors would lead to 40 percent lower enrollment.⁵⁵

Health plans compete on price, and premium prices are \$80 billion lower than required by statute.⁵⁶ In Medicare Advantage and stand-alone Part D Plans, nearly all plans had premiums below the amount limited by MLR⁵⁷, resulting in \$37 billion lower premiums than required.⁵⁸ In the commercial market, 88 percent of Individual Market plans, 92 percent of small group plans and 98 percent of large group plans had premiums below the amount limited by MLR, with the actual premiums \$44 billion lower than required.⁵⁹ The benefits are broadly shared. Taxpayers and the federal government see \$33 billion in lower premiums annually, individuals see \$32 billion in lower premium costs and employers see \$20 billion in lower premiums⁶⁰ (Table 2).

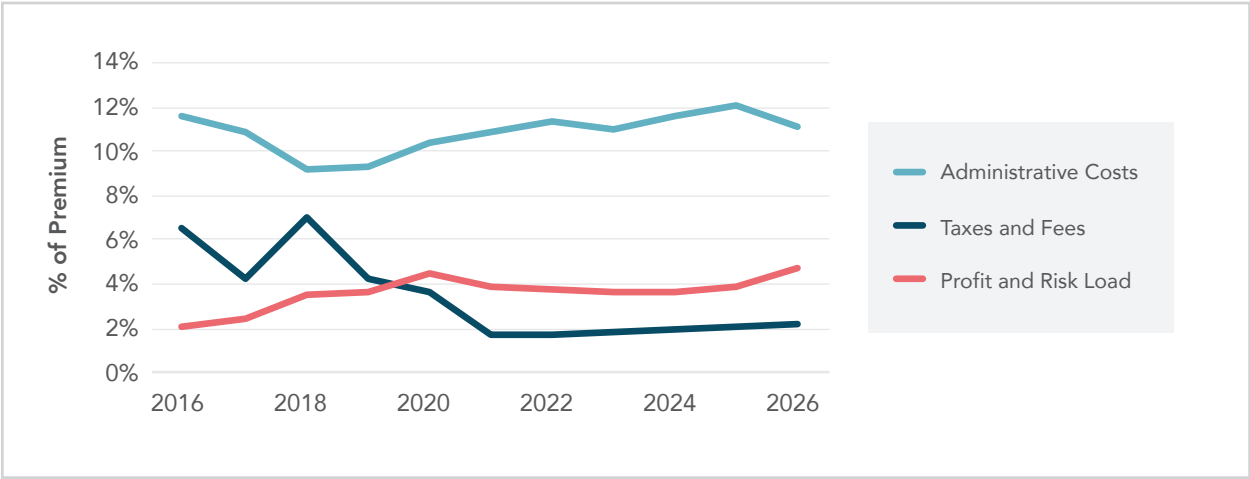
Table 2: Majority of Plans Achieve Higher Medical Loss Ratios Than Required, Reducing Premiums

	Share of Plans Exceeding MLR	Average MLR	Required MLR	Amount MLR Limit Exceeds Premiums (%)	Amount MLR Limit Exceeds Premiums (\$, billions)
Medicare Advantage	99%	91%	85%	7%	\$31
Part D	100%	95%	85%	12%	\$5
Individual	88%	89%	80%	12%	\$16
Small Group	92%	89%	80%	12%	\$7
Large Group	98%	92%	85%	8%	\$21
Total Premium Difference from MLR Limit: \$80 Billion					

Medicare Advantage and Part D figures are from plan year 2023; Commercial market figures are from 2024. To account for differences in plan enrollment, “Share of Plans Exceeding MLR” is calculated from total revenues, not a count of individual plans and “Average MLR” is calculated across all plan revenues and is not the mean of individual plan MLRs. In this table, “Average MLR” is for those plans that exceeded MLR requirements.

In the Individual Market, health plans’ projected profits as a share of healthcare spending have been essentially flat since 2020 (Figure 8). While profit rates were nominally lower in 2016-2019 as the Individual Market stabilized, aggressive competition has led to substantial price competition. Because healthcare is so expensive, both individuals and employers selecting health plans are extremely price sensitive. Health plans respond by offering competitively priced options with low margins, encouraging greater enrollment.

Figure 8: Health Plan Profits Have Been Flat Since 2020



Percentages are the aggregate share of projected plan retained amounts relative to projected premiums reported by health plans in their Individual Market rate filings.

Health plans’ administrative spending benefits consumers

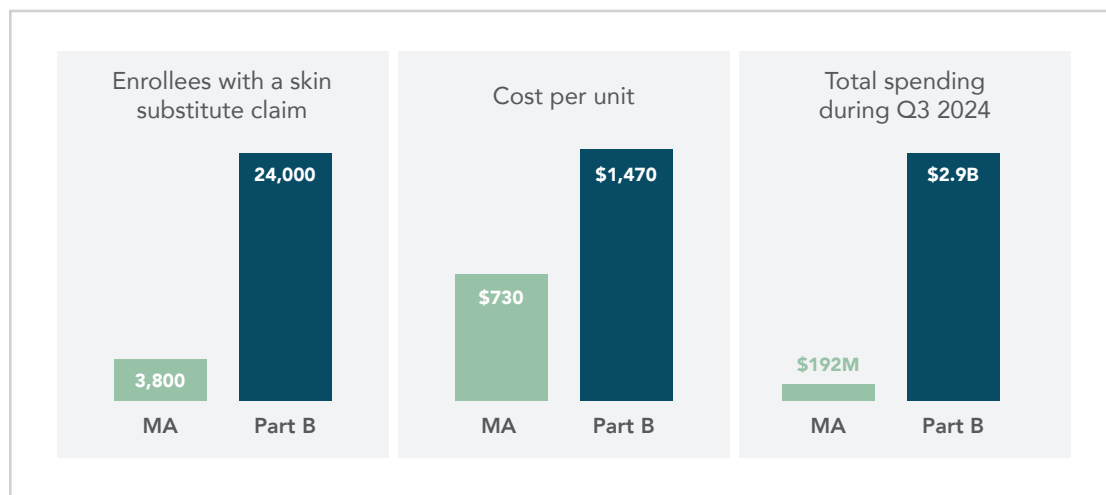
Health plan administrative costs include programs that directly benefit consumers by lowering costs of care, increasing access and improving outcomes. These include programs to combat fraud, waste and abuse; 24/7 nurse lines; medical interpreters and translation services; and interactive consumer transparency tools. These programs are critically important for consumers and purchasers of healthcare, enabling health plans to offer high-quality coverage that helps enrollees meet their health needs. These value-added activities are appropriately included as allowable expenses under health plans’ MLR calculations.

Targeting unnecessary care and waste

The annual cost of waste in the U.S. healthcare system is estimated to be between \$760 and \$935 billion, accounting for approximately 25 percent of healthcare spending.⁶¹ Waste in this case includes fraud and abuse, overuse of healthcare services or inefficient practices and payment for low-value care. Preventing and rooting out fraud, waste and abuse in healthcare are core to the mission of health plans. For decades, studies have shown patients frequently receive inappropriate care across a wide range of services and settings. Many

unnecessary tests and services lack evidentiary support, resulting in patient harm and significant wasteful spending. While plans cannot root out all unnecessary services and waste, their efforts have tangible results: in 2024, Medicare Advantage plans were able to stop providers from abusing Medicare’s reimbursement of skin substitutes, achieving 93 percent lower spending on these products than fee-for-service Medicare (Figure 9).⁶²

Figure 9: Medicare Advantage Plans Prevented Wasteful Spending on Skin Substitutes, Spending 93% Less than Fee-for-Service Medicare



Data reported by HHS OIG.

Health plans are tackling chronic disease to improve health and lower costs

Reducing chronic disease requires addressing its drivers: poor nutrition, insufficient physical activity, low use of preventive screenings, medication non adherence, behavioral health factors such as tobacco and excessive alcohol use and low health literacy, among others.

To help confront these trends, AHIP has identified evidence-based strategies to reduce chronic disease prevalence by at least 10 percent by 2035.⁶³ This roadmap emphasizes stronger prevention, earlier intervention and more effective care management, supported by policy changes that facilitate progress. Health plans are taking action across five categories:

- **Promoting healthy behaviors, early identification and care management** – including increasing uptake of programs that support healthy lifestyle choices, increasing screening for chronic conditions and social needs, increasing enrollment in case management to address gaps in care and improving health literacy.
- **Encouraging behavioral health prevention, screening and integration with primary and specialty care** – including depression and postpartum depression screening and follow-up.
- **Preventing and managing diabetes** – including diabetes education, adolescent weight control counseling, promoting older adult physical activity and blood pressure control for people with diabetes.
- **Reducing cardiovascular disease** – blood pressure control, tobacco cessation and statin therapy when clinically appropriate.
- **Expanding cancer screening and early detection** – colorectal cancer screening, breast cancer screening and cervical cancer screening.

Assessment of plan performance

Health plans are held to public, standardized quality measurement. The Healthcare Effectiveness Data and Information Set (HEDIS) is used by over 90 percent of U.S. health plans to assess performance on important dimensions of care and service,⁶⁴ and over 235 million people are enrolled in plans that report HEDIS results.⁶⁵ HEDIS includes over 90 process, structure and outcome measures that evaluate effectiveness of care, access and availability of care and utilization across acute and chronic care, behavioral health, pediatric care and maternal health.⁶⁶ Nearly ten years ago AHIP launched the Core Quality Measures Collaborative (CQMC), a public-private partnership with CMS whose 70-plus member organizations work to voluntarily align measures across public and private payers and reduce the burden of measurement by moving from paper-based to digital quality measures.

