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Statement for Hearing on
"Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

House Committee on Energy and Commerce
Subcommittee on Health

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AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

AHIP is committed to working with the Subcommittee to address the core drivers of health care affordability throughout the entire health care system. Patient costs, in the form of insurance premiums, ultimately reflect the underlying costs of care – hospital services, prescription drugs, physician visits, diagnostics, and more. Health plans play an essential role in helping to bring down these costs by negotiating more competitive hospital rates and directing patients towards high-value care. Plans use data-driven tools to support value-based care models, identify cost variations, and promote more efficient care delivery. These core functions help reduce rising medical costs, reduce waste, and ensure patients get better value. However, bringing down health care costs will require the participation and alignment of incentives across the whole health care system. Plans alone cannot solve the affordability pressures for consumers and the government. Together, we can find workable solutions that make health care more affordable for patients and more sustainable for the country.

AHIP's statement for the record focuses on the role health plans play in protecting consumers from the full impact of rising health care costs as well as practical policy steps Congress can take to improve affordability in hospital costs, improve provider participation, and modernize practices while aligning incentives across the system and meeting the needs of consumers. We support efforts in Congress to advance common-sense policies that tackle soaring hospital costs, ensure honest billing, and promote competition to make health care more affordable.

Affordability Depends on System-Wide Collaboration

Health plans are ready to be full, accountable partners with hospitals and providers to help drive down health care costs. Health care affordability is a shared responsibility, and patients deserve reforms that lower costs and improve outcomes. Health plans have the tools, data, and incentives to reward value over volume, but hospitals and providers must also be transparent and accountable.

Hospital Pricing is Driving Higher Health Care Costs

Affordability remains out of reach when hospital system practices undermine cost-containment efforts across the system. Hospitals continue to raise their prices at rates that outpace inflation, accompanied by opaque fees that ultimately drive-up costs for patients. AHIP's most recent analysis shows that 40.7 cents of every commercial market premium dollar Americans pay now goes to hospital costs, more than any other category.[1]

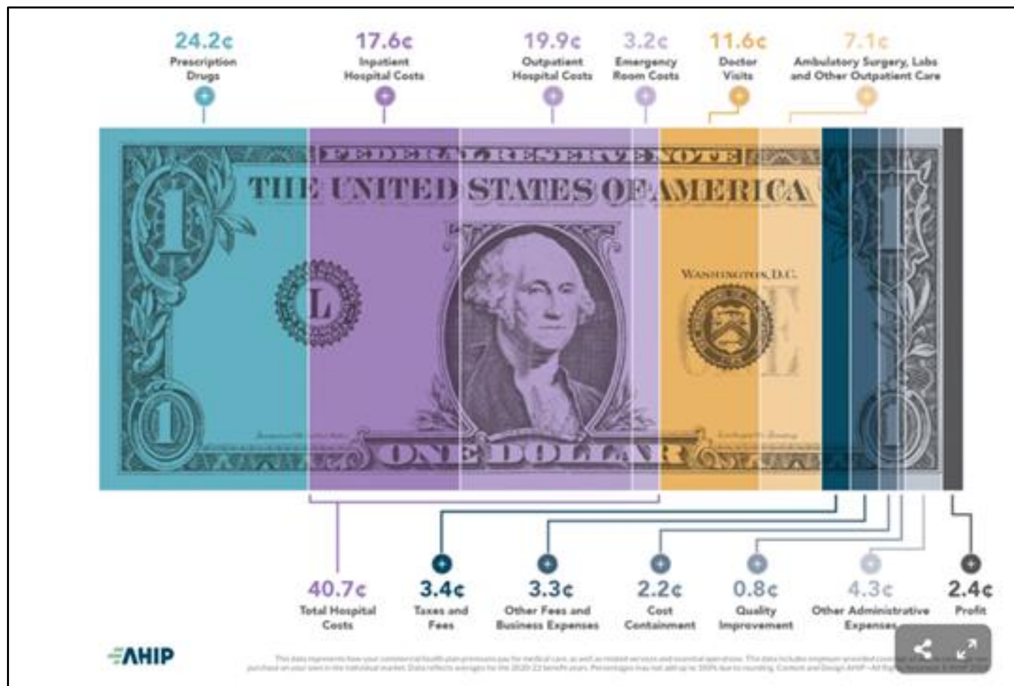

Figure 1: AHIP's Health Care Dollar. The full resource can be accessed at https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf.

