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Association of American Medical Colleges
Statement for the Record
before the
Energy & Commerce Health Subcommittee
Lowering Health Care Costs for All Americans:
An Examination of Health Insurance Affordability
January 22, 2026

The AAMC (Association of American Medical Colleges)[1] appreciates the opportunity to submit this statement for the record regarding the hearing entitled "Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability" before the House Energy and Commerce Committee on January 22, 2026. The AAMC welcomes the chance to share the perspective of academic medicine and to work with you as you evaluate policies that will slow the rising costs of health care.

Health care costs have dramatically risen in recent years due to myriad factors, including inflation, labor costs, exponential drug price increases, supply chain issues, and administrative factors.[2] Academic health systems and teaching hospitals, despite feeling the acute impact of these factors, have continued the pursuit of their missions of high-quality patient care, physician and workforce education and training, life-saving medical research, and community collaboration.

AAMC members continue to grapple with historic workforce shortages, unprecedented capacity challenges, inadequate reimbursement from payers, supply chain disruptions, rising expenses such as labor costs, pending cuts to the Medicaid program, and the looming risk of other harmful Medicare payment cuts. According to the Medicare Payment Advisory Commission (MedPAC), hospitals' overall fee-for-service Medicare margins fell to a record low of -11.6% in 2022, and this downward trend is expected to continue.[3] The recently passed One Big Beautiful Bill Act (OBBBA, P.L. 119-21) will also pose new challenges for our members as they contend with significant Medicaid payment losses and a potential surge in newly uninsured patients. AAMC-

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

[2] Health Care Costs and Affordability. Kaiser Family Foundation, *October 8. 2025.*

[3] Medicare Payment Advisory Commission, *December 2023 Report*, https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf.

member health systems and teaching hospitals, despite experiencing Medicare margins that average -18.2%, continue to be asked to do more with fewer resources, and many are near their breaking point.[4] This is directly reflected in recent activities to offset mounting losses caused by reductions in research funding and anticipated Medicaid cuts at AAMC member institutions. Since January 22, 2025, we have seen 12 members conduct layoffs, four members with unit closures or full closures, and one merger.

While academic health systems and teaching hospitals continue to grapple with balancing a delicate model that preserves their missions and ensures continued patient access to care, it is worth noting that there are parts of the health care ecosystem that are not similarly impacted and, in fact, seem to prosper in even the hardest of times. The largest commercial health insurers post tens of billions of dollars in profit while facing claims that they are limiting access to patient care through prior authorization or automatic initial denials that some have cited as questionable.[5] AAMC members report particularly egregious instances of delayed and denied payments, retroactive denials, narrow networks, and insufficient reimbursement; practices to which hospitals must dedicate vast resources to handle. Constant battles with insurance companies simply to get needed care to patients are taxing not only on hospital resources, but they also weigh heavily on patients.

Premiums across the nation continue to skyrocket, rising 53% from 2014 to 2024.[6] Exacerbating this problem is the expiration of the enhanced premium tax credits (EPTCs) on Dec. 31, 2025. This poses a serious threat to academic health systems and the patients and communities they serve, as steep premium hikes will result in millions of Americans having to forgo insurance. This potential increase in the uninsured rate is expected to further compound hospitals' uncompensated care burden, exacerbating the financial pressures already facing academic health systems and teaching hospitals.

High premiums, administrative hurdles, and convoluted plan designs make it harder for patients to access care. When care is delayed or denied, the costs of treatment ultimately go up. The largest plans in the US continue to point at hospital prices as the primary driver of costs of care, but fail to consider their own emphasis on implementing policies that return maximum value to their shareholders. For AAMC member institutions, their focus is on caring for their patients and communities.

The AAMC recognizes that our health care system is complex and that cost drivers are multifaceted. We appreciate your willingness to investigate key drivers of health care costs and develop policy solutions. As you seek to address the rising costs of care, we ask that you consider the following:

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[4] AAMC analysis of FY2022 Hospital Cost Reporting Information System (HCRIS) released in July 2024. AAMC membership data, September 2024.
[5] Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care.
[6] https://www.kff.org/health-costs/2025-employer-health-benefits-survey/#b80a5be7-6ddd-4d81-b9af-3126336155ca

Address the Overuse and Misuse of Prior Authorization

Prior authorization is a utilization management tactic deployed by insurers to determine whether a given service or item will be covered. While prior authorization is used across all types of coverage, its use in the Medicare Advantage (MA) program has become increasingly burdensome and has drawn widespread concern for its overuse and potential misuse. Medicare beneficiaries have historically experienced limited prior authorization in traditional Medicare. However, MA enrollees face frequent denials, often for medically necessary care. In 2023 alone, more than 50 million prior authorization requests were submitted to MA plans, and although only 11.7% were appealed, 81.7% of those appeals resulted in a full or partial overturn, suggesting the original denials were often unjustified.[7] Some MA plans deny large volumes of claims, often using automated algorithms or artificial intelligence, only to reverse them later upon appeal.