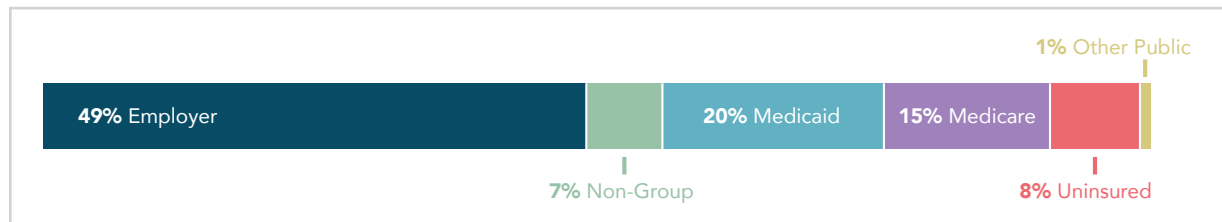
How Americans Access Health Coverage

Health insurance exists to ensure individuals and families have timely access to the quality care they need. With health insurance, consumers have peace of mind that they will have access to the healthcare system and will be protected in the event of a costly injury or illness. This protection requires a broad pool of individuals with varying healthcare needs to share in the costs. By bringing together a large group of individuals with varied health needs into a risk pool, health plans spread the financial risk to offset the costs of sicker, higher-expense members from healthier, lower-expense members, making coverage more stable and affordable. In some markets, risk adjustment further balances the risk by ensuring health plans with sicker populations have adequate funding to cover higher utilization of health services.

Broad health coverage also supports the broader healthcare system. When individuals lose coverage, they are more likely to defer preventive care or interrupt their chronic care, which can lead to the development or exacerbation of more serious health conditions. Without a consistent source of care, individuals without coverage seek care in emergency rooms leading to an increase in uncompensated care and potentially delaying emergency response capabilities. Providers may respond to these costs by raising prices for those with insurance, making care more costly for everyone.

Health coverage in the United States is delivered by health plans that vary in size and business model. In 2025, 1,156 health plans filed health statements with the National Association of Insurance Commissioners (NAIC).⁶⁷ The types of coverage and plans vary across and within markets. In Medicaid managed care, states contracted with 291 managed care organizations as of July 2024; among the 15 parent firms operating Medicaid plans in multiple states, six are publicly traded companies and nine are nonprofits.⁶⁸ In Medicare Advantage, the typical beneficiary can choose among plans offered by eight parent organizations in 2026.⁶⁹ In the Individual Market, an average of nine insurers participated per state in 2026.⁷⁰ In the employer market in 2025, two-thirds of covered workers were enrolled in self-funded plans, in which the employer bears the financial risk and often contracts with an insurer or third-party administrator to operate the plan.⁷¹

Figure 10: Nationwide Health Insurance Coverage by Type, 2024⁷²



Employer-provided coverage and ERISA

Employer-provided coverage (EPC) delivers high-quality, affordable healthcare for more than 180 million Americans, spanning individuals of every age and income level.⁷³ Employers provide coverage for almost half of children and 15 percent of Americans with incomes below the federal poverty line.⁷⁴ On average, employers pay 84 percent of employees' health coverage premiums for a single person and 74 percent for a family.⁷⁵ Employers make this financial investment because affordable and accessible health coverage helps employees stay healthy, and offering coverage contributes to attracting and retaining employees. Eighty-five percent of workers say they would likely leave their jobs if their employer no longer offered health insurance.⁷⁶

Nearly nine in ten workers report satisfaction with their current health plan. Health insurance ranks as the most valued workplace benefit, with 68 percent of workers ranking it ahead of retirement plans or paid time off.⁷⁷ Nearly all individuals with EPC say their insurance is important to their family's financial security, with 69 percent saying that losing coverage would cause significant financial hardship.⁷⁸

Competition among employers to attract and retain quality talent fuels comprehensive coverage – often including benefits exceeding what is required by federal mandates for prescription drugs, behavioral healthcare, emergency services, laboratory services, preventive care and maternity care. EPC's robust benefit offerings result in large part from its stable and predictable regulatory structure under ERISA and state preemption provisions.

EPC generally takes one of two forms: fully insured and self-funded (or self-insured) group health plans. In a fully insured group health plan, the employer purchases coverage from a health insurer, which takes on the financial risk for covered claims. In a self-funded plan, the employer pays claims directly and bears that risk, often using stop-loss coverage and a health insurer or third-party administrator to operate the plan.

Fully insured coverage

Many small businesses cannot absorb the financial risk that comes with self-funding. Fully insured coverage is often what makes offering benefits feasible for small and midsize employers. For these employers, health insurers provide value beyond a predictable monthly premium: they pool and assume the risk of high-cost claims across many employer groups; build provider networks and negotiate rates; process claims; provide care management, disease management and customer service; and help manage state and federal compliance.

Self-funded coverage

In 2025, 67 percent of covered workers were enrolled in self-funded plans, including 80 percent of workers at firms with 200 or more employees.⁷⁹ In these arrangements, the employer or union acts as the plan sponsor. It funds claims with its own assets, determines benefit design, retains ERISA fiduciary responsibility and absorbs annual fluctuations in its population's healthcare spending. The health plan serves as the administrator. Its compensation is an administrative fee, typically calculated per employee per month, rather than the difference between premiums collected and claims paid, because the plan does not collect premiums or pay claims from its own funds.

The self-funded health coverage market is competitive, with purchasers analyzing their data to project costs under different plan options with different plan administrators. Health plans compete for these contracts by offering benefits that help employers attract and retain their workforces. The employer sets premium costs and selects the plan benefit design, including deductibles and cost-sharing limits. Health plans then operate within those employer-defined parameters to develop cost-effective benefit and network designs that meet the employer's needs.

In 1974, Congress enacted ERISA with overwhelming bipartisan support to encourage employers and unions to voluntarily establish employee benefit plans. As an incentive to offer benefits, Congress provided employers flexibility in plan design and assured uniform, nationwide standards of administration and liability. Section 514(a), which expressly provides that ERISA shall preempt 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...' ⁸⁰ is an essential part of this law. This policy has enabled stability in employer benefits, nationally uniform and central plan administration, flexibility in plan benefit design and the ability to treat employees consistently regardless of where they live or work. By mitigating the harmful cost and health consequences of a patchwork of inconsistent state regulation, ERISA preemption prevents disparities in coverage and benefits that would otherwise disadvantage employees in certain states and create serious challenges for multi-state employers and labor unions.

Tax treatment of employer-provided coverage

The tax exclusion for employer-sponsored coverage is the foundation of the nation's largest source of health insurance coverage. It is also the federal government's most efficient coverage investment. There is also evidence of a strong return on that investment: an Avalere Health analysis estimated employers with 100 or more workers earn a 47 percent return on their investment in coverage, driven largely by gains in worker productivity.⁸¹ Because premiums paid by employers and unions are excluded from workers' income and payroll taxes, the policy delivers meaningful savings for middle-income workers; a worker in the 12 percent income tax bracket saves \$254 in federal income and payroll taxes for every \$1,000 in employer-paid premiums.⁸² The exclusion is especially important for union households: 96 percent of private-sector union workers have access to employer medical benefits, often negotiated in lieu of higher wages, compared with 69 percent of non-union workers.⁸³ Taxing employer-provided coverage would fundamentally undermine the largest source of health insurance coverage, weaken workplace risk pools while pushing workers into more expensive federal programs and raising taxes on working families without lowering the underlying cost of care.^{84,85}

Employers with 100 or more workers earn a 47% return on their investment in coverage

– Avalere Health

What health plans as administrators offer employers

Health plans and employers work together to address rising healthcare costs, support innovation and simplify the healthcare experience. When an employer purchases fully insured coverage or retains a third-party administrator, they benefit from capabilities the employer would otherwise need to develop and operate itself, including claims administration, provider network development and contracting, clinical and pharmacy program administration and a regulatory compliance infrastructure.

Regulatory mechanisms from the fully insured market are not applicable to self-funded benefits. For example, a MLR would be inapplicable because the employer funds care as it is needed over the year rather than committing to a certain spending level. This approach enables the employer to set reasonable contributions from employees as premiums balanced against the amount paid to the employee in wages. Employers offer compensation that includes both wages, health insurance and other benefits. Existing regulations place strict liability on employers for how they use employee-paid contributions under their fiduciary responsibilities. Further regulating employer compensation arrangements could cause employers to increase workers' health contributions, which would reduce take-home pay.

Mandating a certain type of employer compensation to a health plan administrator would limit the kinds of arrangements employers can make. Some employers may choose to contract with a single health plan to cover all their benefits, including medical, pharmacy and wellness, while other employers may choose to directly contract with multiple health plan administrators for different portions of the employer's offered benefits. Mandating fixed fees for these arrangements could limit this contracting flexibility and inadvertently increase the total cost of benefits and eliminate employers' ability to negotiate value-based contracts or shared-savings arrangements.

The Individual Market and the Marketplaces

AHIP has long supported a robust, competitive Individual Market for people without other sources of coverage. In 2025, the Individual Market served more than 25 million working families, sole proprietors, employees of small businesses, family farmers, gig workers, residents of rural communities and others with no other source of coverage.^{86,87} Most are enrolled in Marketplace coverage – more than 22 million in 2025⁸⁸ – with about 3 million⁸⁹ in non-group coverage bought directly from a health plan or through a broker. The Individual Market is also critical for people in rural communities. Of those enrolled in Federally Facilitated Marketplace plans, 2.8 million live in rural counties.⁹⁰ A reliable Individual Market directly reduces the amount of uncompensated care hospitals provide.

Impact of expiration of the enhanced tax credits

The Enhanced Premium Tax Credits helped make health coverage more affordable for millions of Americans. After they expired, consumer Marketplace premiums increased significantly. The steepest increases fell on enrollees above 400 percent of the federal poverty level (FPL), who lost eligibility altogether, and on older middle-income consumers. Effectuated enrollment fell to roughly 17.5 million, in line with CBO's projection of an approximately 25 percent decline.⁹¹ Average Marketplace deductibles increased by about \$1,000 per person as consumers moved into lower-premium, higher-deductible plans.⁹²

The expiration has created both premium and deductible impacts. When tax credits are reduced or become unavailable, healthier consumers tend to leave first, the remaining risk pool becomes costlier and gross premiums increase across the market. The deductible shift is the more lasting consequence. A consumer who moves from a silver plan to a bronze plan to keep premiums manageable remains insured and is still counted as covered in enrollment statistics. That consumer now faces a substantially higher deductible and therefore is more likely to delay or forgo needed care.