Hospitals play a central role in driving rising health care costs and are one of the most significant cost pressures facing consumers and employers today. Hospitals alone accounted for 40 percent of national health spending growth from 2022-2024, far outpacing all other care categories.[2] Furthermore, in 2024 alone, spending on hospital care reached a staggering $1.6 trillion.[3] This level of spending places significant and growing pressure on the broader health care system. Since health insurance premiums directly reflect the cost of medical care, rising hospital costs flow directly through to the monthly premiums families and employers pay each month.

Hospital systems – especially large, consolidated hospital systems – are at the center of unsustainably rising costs. As they acquire independent physician practices, consolidated

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[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go

[2] https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/

[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.01683

systems increasingly bill routine services performed in doctors' offices as hospital-based care. Meaningfully addressing certain hospital business practices is one of the most important steps toward bringing costs down.

Anticompetitive Hospital Consolidation

A major reason hospital costs continue to rise is the growing concentration of market power within the hospital sector through consolidation, private equity ownership, and billing practices that push routine care into higher-cost settings. Taken together, this creates an environment where patients and employers face escalating costs year after year without corresponding improvements in value.

The evidence is unequivocal: when health care providers consolidate and create a monopoly, prices go up. In a systematic review of 16 studies of horizontal hospital consolidation, researchers found price increases in every single study.[4] Most recent studies estimate price increases of 4-6 percent from hospital consolidation, though increases were as high as 65 percent.[5]

Decades of consolidation among hospitals have shifted the negotiating power in many local markets – and higher prices have followed. Larger hospital systems use their market leverage to demand higher prices and reimbursement from health plans – and ultimately employers and consumers. Over time, those higher prices become the new threshold for negotiations, leaving families and employers paying more, often without any improvement in access or the quality of care provided.

- **Recommendation:** AHIP urges policymakers to promote greater competition among hospitals by blocking anticompetitive hospital mergers. While federal authorities have successfully challenged provider mergers in the past, many are uncontested due to a lack of resources or because the size of the merger does not trigger federal oversight.[6] Nonetheless, AHIP urges policymakers to scrutinize provider mergers for anticompetitive impacts, combat anticompetitive hospital contract terms, and support health plan-provider integration that improves care efficiency and lowers costs.[7]

Excessive Site-of-Care Price Variation

Hospital consolidation doesn't just raise prices for Americans; it impacts where care is delivered and how care is billed. Routine services increasingly billed in hospital outpatient departments – instead of physician offices or ambulatory surgical centers – come with significantly higher

[4] https://aspe.hhs.gov/sites/default/files/documents/0d2c04fec395bc8c573c5b20c189cdd0/enviromental-scan-consolidation-hcm.pdf
[5] Ibid
[6] https://www.kff.org/health-costs/issue-brief/understanding-the-role-of-the-ftc-doj-and-states-in-challenging-anticompetitive-practices-of-hospitals-and-other-health-care-providers/
[7] https://www.ahip.org/resources/make-provider-markets-more-competitive

prices, often due to facility fees imposed by hospitals. A recent analysis found that for services commonly provided in both settings, prices in hospital outpatient departments were consistently higher than in physician offices, with prices ranging up to 13 times higher for the exact same services.[8] For patients, it is often "the same visit, higher bill." These facility fees and other opaque hospital billing practices mean higher premium costs year after year.