The impact on patients is profound. They must navigate complex appeals processes and delays that can lead to personal financial challenges, worsened outcomes, or, in the most tragic cases, death while awaiting approval for necessary treatment. The burden also extends to physicians, who must "re-prove" the medical necessity of care they have already determined appropriate. Academic health systems, teaching hospitals, and faculty physicians report that they face immense administrative burdens and extended delays in securing prior authorization approvals and payments. Often, they must employ teams of staff specifically to manage prior authorization and denials, adding significant, wasteful costs to the system and effectively siphoning funds that could be used to support their mission-related work. Even MA plans have recognized the broken and burdensome prior authorization process, as evidenced by their recent pledge to "streamline, simplify, and reduce prior authorization."[8] Ultimately, patients may develop distrust of the health care system as they struggle with obstacles to receiving their medically necessary care. The AAMC believes that addressing issues with the prior authorization process will benefit patients and strengthen our health care system.

The AAMC has long supported efforts to reform MA prior authorization practices, including the bipartisan Improving Seniors' Timely Access to Care Act of 2025 (H.R. 3514/S. 1816). We also applaud the Centers for Medicare and Medicaid Services (CMS) for advancing deeply needed regulatory requirements that reflect many bipartisan aspects of that legislation. We urge Congress to support further reforms that limit inappropriate denials, prohibit algorithmic overreach, and center the process around clinical judgment and patient health. These protections will become increasingly important as CMS implements the Wasteful and Inappropriate Service Reduction (WISeR) model, which will implement prior authorization in traditional Medicare in six pilot states.

We also support including Level 1 denial rates in MA Star Ratings to give beneficiaries and policymakers a clearer picture of how often MA plans reverse their own decisions, which will elucidate the reliability of initial determinations.

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[7] Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023
[8] Health Plans Take Action to Simplify Prior Authorization, June 23, 2025.

Create a Prompt Pay Standard in MA

AAMC member academic health systems and teaching hospitals consistently report that they frequently face delayed payments from insurers, particularly in the MA program. While hospitals provide services as quickly as possible to patients, insurers routinely drag out the process of payment when possible. According to an American Hospital Association survey, 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old, amounting to more than $6.4 billion in delayed or denied claims that were more than six months old.[9] While insurers reap the interest off of holding on to patients' premium dollars, hospitals are left with services rendered and unpaid, which imposes further financial burden on hospitals already operating on thin margins, and could ultimately result in reductions in patients' access to care.

The AAMC supports the Medicare Advantage Prompt Pay Act (H.R. 5454/S. 2879), which would apply a federal standard to promptly pay claims. The legislation would impose clear and enforceable prompt payment standards on MA plans. Specifically, plans would be required to reimburse no less than 95 percent of "clean claims," as defined in the bill, within 14 days for services provided by in-network clinicians and within 30 days for out-of-network care. The bill would also strengthen oversight by authorizing civil monetary penalties for plans that fail to meet these timelines and by mandating public reporting of compliance metrics, including data on timely claims payment.

Expand Transparency and Oversight of MA Data

As MA now covers over half of Medicare beneficiaries, Congress must ensure that the same level of data transparency and access available in traditional Medicare applies to MA. Currently, MA encounter data is incomplete, lacks payment details, and its availability is often delayed. Researchers, regulators, and stakeholders cannot fully evaluate MA plan performance without robust, real-time data.

To ensure transparency and optimal data analysis, the AAMC recommends that Congress urge CMS to:

- Publish standardized encounter data, including cost and payment information;
- Expand access to Limited Data Sets (LDS) for researchers, not just Research Identifiable Files (RIFs);
- Collect and report granular prior authorization metrics, including denial rates, timeliness, service categories, and outcomes;
- Require public reporting on the use of algorithms and AI in utilization management, including how these tools are used, what data they are trained on, and whether they result in disparities or adverse outcomes.