The Marketplace provides quality coverage for millions of Americans

The Marketplace is a vital source of quality healthcare coverage for Americans under the age of 65 who do not have access to group coverage and are not eligible for Medicaid. AHIP has worked closely with HHS to implement core Marketplace processes, including benefit and rate submission, enrollment and renewal processes and customer service. Over the past few years, health plans have also partnered with CMS and law enforcement agencies to protect consumers from unauthorized enrollments initiated by agents and brokers and fraud in the Marketplaces, including conducting investigations into agents and brokers suspected of fraudulent activity, terminating contracts with bad actors and coordinating enforcement efforts.

Medicaid

Medicaid covers approximately one in five Americans — including millions of children, older adults, people with disabilities and veterans.⁹³ Most states choose to partner with private health insurance plans to deliver Medicaid benefits through Medicaid managed care organizations (MCOs). About three-quarters of Medicaid beneficiaries receive their care through comprehensive, risk-based MCOs.⁹⁴ As of 2023, 90 percent of children enrolled in Medicaid were served by MCOs,⁹⁵ and between 2004 and 2023, the number of states using managed care to deliver long-term services and supports increased from eight to 24 states.⁹⁶ Nearly 8 in 10 enrolled in Medicaid MCOs rated their health plan an 8 or higher on a 10-point scale.⁹⁷

Under a managed care model, a state pays an MCO a monthly capitation payment and the MCO assumes the financial risk if those payments do not cover its costs. States are required to ensure those payments are actuarially sound. With MCOs assuming that risk, many states have turned to Medicaid managed care as a strategy for improving budget predictability and service to beneficiaries. As evidence that states are maintaining close fiscal control, Milliman analyzed NAIC findings and found that in 2025, MCOs' composite financial performance resulted in a 90.4 percent MLR, with 9.7 percent of premiums allocated for administrative costs, taxes and fees – resulting in a composite profit loss of 0.1 percent.⁹⁸

Over 80 percent of Medicaid MCO beneficiaries report being usually or always able to receive needed care right away,⁹⁹ and on average, Medicaid MCOs' healthcare quality performance is in line with commercial HMO plans.¹⁰⁰ MCOs also have deep experience providing core education and other outreach services for tens of millions of Medicaid beneficiaries, helping them understand their benefits and navigate Medicaid eligibility and renewal policies and processes. MCOs assisted many states as they were conducting eligibility redeterminations after the COVID-19 public health emergency, gathering important insights on effective education and outreach approaches during periods of significant program change. These insights will be valuable to states as they implement upcoming program changes, including the community engagement requirements.

Impact of recent Medicaid policy changes

Legislation enacted in 2025 established significant new restrictions on Medicaid eligibility and on state financing and other policy mechanisms. Complex administrative processes for implementing new coverage limits, combined with tight implementation timelines and inadequate system testing, could lead to processing errors or other procedural coverage losses by low-income individuals otherwise eligible for coverage. Reductions in provider payments could limit beneficiary access to care and cause providers to shift more costs to employers and other payers. In some states, eligibility changes that increase the acuity of remaining enrollees, combined with federal policy changes and rising costs, are threatening the stable and adequate funding needed to ensure Medicaid plans can deliver promised benefits. State Medicaid programs serve millions of low-income Americans, including working families, children, pregnant women, seniors and veterans. Access to care for many of these beneficiaries could be undermined without policy changes that ensure workable implementation timelines, better ensure necessary funding sources for states, simplify eligibility and renewals, facilitate continuity of care and reduce coverage losses stemming from administrative complexity.

Medicare

Most Medicare beneficiaries can choose how they receive their Medicare benefits based on their individual healthcare needs and personal preferences. Beneficiaries can enroll in original Medicare, the fee-for-service (FFS) program administered directly by the federal government, and pair it with a standalone Medicare Part D prescription drug plan (PDP) and often, a Medicare Supplement (Medigap) policy to help cover the substantial out-of-pocket costs that come with FFS Medicare. Alternatively, they can enroll in a Medicare Advantage (MA) plan, which combines hospital, medical and typically prescription drug coverage into a single plan that often includes additional benefits. Regardless of which pathway they choose, beneficiaries have access to coverage built and supported by health plans, giving them options that can be tailored to their health status and individual needs.

Medicare Advantage

Nearly 36 million seniors and people with disabilities choose MA.¹⁰¹ MA is an example of a public-private partnership that relies on choice, competition and strong government oversight to efficiently deliver high-quality, comprehensive benefits for clinically complex populations. MA plans serve a larger share of low-income enrollees (including more than two-thirds of dually eligible Medicare-Medicaid enrollees) and a less healthy population than FFS Medicare.¹⁰²

Through cost-effective and evidence-based approaches that encourage high-value services and reduce the number of unnecessary or wasteful services, MA plans are able to cover the same benefits as FFS Medicare, often offer additional services and coverage such as vision, hearing, dental and wellness care, and can provide substantial savings to enrollees. Furthermore, most MA plans come with integrated prescription drug coverage through Part D, streamlining and simplifying coverage for beneficiaries. On average, MA beneficiaries saved nearly \$1,100 a year in out-of-pocket costs and nearly \$2,100 in insurance premiums compared to a matched set of similar FFS beneficiaries. MA plans also reduce overall costs; annual healthcare expenditures per MA beneficiary from 2021-2023 were, on average, almost \$6,300 lower than the per beneficiary costs for their FFS peers. The value is most evident when it comes to beneficiaries with chronic diseases: total annual healthcare expenditures were \$9,000 less for those with diabetes, \$5,400 less for those with COPD and \$7,700 less for those with rheumatoid arthritis.¹⁰³

Across a range of services, MA also delivers better outcomes such as fewer preventable hospitalizations than FFS.¹⁰⁴ Harvard researchers found MA plans outperformed FFS Medicare on all preventive and chronic care clinical quality metrics, including cancer and diabetes screening, and monitoring patients on persistent medications.¹⁰⁵ Even with lower costs of care despite their more complex conditions, beneficiaries in MA and FFS report similar levels of satisfaction – 95 percent reported they were satisfied with their ability to see their doctor and the quality of healthcare they received.¹⁰⁶

Fee-for-service Medicare, Part D and Medigap

Nearly 29 million Medicare beneficiaries (45%) receive their benefits through FFS Medicare.¹⁰⁷ Because FFS Medicare does not cap annual out-of-pocket spending and does not cover outpatient prescription drugs, most FFS beneficiaries pair their coverage with private options offered by health plans, such as a standalone Medicare Part D PDP and a Medicare Supplement (Medigap) policy.

Standalone PDPs cover outpatient prescription drugs for beneficiaries who do not get drug coverage through an MA plan or other source. In 2026, 24.9 million beneficiaries, or roughly 44 percent of all Part D enrollees, are enrolled in a standalone PDP.¹⁰⁸ Medigap policies help fill the substantial cost-sharing gaps left by FFS Medicare by covering some or all of beneficiaries' deductibles, copayments and coinsurance. More than 14 million Americans currently hold Medigap coverage, and the share of FFS beneficiaries choosing a Medicare Supplement plan has grown for six consecutive years, reaching 43% in 2024.¹⁰⁹

Health plans play an important role in supporting the FFS pathway, delivering value to the beneficiaries who choose it. Medigap enrollees are three times less likely to report problems paying medical bills than FFS beneficiaries without supplemental coverage, and 93 percent of Medigap policyholders say they are satisfied with their coverage.¹¹⁰ Standalone PDPs likewise give FFS beneficiaries access to competitively priced drug coverage with predictable premiums and cost-sharing. Together, these plan options ensure beneficiaries who choose FFS Medicare benefit from the financial protection, market competition and peace of mind health plans bring to Medicare.

Making Healthcare Simpler

Health plans are committed to making coverage for hundreds of millions of Americans consumer-friendly, understandable and easy to use. When people are sick, injured, managing a chronic condition or seeking mental healthcare, they should be able to get the care they need without facing unnecessary paperwork, delays or customer-service obstacles.

Improvements to prior authorization

Prior authorization is an important safeguard selectively used by both public and private payers to help ensure patient care is safe, evidence-based and as affordable as possible. This safeguard is needed because an estimated 25 percent of U.S. healthcare spending is considered wasteful due, in part, to overtreatment, use of low-value care, lack of care coordination, outdated technology and fraud.¹¹¹ Variation in provider practice can contribute to instances in which care deviates from evidence-based clinical guidelines. Medical management tools, such as prior authorization, target areas of meaningful practice variation, increase adherence to evidence-based practice and protect patients from low-value or unnecessary services. When California's Medi-Cal program temporarily suspended prior authorization requirements for most prescriptions in 2022 as part of its transition to the Medi-Cal Rx program, the state saw nearly \$179 million in fraudulent payments from just one scheme alone.¹¹²

At the same time, health plans recognize patients are often frustrated when prior authorization results in delays or uncertainty. In addition, the prior authorization experience suffers from providers' reliance on outdated, error-prone manual processes such as faxes.

Health plans are implementing a multi-year series of voluntary commitments to streamline, simplify and reduce prior authorization. Full implementation of these commitments will result in connecting patients more quickly to the care they need while significantly streamlining the prior authorization experience for providers. The commitments are being implemented in Medicare Advantage, commercial coverage and Medicaid managed care consistent with state and federal regulations.

Progress to date

Health plans are continuing to reduce the scope of claims subject to prior authorization and focus prior authorization on services that have higher clinical risk or wide variation in practice. Since announcing the voluntary commitments 15 months ago, health plans have eliminated approximately 6.5 million prior authorizations for patients.¹¹³ Moving forward, health plans will continue to assess what services and prescription drugs require prior authorization. Health plans also affirmed improvements that make it easier for members who switch insurance to maintain their prior authorization approvals, reporting continuity of care support for new members across a wide range of treatments and services, including chemotherapy, cardiac rehabilitation, post-surgery physical therapy, infusion therapy and scheduled surgery. To bridge the gap until new interoperability requirements take effect in 2027, health plans are also securely sharing data between members' current and former health plans. Plans have reviewed and revamped their member communications for clarity, completeness and consistency. Improvements have focused on providing consumer-friendly, straightforward language, including information on appeals processes and actionable next steps patients can take.