- **Recommendation:** Protecting consumers with site-neutral payment reforms will help level the playing field on prices, reduce patient cost-sharing, and lower premiums – saving more than $170 billion over 10 years.[9] Congress should pursue policies that equalize payments for provider-based, off-campus outpatient clinics for low-acuity services with that of physician offices, and require upfront patient disclosure notices when physician offices convert to provider-based, off-campus clinics so patients are aware of higher out-of-pocket costs.

Program Integrity: Ensuring Fair and Appropriate Hospital Billing

Health plans are advocates of program integrity across the commercial market and public programs and have long supported strong program integrity measures to protect taxpayers and consumers. Efforts to reduce health care costs must include a serious focus on eliminating fraud, waste, and abuse in hospital spending.

Certain hospital practices – such as overbilling, opaque pricing, and charging hospital-level prices for routine care – add billions of dollars in avoidable costs to the system each year and directly increase premiums and out-of-pocket expenses. Greater transparency and accountability are essential to ensuring hospitals are paid fairly for care, not rewarded for wasteful spending.

For example, hospitals are increasingly billing health plans for more complex care than what was actually delivered, ballooning health care spending.[10] Great price variation among common hospital-administered drugs also exists; for many, pricing remains “opaque,” with hospitals often listing multiple prices for the same drug on the same day, despite federal transparency rules.[11] Hospitals substantially mark-up drug costs for commercial health plans, charging 50 percent to 103 percent more than specialty pharmacies for the same drug.[12] These markups increased commercial insurance premiums by $13.1 billion in 2024 alone, forcing patients to pay even higher costs for already expensive prescription drugs.

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[8] https://healthcostinstitute.org/all-hcci-reports/trends-in-utilization-and-prices-for-site-neutral-services-in-hospital-outpatient-and-physician-office-settings/

[9] https://www.cbo.gov/budget-options/60908

[10] https://www.bcbs.com/news-and-insights/report/ai-boosting-hospital-billing

[11] https://www.axios.com/2026/03/05/disparities-hospital-drug-prices

[12] https://www.ahip.org/news/press-releases/new-research-highlights-premium-impact-of-provider-markups-on-specialty-drugs

These trends make it clear that stronger program integrity safeguards are needed to address wasteful spending and opaque billing by hospital systems in order to lower costs for patients, employers, and taxpayers.

The Growing Role of Private Equity in Hospital Care

As of February 2025, 488 U.S. hospitals were owned by private equity firms, and at least 27 percent of private equity-owned hospitals are in rural communities.[13] This ownership trend regularly translates into access and affordability challenges, including higher prices, for patients.

Research shows that private equity ownership results in inflated sticker prices for care and higher negotiated prices between hospitals and commercial health plans. One study found that after private equity takeover of a physician practice, the average bill submitted to a health plan rose by 20 percent, and the average payments health plans made rose by 11 percent – despite the fact that patients were no sicker than comparable practices across that same time period.[14] Private equity's focus on generating short-term profits often leads to reduced health care staffing, stretching workers further and putting patients at risk.[15] These studies demonstrate how when outside investment groups who are focused on profit, not patient care, acquire local providers, costs increase and quality suffers.

- **Recommendation:** AHIP urges policymakers to enforce and publicly disclose existing hospital cost reporting requirements on private equity investment and real estate holding companies. Hospitals should also be required to disclose staffing arrangements with private equity-backed provider groups, including the compensation structure and any incentives.

Provider Partnerships Are Essential to Affordable, High-Quality Care

Plans and providers share the same goal: high-quality, affordable care, and collaboration is essential to modernize prior authorization, expand telehealth, strengthen network adequacy, and eliminate surprise medical billing. Health plans have built and maintained the infrastructure to support these reforms, but meaningful progress requires provider engagement to ensure patients see real improvements in affordability.

Value-Based Care: Aligning Incentives Around Patient Outcomes

Value-based care is the connective tissue of the plan-provider partnership, aligning incentives so providers are rewarded for delivering better outcomes and more efficient care, rather than higher volume or higher prices. Health insurance exists to protect individuals and families from the unpredictable costs of medical care – and value-based care is central to that mission. By shifting away from volume-driven incentives, health plans are working to shield Americans from high

[13] https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/
[14] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795946
[15] https://www2.nber.org/digest/202104/how-patients-fare-when-private-equity-funds-acquirenursing-homes

and rising health care costs while improving care delivery. This protection depends on a strong, balanced risk pool and payment models that encourage high-quality, efficient care for individuals with diverse health care needs throughout the year.

Patients deserve a health care system focused first and foremost on delivering affordable, evidence-based care that works. By aligning incentives around outcomes, value-based care helps curb avoidable hospital spending and supports a more sustainable cost trajectory across the entire health care system. Health plans are committed to working hand-in-hand with hospitals and provider organizations to advance value-based care and deliver patient-centered, high-quality, coordinated care that is more affordable for Americans.

Health plans continue to invest in value-based care models – such as alternative payment models (APM) – that emphasize quality and patient outcomes while safely reducing costs. Results from the 2025 APM Adoption Survey conducted by AHIP in collaboration with CMS reaffirm the commitment of public and private payers to transition from fee-for-service toward payment models that incentivize quality, efficiency and improved patient outcomes.[16]

The APM Adoption Survey found that 44.9 percent of all health care payments were tied to APMs that hold providers accountable for quality and cost of care, while 28.7 percent of health care payments were tied to APMs with downside risk. The survey also captured perspectives on future trends; 70 percent of respondents expect APM activity to increase over the next 24 months, citing provider readiness, health plan engagement, and health plans' ability to operationalize such models as key facilitators.[17]

While the survey findings demonstrate health plans' continued commitment to value-based care models, wider engagement among hospitals and other provider organizations could help strengthen momentum and grow broad-based participation in value-based care arrangements that improve outcomes – and affordability – for families across the U.S.

Medicare Advantage

Medicare Advantage (MA) illustrates how health plans, through risk-based payment and accountability, have powerful incentives to control costs and improve affordability across the health care system. MA delivers significantly lower total health care costs for beneficiaries than traditional fee-for-service (FFS) Medicare while also delivering better patient outcomes. Research shows that MA beneficiaries experience fewer avoidable hospitalizations, stronger hospital recovery, and lower hospital readmissions.[18,19]

[16] https://www.ahip.org/resources/2025-apm-measurement
[17] Ibid
[18] https://www.inovalon.com/wp-content/uploads/2025/05/INOV_MA-vs-FFS-Outcomes-Study_5.28.25-v1.0.0.pdf
[19] https://www.thinkbrg.com/insights/publications/black-hispanic-aapi-ma-beneficiaries-receive-primary-care-potentially-avoidable-care/

MA also has a lower improper payment rate compared to FFS Medicare.[20] In 2025, FFS improper payment rate was 6.55 percent, costing the federal government over $28 billion, compared to 6.09 percent for MA plans – all while MA plans are serving more Medicare beneficiaries. This performance reflects the accountability built into MA, where plans are financially responsible for managing care, preventing fraud, waste, and abuse, and ensuring services are medically appropriate. By contrast, FFS Medicare lacks many of these safeguards, underscoring how MA's care coordination, oversight, and utilization management tools protect both beneficiaries and taxpayers while delivering high-quality coverage at scale.