Health Plan Voluntary Commitments to Simplify Prior Authorization

59 Health Plans covering 270 million Americans

2026

- Reducing the Scope of Claims Subject to Prior Authorization
- Ensuring Continuity of Care When Patients Change Plans
- Enhancing Communication and Transparency on Determinations

2027

- Standardizing Electronic Prior Authorization
- Expanding Real-Time Responses

In Effect

- Ensuring Medical Review of Non-Approved Requests

What comes next

Health plans are now focused on implementing meaningful commitments that start in 2027, including the adoption of new electronic prior authorization interoperability requirements and faster response times when all information is submitted electronically. Health plans voluntarily committed to determining real-time electronic prior authorization approvals at least 80 percent of the time. Participating plans are implementing a standardized approach to the documentation requested for prior authorization submissions for 66 medical services starting in 2027,¹¹⁴ covering a majority of commonly prior authorized medical services, including orthopedic surgeries and imaging services such as CT scans and MRIs. This standardization will help reduce the number of requests that come in with incomplete supporting documentation, resulting in faster decisions and faster access to care.

Maximizing progress will require strong provider and vendor commitments. Vendors need to support new functionality in their systems and make it affordable for providers to access new technology. Providers need to move away from error-prone manual processes and adopt electronic prior authorization as part of their electronic health records. Nearly half of prior authorization requests to commercial plans are submitted by providers manually (phone, fax, mail).¹¹⁵ As more providers shift from phone and fax to electronic prior authorization, faster response times, a more consistent experience and less friction for everyone will become a reality.

Claims processing

Health plans process over five billion healthcare claims annually. Most claims are approved without any issue or delay.¹¹⁶ Patients can experience frustration and confusion when an explanation of benefits arrives with a denial code, and providers report administrative burden from submissions that do not process on the first pass. Many claims that are not initially processed for payment are ultimately paid by the health plan after more information is sent by the provider or administrative challenges are resolved. Many claims that should be appropriately considered “pending” are wrongly categorized as “denials” even though they are ultimately paid. Some providers routinely submit duplicate claims that are often categorized as denials even though the claim was paid. Publicly reported data do not show the full lifecycle of the claim, including what happened to the patient, why payment was denied, whether an administrative problem was later resolved through a corrected or newly submitted claim or whether the event reflected a clinical coverage determination. The limitations are evident in federal reporting for Marketplace plans. In its analysis of the limited information available on reasons for in-network denials, KFF found five percent involved medical necessity, 25 percent were administrative and 36 percent fell into an “other” category. As part of this analysis, KFF identified important limitations in linking denial reasons, resubmissions, services and ultimate payment outcomes.¹¹⁷

As a first step, AHIP supports examining claims processing across the full lifecycle to clearly distinguish clinical coverage determinations from administrative processing issues. This approach would enable regulators and the public to clearly understand actual claims outcomes. This examination would provide much-needed clarity about how to improve the claims process and significantly reduce claims denied for administrative reasons.

Consumer-friendly enrollment and reenrollment

Many Americans are enrolled in employer-sponsored coverage, the Individual Market, Medicaid and Medicare at different points over their lifetimes. Each transition brings different eligibility rules, enrollment windows, documentation requirements, renewal processes and terminology. As a result, individuals are left to manage these coverage transitions on their own. A consumer whose hours are reduced, who moves to another state or whose income exceeds an eligibility threshold must recognize their coverage status has changed, determine their eligibility, find the right application process and act within deadlines of which they may be unaware.

AHIP supports streamlining enrollment across all sources of coverage by using modern technology to make the process faster, easier and more intuitive.

Simplified enrollment: one state’s experience

Unified enrollment platforms across commercial and public coverage can give consumers one place to begin, regardless of which program ultimately fits their circumstances.

Minnesota pursued this integration, building a single technology platform intended to bring together commercial Marketplace enrollment, Medicaid eligibility and Basic Health Program (BHP) eligibility. The state established a unified entry point, and residents could begin in one place. However, the underlying integration proved substantially more difficult on operational, technical and financial dimensions. Minnesota ultimately moved away from the original vision of a fully unified eligibility system and redirected resources toward

maintaining multiple interconnected systems. A single system applying Marketplace, Medicaid and BHP rules (where applicable) to a shared data model is far more difficult to build because the rules vary considerably. Medicaid eligibility varies by state, category and waiver; and BHP operates in only a limited number of states under distinct terms.

Enrollment enhancements should prioritize interoperability over consolidation: common data standards; real-time verification APIs for Marketplaces, state Medicaid agencies and health plans; standardized account transfers; and reliable status-change notifications across programs. This approach can deliver the seamless consumer experience of a single platform without requiring consolidation.

State-Based Marketplaces support the same conclusion. Several have developed enrollment and account-security architectures that outperform the federal platform on consumer experience and integrity simultaneously. For example, Maryland's Easy Enrollment program demonstrates a low-cost administrative change can reduce administrative burdens and make enrollment simpler.

Reenrollment and continuity of care

Reenrollment should be simple, data-driven and designed to keep eligible people covered. Health plans strongly support preventing fraud, waste and abuse. Program integrity efforts should target documented misconduct rather than creating paperwork barriers that inadvertently cause eligible people to lose coverage. Today's verification systems often require consumers to prove facts government data may already confirm, leading to avoidable coverage losses, as seen during Medicaid redeterminations after the COVID-19 public health emergency.

CMS estimates seven percent of applicable individuals will lose coverage (or be unable to enroll) with implementation of Medicaid community engagement requirements due to administrative or procedural reasons,¹¹⁸ and procedural losses could be even higher given tight implementation timelines and inadequate system testing. Even temporary coverage losses can interrupt important care, lessen quality, reduce health outcomes and ultimately raise program costs.

Eligibility verification should use trusted data sources, resolve data matching inconsistencies automatically, preserve continuity by default and focus active review on genuinely high-risk cases. This approach is especially important in the Marketplaces, where a small number of bad actors in the agent and broker market initiated unauthorized enrollments or plan switches. Stronger agent authentication, auditable consent, faster revocation of access for bad actors, two-factor authentication on the federal platform and strong federal enforcement would protect consumers effectively.

Accurate provider directories

Accurate provider directories are critical as families select health insurance coverage and when seeking care after enrollment. Provider directories are comprehensive listings of the physicians and other clinicians, facilities and pharmacies that contract with a health plan. Maintaining accurate directories is a shared responsibility that requires a joint commitment from health plans, providers and federal payers. Health plans are required to routinely verify directory information, but plans have no way to know when a provider changes a practice location, stops accepting new patients or changes contact information in between regular check-ins unless the provider supplies timely and accurate updates. Providers share responsibility for keeping their information current.

Plans depend on providers for accurate data, but provider response rates remain a challenge. Especially for small or rural providers, responding to outreach from multiple health plans about different products and programs can be burdensome. A national directory could ease that burden, but reducing burden alone has not been enough to drive provider participation. CMS is conducting a pilot with Marketplace health plans in Oklahoma to test whether directory accuracy could be improved using technology. While preliminary results are positive, provider participation remains very low. In 2016, AHIP conducted a pilot with a dozen health plans in which one state (California) included strong accountability measures that successfully incentivized providers to respond to requests to update their information. Requirements or incentives to ensure providers keep their information current must be present in any national directory solution.

AHIP supports CMS's investment in a National Directory of Healthcare Providers & Services (NDH). AHIP believes the effort should be expanded to a public-private partnership to avoid duplicate provider requests from public and private payers. Efficiency gains will be achieved through a system in which providers maintain core demographic and practice information in a unified, standardized source used across federal programs and health plans. Health plans should remain responsible, outside of the national directory, for mapping that information to plan-specific networks, products and contracting arrangements. The NDH should be the source of truth for the provider data common across payers without replacing or replicating health plans' directories.

Data sharing that supports coordinated care

Moving toward a healthcare system in which data flow seamlessly and securely among appropriate stakeholders will benefit all Americans. Data interoperability is foundational to sharing timely, complete and reliable health information among patients, providers and health plans. Improving how data moves within electronic health records and to trusted parties will support better coordination of care. Health plans can assist clinicians in seeing the full picture to avoid duplicative testing, conflicting prescriptions, gaps in care and rising risks for preventable conditions.

Health plans are investing significantly to make plan-held data more accessible and interoperable. Under CMS's 2020 Interoperability and Patient Access Final Rule and 2024 Interoperability and Prior Authorization Final Rule, impacted health plans are working to implement standardized FHIR-based APIs by January 1, 2027, to support patient access, provider access, payer-to-payer exchange and automated, more real-time prior authorization. These capabilities will give patients access to their claims, clinical and prior authorization information through the applications of their choice, provide treating clinicians with access to plan-held patient data and facilitate continuity of information when individuals change health plans.

Ensuring Reforms Target Real Healthcare Cost Drivers

The American healthcare system is too expensive and creates too much confusion for patients, providers and employers. Because health coverage is where the affordability problem is most visible, it is also where reform proposals often focus. Many states and programs that have focused reforms on health plans have found these actions did not result in lower costs or make care accessible, providing important lessons for future policy efforts.

Mandated premium targets do not reduce underlying costs

State public option efforts that include premium reduction targets fail to address underlying factors driving up the costs of healthcare. Premium targets set arbitrary premium reduction requirements and create additional standards including those that undermine the ability of health plans to lower premiums.

Experience in Colorado underscores the ineffectiveness of arbitrary premium reduction targets in reducing costs. An analysis of data published by CMS and in plan rate filings shows the Colorado Option has fallen far short of its 10 percent premium reduction target. In 2026, Colorado Option plans are more expensive than non-Colorado Option plans for 85 percent of Coloradans who seek coverage in the Individual Market. In the overwhelming majority of service areas, the Colorado Option reduced premiums by less than two percent. In Denver, the Colorado Option reduced premiums by less than 0.3 percent, but offering more robust reinsurance to health plans at the same time reduced premiums by 16 percent.¹¹⁹

A public option sidesteps the actual problem

A public option sidesteps the root causes of rising healthcare costs and the accompanying rise in premiums. Rising medical costs are the barrier to affordable coverage, and that challenge cannot be solved without focusing on the prices of care itself. A federal public option would rely on government rate setting and the flaws of fee-for-service reimbursement.