Furthermore, MA can play an important role in supporting rural health system stability and improving care quality, at a time when rural Americans face growing challenges accessing and affording care due to hospital closures and reduced services. In fact, one study that examined rural hospitals in 14 US states, found that an increase in county MA penetration was associated with an increase in hospital financial stability and a reduction in risk of closure. In fact, the study found that every percentage point increase in MA penetration was associated with a 4 percent reduction in risk of hospital closure.[21] Another recent survey found that rural Americans saved $5,500 on MA, compared to FFS, thereby improving affordability in low-access regions.[22]

As policymakers look for ways to address the affordability crisis facing Americans, particularly in rural communities where access to care is already strained, MA remains a proven tool for protecting beneficiaries from the rising cost of medical care. While health plans support reforms to strengthen the program for seniors, flat funding during a period of sharply rising medical costs and high utilization – as is currently proposed in CMS's 2027 MA and Part D Advance Notice – could result in reduced benefits, fewer choices, and increased costs for millions of seniors when they renew coverage in October 2026.

MA's value-based care approach helps reduce unnecessary hospital utilization, strengthen hospital stability and lower overall health care costs for beneficiaries and taxpayers.

Simplifying Prior Authorization

Prior authorization is another value-based tool health plans use to ensure care is safe, evidence-based, and as affordable possible. By applying prior authorization in a targeted and clinically grounded way, health plans help to coordinate care, promote value, reduce unnecessary or duplicative treatments, and avoid complications that drive costs higher.

The targeted, clinically driven use of prior authorization reflects the distinctive role of health plans as the only part of the system that does not benefit from higher utilization or higher prices.

[20] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet
[21] https://www.ahip.org/resources/ma-increases-rural-health-system-stability-improves-care-quality-2
[22] https://www.ahip.org/resources/medicare-advantage-leads-to-savings-for-seniors-and-taxpayers

Health plans are incentivized to help ensure patients receive the right care at the right time. Because unnecessary costs and excessive reimbursements lead directly to higher premiums, health plans are structurally motivated to selectively use prior authorization to reduce low-value care, reinforce clinical best practices, and drive better outcomes.

Electronic prior authorization also reduces administrative burden for providers, accelerates patient access to necessary treatments, and minimizes delays in care. Health plans have invested heavily in building electronic prior authorization options. Yet nearly half of prior authorization requests (45 percent for medical services and 47 percent for prescription drugs) are still manually submitted by providers using phone, fax or traditional mail – creating inefficiencies. As plans deploy the next generation of electronic prior authorization that integrates into electronic health records by January 1, 2027, vendors must build and providers must adopt the new technology. Without the greater use of modern technologies, continued reliance on manual processes negates the efficiencies of electronic prior authorization. Looking forward, a coordinated effort from both plans and providers will be essential to fully streamline the prior authorization process.

Last June health plans announced a series of further commitments to streamline, simplify and reduce prior authorization. Building on health plans' existing efforts, these new actions are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers. These commitments are being implemented across insurance markets, including for those with MA, Commercial coverage, and Medicaid managed care consistent with state and federal regulations, and will benefit nearly 270 million Americans.[23]

AHIP looks forward to working with the Subcommittee and sharing progress on health plans' commitments to improve prior authorization this spring.[24]

Improving Provider Directory Accuracy

Health plans are also committed to ensuring beneficiaries have accurate, reliable provider directories so individuals can easily find in-network providers who meet their clinical needs and are accessible and appropriate for them. Provider directories are a critical consumer protection tool, offering essential information such as contact details, specialties, and board certifications, and enabling patients to maximize the value of their coverage. Health plans invest significant resources to keep this information current through ongoing outreach, validation, and audits.

Despite these efforts, two persistent challenges undermine directory accuracy: some providers do not consistently submit timely or complete updates to their information, and there is no single source-of-truth for provider information that can be utilized. These challenges are compounded by a complex environment of federal and state rules, with different provider directory

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

requirements across different and state-specific rules in nearly all 50 states.[25] The creates fragmentation and operational complexity without necessarily improving accuracy for patients.

Health plans have worked closely with their provider partners for years to improve directory data. These efforts include streamlining processes and leveraging data to flag outdated information. Achieving meaningful and durable improvement requires a shared, system-wide commitment – including stronger provider responsibility for keeping information current and avoid the real-world consequences of inaccurate listings for consumers.