A public option administered by the federal government would disrupt the market by coercing provider participation and setting rates below the cost of care, while exempting itself from the substantial financial obligations and regulatory requirements with which health plans must comply. This uneven playing field would drive health plans out of the market, reducing consumer choice and stifling competition. Today, Americans are highly satisfied with their current health plans – 90 percent of patients with employer-provided coverage and 95 percent of seniors with MA are satisfied with their access to medical care.^{120,121}

Americans are highly satisfied with their current health plans:

90% of patients with employer-provided coverage

95% of seniors with MA are satisfied with their access to medical care

– AHIP and BMA

Health plans have invested heavily in developing innovative care delivery models and payment systems that prioritize patient outcomes, efficiency and affordability. A federal public option would divert resources away from these efforts, impeding health plans' ability to invest in value-based care, personalized health management tools and alternative payment models.

Government-run systems have proven unaffordable and difficult to implement

States that have attempted to enact new statewide government-controlled health insurance systems have found them unaffordable and difficult to implement, and similar experiences are likely for any future federal approaches. In Vermont, the government abandoned its single-payer effort after predicting it would need a new employer payroll tax of 11.5 percent and an individual income tax of up to 9 percent.¹²² In 2016, Coloradans defeated Amendment 69, which included new taxes that would have nearly doubled state government spending and which the Colorado Health Institute predicted would slide into ever-increasing deficits.¹²³

In 2017, RAND estimated financing a single-payer system in Oregon would require increasing state income tax revenue by 83 percent and creating a new 6.5 percent payroll tax.¹²⁴ In California, the state Senate Appropriations Committee estimated enacting single-payer under SB 562 would cost roughly \$400 billion annually and would require new tax revenue — potentially a 15 percent payroll tax on earned income.¹²⁵

Both state-run systems and Medicare-for-All approaches often result in long wait times and rationing rather than increases in patient access. Indeed, Congressional Budget Office (CBO) found that under every single-payer design it analyzed, “the total increase in demand would exceed the total increase in supply,” causing “increased congestion in the health care system” with “delays and forgone care.” In one scenario (lower provider payment rates and lower cost sharing), demand for care would rise 11 percent while supply would grow only 5 percent, leaving 6 percent of demand unmet.¹²⁶ The results are clear in other countries: in 2022, Canadian specialist physicians reported a median waiting time of 27.4 weeks between referral from a general practitioner and receipt of treatment, up from 25.6 weeks in 2021.¹²⁷ England’s NHS waiting list was 7.31 million in November 2025. Only 61.6 percent of patients began treatment within the 18-week standard, and about 154,000 had waited more than a year.¹²⁸

Mandated standardization of benefits and cost-sharing limits choice

AHIP shares the goal of making it easier for consumers to choose the plans that best meet their needs. Selecting coverage is harder than it should be, and consumers deserve clear, comparable information. Standardization should facilitate comparison, not eliminate meaningful consumer choice. Consumers differ considerably in their health status, financial circumstances, preferred providers and prescription drug needs. They also differ in how they prefer to balance monthly premiums against out-of-pocket costs. Plan design is one of the main ways health plans respond to these differences. Requiring health plans to converge around a single prescribed benefit design restricts their ability to develop products for different consumer needs. Standardization also removes an important dimension on which plans compete.

When CMS required health plans to offer standardized plan options, enrollment in those plans remained proportionally low. The policy limited consumer choice without improving plan selection or the consumer experience. AHIP conducted a member survey to understand the impact of mandated standardization of plan designs and limitation of non-standardized plan options to four non-standardized plans per product network type for each metal level in a service area. The survey indicated a 24 percent reduction in plan offerings – over 2,500 individual plans impacting more than 900,000 enrollees. Plans that were discontinued tended to be those with broad networks, virtual primary care and varied cost-sharing or deductible designs.¹²⁹

The same logic applies to cost-sharing mandates. Different cost-sharing and actuarial value levels allow health plans to offer products that respond to different medical needs – leaner plans for younger and healthier people, richer plans for those who expect to use a lot of healthcare and want to spread costs over the year. Health plans leverage market competition to drive lower costs for patients. Under a fixed cost-sharing amount, health plans would have limited ability to drive lower prices among competing providers, leading to higher prices and higher premiums for all patients.

Affordable and comprehensive benefits

A clear, consumer-centered essential health benefits (EHB) framework is critical for comprehensive individual and small group coverage. EHB designation carries important protections: it bars annual and lifetime dollar limits, counts covered services toward the annual cost-sharing limit and requires benefit designs to meet federal nondiscrimination standards. It also supports actuarial value tiers, risk adjustment and meaningful plan comparisons. Because premium tax credits are tied to the cost of EHB and cannot be used for benefits outside the EHB categories, the EHB framework also determines federal financial assistance.

Every added benefit increases coverage costs for the full risk pool. The ACA recognized this tradeoff. States may require benefits beyond EHB, but they must defray the cost of post-2011 mandated benefits by paying enrollees or their health plans. Individual mandates may appear modest in isolation, but their cumulative impact can increase the underlying cost of coverage and premiums. Any expansion beyond the typical-employer-plan standard should therefore be evaluated transparently, including its effect on premiums and federal spending, and should preserve the ACA’s cost-defrayal safeguards. When a state mandate is not defrayed, its cost is built into premiums. For Marketplace enrollees, much of that added EHB cost is financed through federal premium tax credits, meaning federal taxpayers pay for a benefit decision made by the state. Consumers not eligible for premium tax credits and small employers pay the full amount themselves.

Rate review and solvency are inextricably linked

Strong state oversight of insurance rates and insurer solvency is essential to protecting consumers and maintaining stable insurance markets. State insurance regulators are best positioned to evaluate local provider costs, utilization and enrollment trends, market conditions and issuer financial requirements. They also oversee insurer capital and reserves and are responsible for ensuring insurers remain financially capable of paying claims and meeting their obligations to policyholders. The National Association of Insurance Commissioners (NAIC) further supports this state-based framework by developing model standards and coordinating financial surveillance and solvency oversight across jurisdictions.

Rate review is an essential component of that solvency framework. Premiums must be sufficient to reflect the expected cost of providing coverage and paying members' claims. A premium that is artificially constrained below the actuarially justified cost of coverage does not reduce the underlying cost of medical care; instead, it creates financial pressure that can ultimately threaten an insurer's ability to meet its obligations to consumers.

Federal requirements can promote transparency and accountability, but they should complement rather than duplicate or override state regulatory processes. Arbitrary federal limits on premium increases or a duplicative federal rate-review process could separate rate oversight from solvency regulation and prevent premiums from appropriately reflecting changes in medical costs. Federal policy should preserve state regulators' ability to evaluate actuarially justified rates and respond to conditions in their local markets.

The importance of plan choices for all consumers

Everyone needs insurance for unexpected medical costs. Consumers also need options that enable them to select the most appropriate health plan for their expected medical costs. The marketplace structure reflects this, establishing plan metal levels with different actuarial values that allocate the share of costs paid by the plan from premiums and paid by patient cost-sharing. CMS regulates these actuarial values, requiring Bronze level plans to cover 60 percent of costs, Silver plans to cover 70 percent of costs, Gold plans to cover 80 percent of costs and Platinum plans to cover 90 percent of costs. But CMS also recognizes total costs are not the same across these metal levels, requiring plans to account for "induced utilization" across different plan designs.

If cost-sharing is lower, some patients may use more healthcare services than they would otherwise. Based upon the state average "induced utilization" factor, CMS estimates consumers in a Silver plan have total benefit costs 3 percent higher than a Bronze plan, while consumers in Gold and Platinum plans have benefit costs 8 percent and 15 percent higher than a Bronze plan, respectively.¹³⁰ While moving from a Bronze plan to a Silver or Gold plan will increase an individual's premium because of the change in the actuarial value, induced utilization will increase an individual's premium even further. As shown in Table 3, an individual moving from a Bronze plan to a Silver plan would see a premium increase of \$92 per month. Eighty-five percent of that increase results from the change in actuarial value, but the remaining 15 percent is due to higher healthcare costs from greater utilization. Moving to a Gold plan generates an even larger increase of \$201, nearly 20 percent of which is due to greater utilization.¹³¹

Table 3: Projected Premium Increases from Removing Metal Level Tiers in the Individual Marketplace

	Current Bronze Plan	Removing Bronze Level	Removing Bronze and Silver Levels	Removing Bronze, Silver and Gold Levels
Total Premium	\$456	\$548	\$657	\$787
Premium Increase due to Lower Cost-Sharing	-	\$78 (17.1%)	\$162 (35.5%)	\$254 (55.8%)
Premium Increase due to Greater Utilization	-	\$14 (3.1%)	\$39 (8.5%)	\$76 (16.7%)
Premium Increase over Bronze	-	\$92 (20.2%)	\$201 (44.0%)	\$330 (72.5%)

Premium increases are estimated for moving individuals enrolled in Bronze plans into Silver plans (and subsequently into Gold and Platinum plans). Premiums are based on KFF's reported national average lowest-cost premium for a 40-year-old enrolling in a Bronze plan. Greater utilization is based on CMS' reported national average induced demand factor across metal levels.

Consumers who expect to have low healthcare costs need to have affordable health insurance options; otherwise, they may choose to skip purchasing health insurance. Because increasing the actuarial value of a plan raises total costs due to induced demand, a one-size-fits-all plan design would generate premiums too high for some consumers. While the Marketplace plan structure needs to be modernized to protect consumers from the increase in underlying healthcare costs, any reforms must ensure consumers who want a lower-cost health plan can choose one.

Existing law comprehensively regulates health plans' transactions with affiliates

Extensive state and federal rules govern what a health plan may pay an affiliate, how shared costs are accounted for and what a health plan may count toward its MLR. These are not special rules created for health coverage: every state applies the same framework to transactions between insurers and their affiliates, whether the insurer underwrites life, property and casualty or health insurance.¹³² Common ownership should not be presumed to increase costs.

Regulators review health plans' payments to affiliates to ensure they are fair and reasonable. State law requires every arrangement between a health plan and its affiliates to have fair and reasonable terms as well as reasonable charges for services, and statute requires the plan's books to clearly document each arrangement.¹³³ Health plans must notify state regulators in advance before entering into service, management or cost-sharing agreements with affiliates, and regulators may disapprove arrangements that do not meet these standards.¹³⁴ In MA and Part D, plans must disclose related-party arrangements in their bids. Related-party expenses above a certain percentage trigger additional information and data reporting and a demonstration that related-party costs meet certain comparability or other requirements, and each bid must include a certification by a qualified actuary that the bid complies with applicable CMS requirements.¹³⁵

Changes to affiliate arrangements receive the same scrutiny. A health plan cannot simply increase what it pays an affiliate. Amendments to previously filed affiliate agreements must also be submitted to state regulators in advance, with the reasons for the change and its financial impact on the plan, so any increase must meet the same fair and reasonable standard.¹³⁶ State examiners also test affiliate agreements and payments during periodic, risk-focused financial examinations of each health plan.¹³⁷

Strict accounting principles govern how costs are shared across entities. Health plans may share personnel, technology and other overhead with affiliates, which spreads fixed costs across a larger organization and can lower the administrative expenses reflected in premiums. Statutory accounting principles set strict rules for these arrangements: shared costs must be allocated to each entity as if it had paid them on its own, affiliate arrangements must be documented in written agreements and disclosed in financial statements filed with regulators and amounts affiliates owe a health plan that go unpaid cannot be counted toward its capital.¹³⁸ Federal MLR rules similarly require health plans to allocate expenses using a generally accepted accounting method and to document the methods they use.¹³⁹

State and federal regulators can audit health plans in the Marketplaces and Medicare. Health plans' annual financial statements must be audited by independent certified public accountants for compliance with the fair and reasonable affiliate arrangement standards, and state regulators conduct periodic examinations that include affiliate arrangements.¹⁴⁰ Federal rules define which expenses count toward the MLR, including detailed criteria for premium revenues allocated to clinical services, quality improvement activities, administrative costs and rebates. Health plans report those expenses to state and federal regulators. In the individual and group markets, including the Marketplaces, HHS may audit health plans' MLR reports and order payment of any rebates owed and may rely on MLR audits conducted by states.¹⁴¹ In Medicare Advantage and Part D, CMS reviews MLR submissions, validates the amounts reported, recoups remittances when data are materially incorrect and may impose sanctions.¹⁴²

Self-funded employers have multiple transparency tools. When a health plan administers coverage for a self-funded employer, the employer's plan bears the financial risk and is governed by ERISA rather than state insurance law.¹⁴³ Employers have fiduciary obligations to monitor their administrators and what their plans pay,¹⁴⁴ and federal law gives them the tools to do so. Health plans may not agree to contract terms that restrict an employer's access to its own cost, quality and claims data.¹⁴⁵ Plans must publish the rates they pay both affiliated and independent in-network providers.¹⁴⁶ Brokers and consultants who advise employer plans must disclose their compensation.¹⁴⁷ Employers may also negotiate audit rights and other contractual protections in administrative services agreements, providing additional mechanisms for oversight of plan expenditures.

Taken together, affiliate arrangements and MLR reporting are already subject to significant regulatory, reporting, audit and enforcement oversight at both the state and federal levels. Changing how MLR is calculated for plans with affiliated providers would not lower premiums or reduce consumer costs; it would add administrative complexity without giving consumers or regulators meaningful new information. Because existing state and federal standards already require transactions to be fair, reasonable, transparent and subject to regulatory review, any additional requirements should be targeted to an identified regulatory gap rather than the corporate structure through which healthcare services are delivered.

Integrating coverage and care improves coordination and lowers costs

At both the state and federal level, some policy proposals assume, without evidence, that common ownership of health plans, care providers, pharmacies or pharmacy benefit managers raises costs. The evidence points the other way. When a health plan and the clinicians and pharmacies that serve its members work within one organization, they can share data, align incentives and coordinate care in ways that fragmented arrangements cannot. For example, one large integrated health system used a shared patient registry, performance data, follow-up visits led by medical assistants and simplified medication regimens to raise hypertension control from 44 percent to 80 percent in eight years, far outpacing national gains over the same period.¹⁴⁸ Better integration of coverage and care can also lower costs. The HHS Office of Inspector General found vertically integrated Part D sponsors paid their affiliated pharmacies slightly less than they paid independent pharmacies,¹⁴⁹ and a recent study found MA enrollees who used an integrated specialty pharmacy received their medications nearly six days sooner, at lower annual cost, than similar enrollees who did not.¹⁵⁰ Integrated plans and pharmacies deliver a range of services that benefit patients, including specialty drug cold-chain logistics and patient support, integrated medication adherence and chronic disease management programs and home delivery and home infusion pharmacy services. If health plans were required to outsource these programs, costs may increase and care coordination may be less effective. Sharing administrative functions across a larger organization also spreads fixed costs, reducing the overhead reflected in premiums.

MA enrollees who used an integrated specialty pharmacy received their medications nearly six days sooner

– A. G. Hames, et al., Health Affairs Scholar

Proposals to arbitrarily separate coverage and care would cause disruption for millions of patients while delivering no corresponding benefits. Some proposals would prohibit any company from owning both a provider or management services organization and a health insurer or pharmacy benefit manager, requiring divestiture within one year of enactment, backed by disgorgement of profits and forced asset sales. Because these definitions are broad, such prohibitions would disrupt integrated organizations of all sizes, including long-standing integrated delivery systems and the health plans that hospitals and physician groups operate in communities across the country. Forcing these organizations apart on a one-year timeline would suddenly disrupt

established relationships between millions of patients and their doctors, pharmacies and care teams; fragment the data and coordination that integrated care depends on; and add administrative costs as functions now shared within an organization are duplicated. The concerns such policies purportedly seek to address, such as steering business to affiliates or shifting margin through affiliate payments, are already subject to the extensive state and federal oversight described above.

The consolidation most clearly linked to higher prices is among providers themselves. When hospitals acquire physician practices, prices for the acquired physicians' services rise by an average of 14 percent, and spending for patients of acquired primary care physicians rises by nearly 5 percent.¹⁵¹ When PE firms focused on short-term profits acquire physician practices, the average amount paid per claim rises by 11 percent,¹⁵² and following PE acquisitions of gastroenterology practices, colonoscopy prices rose 4.5 percent with no measurable change in quality.¹⁵³ These higher prices ultimately fall on workers and families. Research examining hospital mergers found each one percent increase in healthcare prices lowers payroll and employment at local employers by 0.4 percent – with job losses concentrated among lower- and middle-income workers – and reduces federal income tax revenue.¹⁵⁴ Yet some proposals would leave PE ownership of physician practices and hospital acquisitions of physicians largely untouched while dismantling integrated models that lower the total cost of care. Policymakers should build on existing oversight rather than dismantle integrated care models that improve quality and lower costs.

AHIP's Agenda to Make Healthcare Less Expensive and Easier to Use

AHIP and its member health plans believe Americans should have choices of comprehensive health insurance coverage they can afford and use. Premiums should be affordable for people and employers and sustainable for the country. Cost-sharing should incentivize informed, high-value choices and not be a barrier to needed care. Primary care should be an affordable entry point to the healthcare system. The costs of core preventive care should be covered by premiums with no or limited cost-sharing or deductibles. Americans should be able to enroll in coverage easily and seamlessly transition from one coverage type to another. AHIP supports a healthcare system that is more affordable, more accessible and more convenient.

Make coverage affordable and easier to keep

Ensure the Individual Market is affordable

AHIP supports an enhanced premium tax credit structure that includes a percentage-of-income cap that phases down gradually coupled with funded cost-sharing reductions (with adequate lead time).

Enhanced premium tax credits, paired with strong program integrity and anti-fraud provisions, are important to keeping premiums affordable for Americans purchasing coverage through the Individual Market. When changes are being considered to the premium tax credits, a path to cost-sharing reduction (CSR) funding should be established.

Under the ACA's original premium tax credit structure, eligibility ends at 400 percent of the federal poverty level, so a household just above the threshold loses the entire credit. The impact is most acute for older enrollees, whose age-rated premiums can become unaffordable immediately above that line. A percentage-of-income cap that phases down gradually, rather than ending at a hard cutoff, would address this problem.

Cost-sharing reduction payments have not been made since 2017. Health plans are still legally required to provide those reductions and the cost has been covered through varying CSR loading approaches, which can increase benchmark silver premiums and, because premium tax credits are tied to the second-lowest-cost silver plan, result in higher federal premium tax credit spending. CBO and JCT have concluded this approach costs the federal government more than directly appropriating CSR funding would.

Direct appropriation is more transparent, less costly for the federal government and eliminates an approach that has become embedded in the market structure. Ending silver loading reduces benchmark silver premiums. Because premium tax credits are calculated from that benchmark, the same change also lowers tax credits, raises net premiums for some subsidized enrollees and reduces enrollment relative to current law.

Adequate lead time is essential. An effective date at least one full rate-filing cycle in the future will enable health plans to price the change and give state regulators time to update silver-loading guidance in an orderly way. Retroactive or mid-cycle implementation would create rate instability.

Modernize metal levels and out-of-pocket limits

AHIP supports modernizing the maximum out-of-pocket limit in the Individual Market to create more affordable plan offerings.

The ACA was designed to offer consumers choices for their healthcare costs – lower premiums for a Bronze plan with higher cost-sharing, or higher premiums for a Gold plan with lower cost-sharing. These choices reflect the Actuarial Value (AV) of a plan. Consumers who do not anticipate many medical expenditures can choose a lower-premium plan, while consumers who may have a chronic condition can spread those costs over the year with a higher-premium plan that has lower cost-sharing.

But when families face affordability challenges beyond healthcare, they may not be able to afford a higher-premium health plan even when it may better correspond with their expected healthcare needs. This circumstance can leave consumers selecting a lower-premium plan with higher cost-sharing than they can afford. Because the ACA requires health plans to be set at these premium and cost-sharing AV tradeoffs, health plans cannot offer lower-premium options without high cost-sharing.