Using Telehealth to Lower Prices and Challenge Anti-Competitive Provider Practices
Plans and providers must also work together to expand high-value telehealth that improves access while reducing unnecessary utilization; modernize prior authorization so it is targeted, data-driven, and focused on patient safety rather than paperwork; ensure network adequacy that gives patients meaningful access to high-quality, cost-effective care; fully eliminate surprise medical billing by honoring clear rules and good-faith contracting; and jointly identify and stop fraud, waste, and abuse that siphon billions of dollars from the system every year.

Expanded access to telehealth can foster greater competition on quality and costs, particularly in regions with monopoly health systems. As health care provider markets become increasingly consolidated, telehealth spurs crucial price competition that would otherwise be limited in or absent from local markets.

Telehealth can also address inflated pricing from hospital systems that acquire physician offices and redesignate them as hospital outpatient departments: charging higher prices even though nothing about the office has changed. Further, telehealth providers compete with each other, not just with local providers. This dual competition benefits individuals and other customers purchasing coverage, such as employers.

- **Recommendation:** To boost telehealth competition, AHIP urges policymakers to allow physicians to deliver care across state lines and modernize network adequacy regulations to reflect the availability of telehealth as an option for patients. Congress should also pursue policies that allow for flexibility in plan benefit and payment design to support value-based care via telehealth, ban distant site facility fees for telehealth services to lower costs for patients, and make permanent the telehealth flexible benefit offerings Medicare implemented that are currently extended through 2027.

Preventing Private Equity-Backed Providers from Exploiting Surprise Billing Protections
A fragmented health care system – combined with the rapid expansion of private equity ownership – has intensified out-of-network billing, balance billing, and opaque pricing that harms consumers.

[25] https://www.ncsl.org/health/health-insurance-network-adequacy-requirements

When private equity and other investment firms focus on extracting short-term profit cost, quality and patient experience can be negatively impacted. When private equity-backed providers game patient protections against surprise billing, policymakers need to take action to hold down wasteful spending.

Private equity-backed provider groups often rely on aggressive billing strategies, including remaining out-of-network or exploiting payment disputes, to maximize their revenue at the expense of American consumers. Private equity firms initiate the vast number of arbitration challenges raised under the *No Surprises Act*: 63 percent of surprise billing arbitrations were filed by just five private equity-linked firms.[26] These investment groups are flouting the intent of the Federal Independent Dispute Resolution (IDR) process, filing improper claims to arbitrators who operate without oversight, driving over $5 billion in wasteful spending in just two years.[27] These practices contribute to surprise medical bills, medical debt and financial instability for individuals, families, and employers.

Investment capital can meaningfully improve the performance of the health care system by supporting innovations and scaling capabilities that reduce unnecessary costs, improve experience and drive higher quality. Too often, however, PE-backed investments prioritize short-term returns at the expense of patient care. Transparency and oversight are needed to ensure that private equity investment in the health care sector improves quality at a lower cost.

- **Recommendations:** Common-sense solutions include strengthening enforcement in the IDR process to stop private equity-backed groups from flooding the system with ineligible claims and requiring more stringent oversight of arbitrators, such as greater transparency, audits and penalties for non-compliance These solutions can provide relief to employers and consumers who are still bearing the brunt of private equity's abuse of the surprise billing arbitration system.

Conclusion

AHIP thanks the Subcommittee for its attention to the growing impact of hospital pricing on rising health care costs. As Congress considers these challenges, AHIP appreciates the opportunity to comment on ways to improve affordability in hospital and provider markets while preserving access to high-quality care. AHIP looks forward to continuing to work collaboratively with the Subcommittee to identify and implement common-sense, market-based policy solutions that make the health care system more affordable for patients and families and more sustainable for the country over the long-term.

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[26] https://www.healthaffairs.org/content/forefront/independent-dispute-resolution-process-2024-data-high-volume-more-provider-wins

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