From 2016 to 2026, the underlying costs for providing essential health benefits for an Individual plan rose from \$5,600 per year to \$9,450 per year, a 69 percent increase.¹⁵⁵ This amount, called the “Index Rate,” is the basis for calculating Individual Market premiums, subject to a variety of adjustments. At a simple level, in 2016, applying the index rate to a Bronze plan with a 60 percent AV meant consumers, on average, were expected to spend \$2,240 (40 percent of the 2016 Index Rate) in cost-sharing annually, while the plan would pay \$3,360 (60 percent of the 2016 Index Rate) to finance the rest of care. Applying the same 40 percent factor for 2026, the average expected cost-sharing increases to \$3,780 – more than a plan’s expected spend 10 years prior. Because the total cost of providing care has increased so much, the statutory AV requirements require cost-sharing many American families struggle to afford.

Those consumers face out-of-pocket spending requirements that are governed by statute and have grown far too high since the ACA was created. Under the statute, the 2014 out-of-pocket maximum was \$6,350 for an individual, linked to existing High-Deductible Health Plan limits for that year.¹⁵⁶ Now in 2026, the out-of-pocket maximum has grown 67 percent to \$10,600 under the statutory formula, which calculates the increase based on the rate of premium growth.¹⁵⁷ For a family, the statute now sets the out-of-pocket maximum at \$21,200,¹⁵⁸ an unaffordable number for most families in the Individual Market.

Modernizing the Individual Market metal level AVs and out-of-pocket limits must be done in tandem. Lowering the out-of-pocket limit without adjusting the statutory AV requirements would require corresponding changes elsewhere and could increase premiums. Regulators have attempted to increase plan flexibility through changes to the AV de minimis requirements or allowing for higher out-of-pocket limits in Expanded Bronze plans, but these efforts only underscore the challenges of maintaining lower cost-sharing within the base AV constraints of the statute.

AHIP supports updating and lowering the maximum out-of-pocket limit in the Individual Market to a level that would be more affordable for more consumers and their dependents. Increasing the out-of-pocket limit at the same rate as healthcare cost growth meant the limit too quickly became unaffordable for many families. AHIP is committed to working with Congress to determine an affordable limit and determining financing solutions to avoid significantly higher premiums.

Simplify enrollment and preserve automatic re-enrollment

Consumer-facing technology has changed significantly since the Individual Market eligibility framework was created. Tax filing, banking and identity verification increasingly rely on pre-populated information, real-time confirmation and continuous account access.

AHIP supports pre-populated enrollment applications.

Applications should begin already populated with what federal data can supply — income data available to the IRS, citizenship and immigration status available to SSA and DHS, household composition where reliable. The consumer’s role becomes confirming or correcting rather than assembling and attesting from scratch.

AHIP supports the preservation of automatic re-enrollment in the Individual Market.

Automatic re-enrollment should be preserved for consumers who complete pre-enrollment verification and do not actively select new plans. Automatic re-enrollment is an effective continuity mechanism in the Individual Market today. Eliminating this mechanism for the more than 20 million people who purchase their own coverage would likely produce unintended disenrollment because of paperwork issues and missed deadlines.

Strengthen program integrity and ensure eligible consumers can access the coverage they need

AHIP supports strong program integrity protections paired with approaches that help ensure eligible consumers can access the coverage they need:

- Prioritize upfront screening, verification and enrollment controls particularly among high-risk enrollment pathways.
- Enhance residency verification and enforcement against body-broker schemes. Health plans have reported instances of enrollees being enrolled in commercial benefits in a state the enrollee does not live in to receive medical treatment.
- Use AI to detect enrollment fraud, with appropriate guardrails. AI can help identify enrollment fraud at the point of enrollment.

Expand the range of coverage options available to consumers

AHIP supports codifying CHOICE arrangements.

CHOICE Arrangements, previously known as Individual Coverage Health Reimbursement Arrangements (ICHRA), allow employers to help employees purchase Individual Market coverage on a tax-favored basis. They have operated under regulation since 2019. Codification with existing nondiscrimination guardrails included in current regulations would give employers a predictable way to support employee-selected coverage and strengthen the Individual Market by adding a steady, employer-funded source of year-round enrollment and create good coverage options for many employers who may not have offered health insurance as a benefit. AHIP supports exploring employee choice within this framework, with guardrails preventing adverse selection.

AHIP supports expanding HSA flexibility to improve access and reduce barriers to care.

Health Savings Accounts (HSAs) are portable when people change jobs, balances carry over from year-to-year, and they encourage consumers to compare price and quality for healthcare services. In 2025 Congress expanded HSA eligibility to Marketplace bronze and catastrophic plans. HSAs are valuable for consumers who choose them, and AHIP is open to proposals that give consumers more flexibility in how they use federal financial support. Account-based options can complement premium tax credits, provided they build on the credit rather than reduce it and keep consumers connected to comprehensive coverage that protects them against major medical events. For example, enrollees who choose a lower-cost plan could direct unused tax credit dollars into an HSA for out-of-pocket costs. This would maintain the program integrity features of the current system, including payment tied to a verified enrollment and reconciliation against actual income at tax filing.

HSAs are valuable options for consumers who choose them and have income available to contribute. They complement comprehensive coverage and an affordable tax credit structure but should not replace existing tax credits. Some current proposals treat premium tax credits and consumer-directed accounts as substitutes, reducing credit generosity and shifting the savings into direct contributions to individual accounts. Substituting accounts for credits would give consumers funds without ensuring they have coverage with which to use them.

Support employer-provided coverage

AHIP supports preserving broad ERISA preemption and a uniform national minimum benefit standard.

Allowing individual states to impose separate benefit, administrative or claims requirements on self-funded plans could subject a single employer plan to different and potentially conflicting requirements depending on where employees live or work. The resulting complexity would increase administrative costs and undermine employers' ability to provide consistent benefits nationwide.

AHIP supports maintaining the tax exclusion in full and does not support caps, limits or new taxes on the healthcare benefits of American workers and their dependents.

Give small businesses more affordable choices

AHIP supports modernizing the small business healthcare tax credit.

Small businesses need affordable ways to offer health coverage to their employees. The current small business health care tax credit is underused because it is difficult to claim and too limited to meaningfully reduce the cost of a group health plan. An updated, simplified, and expanded credit is needed to help more small employers provide and maintain coverage.

Provide predictable and stable Medicaid funding

AHIP supports stable and predictable federal Medicaid funding.

Medicaid is one of the largest budget line items for all states and an extremely complex program jointly administered by states and the federal government. States are subject to numerous federal requirements, including operational standards, and policies can change frequently, be ambiguous or be difficult to implement based on systems and resource constraints. Medicaid serves populations that are low-income and clinically complex, with many beneficiaries living in areas without an adequate number of providers. State budget challenges can limit states' ability to invest in technology to update eligibility and enrollment systems or to ensure adequate funding for benefits.

AHIP looks forward to working with policymakers on developing a path forward that will strengthen and ensure the long-term sustainability of Medicaid. It is critical to have predictable and stable funding sources for states, beneficiaries and other stakeholders such as providers and the health plans most states use to run their programs. Funding needs to account for the particular challenges states face when local economic conditions can expand Medicaid coverage needs at the same time state revenues decline. Clear federal rules and realistic implementation timelines are also necessary for the long-term sustainability of the program. As CMS implements the Medicaid community engagement requirements, **AHIP supports policies that limit burdens and uncertainty for states, beneficiaries and other stakeholders; minimize erroneous disenrollments; and make technology solutions as scalable and cost-effective as possible.**

Make health insurance simple to use

Complement health plans' prior authorization commitments

Because federal electronic prior authorization requirements apply only to certain federal programs, health plans have voluntarily committed to expanding standardized electronic prior authorization across commercial coverage beginning in 2027 and are advancing broader industry efforts to streamline, expedite and simplify prior authorization. AHIP is working with EHR developers and provider stakeholders to support implementation of interoperable standards and optimize workflows for clinicians. As interoperability requirements for health plans go into effect, policymakers should help ensure, through appropriate requirements and incentives, that providers' adoption of interoperable technology capabilities meaningfully accelerates.

Examine claim outcome reporting

AHIP supports examining the reasons for claims denials across the claims processing lifecycle to distinguish clinical coverage determinations from administrative processing issues.

Reducing avoidable administrative denials will take coordinated work across stakeholders. Health plans are investing in tools to reduce manual processes for claim approvals and to pend incomplete claims and contact providers rather than categorize such claims as denied. Providers can strengthen coding accuracy, front-end data quality and use of claims status transactions to substantially reduce the large number of duplicate claims submitted. Together, these steps can improve the experience for providers and members while preserving payment accuracy and program rules.

Make coverage easy to compare

Consumers select plans based on an array of features, including premiums, cost-sharing, networks, formularies, care management, negotiated rates, value-based design, HSA eligibility, virtual care and additional benefits such as vision or dental coverage.

AHIP supports making coverage easier to compare across plans and markets:

- Standardized, plain-language plan information, using consistent definitions across plans and markets.
- Better decision-support tools on HealthCare.gov and State-Based Marketplaces to estimate a consumer's total annual cost, including premiums and expected cost-sharing, based on their anticipated use of care.
- Clear display of the features that matter most to consumers: which providers are in network, whether their prescriptions are covered and at what tier and their maximum out-of-pocket exposure.
- Search and filter tools that let consumers narrow choices by their doctors, prescription drugs and budget, rather than limiting the plans available to them.

Maintain a consistent national essential health benefits framework

AHIP supports a consistent national EHB standard.

A clear, consumer-centered EHB framework is critical for comprehensive individual and small group coverage based on the ten statutory categories in federal law and applied consistently across states and plan years. States that require benefits beyond EHB should fund them and report mandate costs transparently, so those costs are not hidden in premiums paid by individuals and small businesses. Independent evidence and costs must be reviewed before new mandates take effect. One example of this approach is the California Health Benefits Review Program, which analyzes the medical effectiveness, cost and coverage effects of proposed mandates for the state's legislature.

Address the cost drivers that determine premiums

While some healthcare price increases may reflect higher labor and input costs, the research is clear: anticompetitive practices drive higher healthcare prices. Health plans operate under regulated profit margins and compete on premium and benefit design to win enrollees, but plans can only negotiate lower prices when markets are competitive. AHIP's Healthier Markets, Healthier People platform is a policy roadmap built around three pillars for delivering lower costs, better access and improved health outcomes.¹⁵⁹

Restore competition in provider markets

Providing healthcare is very capital-intensive, and established players can use their scale to purchase rivals and discourage new entrants. Appropriate oversight can help ensure local healthcare provider markets are more competitive and providers cannot use monopoly power to overcharge patients and health plans. Mergers, expansions and new investments can all strengthen the healthcare system if they focus on quality and long-term success rather than local market consolidation and short-term profits.

AHIP supports:

- Scrutinizing provider mergers for anticompetitive impacts at the federal and state levels.
- Combating anticompetitive hospital contract terms at the federal and state levels.
- Reviewing state Certificate of Public Advantage (COPA) and Certificate of Need (CON) laws for their impact on market competition, overhauling any provisions that unnecessarily discourage competition and competition-enhancing market entry.
- Health plan and provider integration that improves care efficiency and lowers costs.
- Flexible network adequacy standards that accurately reflect today's provider and patient landscape.
- Enforcing and publicly disclosing existing hospital cost reporting requirements on private equity investment and real estate holding companies and requiring hospitals to disclose staffing arrangements with private equity-backed provider groups, including the compensation structure and any incentives.

Pay the same amount for the same service

Patients can receive outpatient services at different provider locations, such as a physician's office, ambulatory surgical center, hospital outpatient department or freestanding emergency department. Although care may be equivalent across settings, the amount patients and their health plans pay is not. Patients and health plans should not have to pay more for the same service, at the same location, by the same physician just because a hospital buys a physician practice. Estimates show expanding site-neutral payments in Medicare would generate annual savings of \$6.0 billion in Medicare savings and \$1.5 billion in beneficiary cost-sharing savings.¹⁶⁰ Furthermore, if site-neutral payment expansion were applied in the commercial market, it would reduce annual spending by \$58 billion.¹⁶¹

AHIP supports:

- Equalizing payment for provider-based, off-campus outpatient clinics for low-acuity services with that for physician offices.
- Requiring providers obtain separate national provider identifiers to use when billing for provider-based, off-campus hospital outpatient departments.
- Requiring upfront patient disclosure notices when physician offices convert to provider-based, off-campus clinics so patients are aware of higher out-of-pocket costs.

- Narrowing the definition of free-standing emergency departments to facilities that provide most services on an unscheduled basis.
- Requiring hospitals and physician offices to accept patient-specific drug deliveries from specialty pharmacies without excessive fees and protect patient choice of specialty pharmacy access to provider-administered drugs.

Bring down monopoly drug prices

Pharmaceutical innovation is essential, but drugs need to be affordable to sustainably improve patient health and wellbeing. When prescription drug monopolies are open-ended and inhibit competition, or when drug manufacturers delay introducing better medicines just to extend their monopoly pricing, patients are harmed. Drug manufacturers should compete on price and quality, not through exorbitant ad campaigns and cash subsidies that thwart price competition.

AHIP supports making biosimilars easier to bring to market and cheaper.

Accelerate the approval process for interchangeable biosimilars and finalize FDA guidance on demonstrating interchangeability without switching studies. Pass legislation to eliminate the statutory distinction between biosimilars and interchangeable biosimilars. Shorten the exclusivity period for biologics to match with protections granted to small molecule drugs to avoid favoring development of more expensive products. Remove state barriers to biosimilar substitution and pass legislation designating biosimilars eligible for automatic substitution, including substituting one biosimilar for another biosimilar and not just the branded product.

AHIP supports ending patent abuse.

Make it easier for generic companies to challenge patent disputes and create an equitable royalty system for secondary patents that brings generics to market earlier while still encouraging innovation. Pass legislation to limit the number of patents that can be asserted on brand drugs. Limit exclusivity for later product changes that do not represent meaningful clinical innovation and encourage manufacturers to develop patient-friendly innovations earlier in the product lifecycle.

AHIP supports making manufacturers compete on price, not cash subsidies.

Preserve and strengthen the existing protections against manufacturer abuse of charitable structures within Medicare and Medicaid. Encourage price competition by protecting health plans' ability to exclude third-party payments, including manufacturer cash subsidies, from accruing towards deductible and out-of-pocket limits. Regulate manufacturer assistance programs to prohibit patient steering to any particular drug, as required in the Medicare program. Limit direct-to-consumer advertising and require price disclosures in all advertisements. Eliminate the tax benefit for drug advertisements and physician detailing.

Stop the gaming of IDR

While the *No Surprises Act* restricted most instances of one of the most abusive practices in American healthcare by protecting patients from surprise medical bills, the arbitration process has been subject to fraud, waste and abuse, which drives up costs for everyone. This undermines the *No Surprises Act*'s core goal of lowering costs for patients, families and employers. Common-sense reforms are needed to make the law work as originally intended. Out-of-network providers should be fairly compensated for the care they deliver.

AHIP supports:

- Grounding IDR payment determinations in market-based rates and mandating upfront eligibility review.
- Closing loopholes exploited by bad actors, such as using IDR for scheduled services and enacting meaningful penalties for bad-faith actors.
- Transitioning IDR entities to salaried government contracts and prohibiting IDR entities from issuing both eligibility and payment determinations.
- Mandating arbitrator audits and enhancing professional requirements, including greater transparency and penalties for non-compliance.
- Requiring each party to share its documentation and increasing transparency into IDR entities – including ownership structure, conflicts of interest and performance metrics.

Foster pro-patient competition

Healthcare only benefits patients if they can affordably access it. With policy changes, a more competitive framework can bring patients more home-based care options, expand high-quality telehealth at lower costs and invigorate the dialysis market.

AHIP supports:

- Making permanent the “Acute Hospital Care at Home” program and empowering providers to directly admit patients to home in order to avoid unnecessary hospitalizations.
- Allowing physicians to deliver telehealth across state lines; modernizing network adequacy regulations to reflect the availability of telehealth; banning distant site facility fees; expanding broadband access in rural and low-access communities; and making permanent the flexible benefit offerings Medicare implemented during the COVID-19 pandemic, such as removal of originating site and geographic restrictions.
- Jumpstarting home dialysis market competition by expanding Medicare coverage, increasing patient and caregiver education and broadening the personnel who can offer it and cutting regulations that stifle competition. Preventing dialysis providers from improperly steering patients into specific commercial health plans, requiring greater transparency from dialysis providers about their consumer education and outreach and promoting competitive contracting rather than mandating high commercial reimbursement.

Advance policies that improve health

Because 60 percent of spending growth comes from utilization rather than price,¹⁶² reducing the volume of avoidable care is as important as what each unit costs. Reducing avoidable utilization requires a focus on improving the health of Americans by reducing the prevalence of chronic disease, shifting more care to accountable value-based models and increasing healthcare data flow for better care management and coordination.

Address chronic disease as the main cost driver

While voluntary actions by health plans can help prevent and better manage chronic disease, policy changes are also needed.

AHIP supports the following targeted policies:

- Modernize regulatory policies to reward healthy behaviors. Modernize and improve regulations governing employer wellness programs, and facilitate states’ ability to incorporate wellness programs in the Individual Market.
- Measure and enable quality and payment models emphasizing prevention. Ensure MLR definitions incentivize prevention strategies; support quality measures focused on prevention; and support federal value-based contracting programs’ inclusion of chronic disease prevention measures.
- Optimize care delivery and the healthcare workforce. Support community health workers, encourage multi-state licensing and support behavioral health integration.

Promote high-quality, affordable care through value-based models

Health plans are collaborating with their provider partners to try and move toward a healthcare system that puts patients at the center with aligned incentives. Value-based care programs have achieved better patient outcomes, improved patient experience and lower costs. These arrangements advance prevention, reliable evidence-based care, chronic disease management, care coordination and technological innovation.

Based on the 2025 national APM Measurement Effort, conducted by AHIP, CMS and the Blue Cross Blue Shield Association, MA continues to lead the way, with 60 percent of payments flowing through value-based models in CY 2024. The commercial market is also making progress with 40 percent of payments in these models.¹⁶³

While nearly 50 percent of Medicare beneficiaries are enrolled in MA, CMMI models remain almost exclusively geared toward fee-for-service providers, and model designs are not focused on the more than 65 million Americans covered through Medicaid managed care.

AHIP supports CMMI developing models in which plans may be applicants and participants as well as ones where plans are partners in aligned models to reduce provider burden. **AHIP supports implementation of voluntary multi-payer value-based programs that incorporate chronic disease prevention-focused quality measures and models that provide financial rewards for reducing chronic disease burden through CMMI.** Successful CMMI-led multi-payer alignment requires early collaboration with plans on model design, integration of proven private-sector approaches and attention to the planning factors that can drive plan participation, including aligning model application and award timing with annual bid and enrollment processes.

Provider participation in value-based arrangements should be sustained. Financial bonuses for provider participation in MA Advanced Alternative Payment Models (AAPMs) expired at the end of CY 2024. To the extent Medicare is structured to encourage providers to participate in AAPMs, those organizations are more likely to enter value-based contracts and to be successful in them.

Conclusion: Building on What Works

AHIP believes health insurance should be affordable, easy to use and simple to navigate.

Policymakers and stakeholders should focus on common-sense, data-driven reform efforts that build on what is working, strengthen existing public-private partnerships and address the root causes of high healthcare costs that impact premium affordability. Increasing competition in provider, pharmaceutical and other markets would give Americans lower costs, more choices and better quality.

Without a concerted focus on healthcare affordability, the costs of providing care in the current healthcare system will continue to rise and Americans will face more challenges affording access to high-quality coverage and care.

AHIP and its member health plans are committed to partnering with the Finance Committee to make healthcare cost less and work better for everyone.

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