[9] https://www.aha.org/system/files/media/file/2022/10/Survey-Commercial-Health-Insurance-Practices-that-Delay-Care-Increase-Costs.pdf

Reject Cuts to Hospital Outpatient Departments
As you seek to reduce costs in the health care system, we strongly urge you to reject permanent so-called "site-neutral" Medicare payment cuts to off-campus outpatient departments, which would disproportionately impact teaching hospitals, including those serving rural and other medically underserved communities. Although teaching hospitals represent only 5% of U.S. hospitals, we estimate they would be responsible for nearly half of the payment cuts associated with a variety of site-neutral proposals. These facilities treat patients with significantly higher clinical and social complexity than physician offices or ambulatory surgical centers and must meet enhanced licensing, regulatory, and accreditation standards. Policies that ignore these differences will limit patient access to life-saving outpatient drug administration and other critical services, especially for Medicare beneficiaries who rely on hospital-based care.

Protect Access to Specialty and Subspecialty Care
Many AAMC academic health systems and teaching hospitals have reported being excluded from plan networks, which limits patients' access to specialized, complex care. Insurers are increasingly relying on narrow networks to meet network adequacy requirements, which is harmful to high-need patients and those in rural and underserved areas. Congress should ensure reimbursement policies support both in-network and out-of-network access to care and prevent financial disincentives that undermine provider participation.

Additionally, plans are increasingly offering high-deductible health plans, which have shown to be confusing and inadequate for patients who have difficulty understanding their cost-sharing obligations under the convoluted plan design. Patients will seek care from an in-network provider and receive a high medical bill, often believing that they have received a "surprise" bill, when in fact, their cost-sharing obligation is astronomical and unaffordable. The threat of these high bills is enough for patients to avoid seeking treatment, sometimes until it is too late and even more expensive. The AAMC urges you to ensure that plans provide adequate coverage and that cost savings do not come at the expense of losing access to comprehensive, affordable care.

Investigate Insurer Consolidation and Its Effect on Patient Access, Quality, and Costs
In recent years, there has been a significant increase in insurer consolidation, which can lead to the exercise of market power, harming consumers and providers. A recent study found that 73% of the MSA-level markets were considered highly concentrated according to federal guidelines, 90% of MSA-level markets had at least one insurer with a commercial share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.[10] Another recent study showed that the top three large-group insurers hold an average of 82.2% of the market share in each state.[11] Mergers and acquisitions involving health insurers raise antitrust concerns. With so much market share, insurers have the ability to increase health insurance premiums above competitive

[10] American Medical Association. Competition in health insurance: A comprehensive study of U.S. markets, 2023. (amaassn.org). https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.
[11] Association of American Medical Colleges Research and Action Institute. Why Market Power Matters for Patients, Insurers, and Hospitals (May 1, 2024). https://www.aamcresearchinstitute.org/our-work/data-snapshot/why-marketpower-matters.

levels. In addition, it enables them to reduce reimbursement rates to physicians, hospitals, and other providers below competitive levels, ultimately harming consumers.[12] This lower reimbursement may result in a reduction in the type of services offered by physician practices and hospitals, or even closure.

In addition to insurer-to-insurer horizontal consolidation, increasingly, insurers have been vertically integrating with pharmacies and pharmacy benefit managers (PBMs), which leads to anticompetitive practices. Four PBMs, all of which are owned by major insurers, make up 70 percent of the PBM market share.[13] One key function of PBMs is to negotiate discounts with drug manufacturers to reduce the costs for payers and consumers. Having the plan, the PBM, and the pharmacy consolidated under one entity may raise health spending by driving patients to use higher-priced drugs in exchange for discounts from the drug manufacturers and preferred placement on the plan's formulary. Additionally, PBMs and payers often will steer patients to their own pharmacies in their network, which in turn limits patient access and could lead to higher out-of-pocket costs.[14] These networks often exclude hospital-operated retail and specialty pharmacies, restricting the ability of patients to have their prescriptions filled at convenient and accessible locations. The AAMC urges you to investigate insurer consolidation and its impact on patient access, quality, and costs.

Improve Oversight of Supplemental Benefits and Plan Marketing
The AAMC recognizes that supplemental benefits in MA can play an important role in meeting social and clinical needs. However, plans must be accountable for how they administer and advertise these benefits. We urge Congress to support CMS efforts to:

- Ensure that Special Supplemental Benefits for the Chronically Ill (SSBCI) are evidence-based and equitably distributed;
- Improve transparency and limit misleading marketing practices by brokers;
- Monitor and enforce compliance with mid-year benefit notifications and access standards.

Strengthen Quality Measurement and Equity Standards in MA
Finally, Congress should ensure that MA quality reporting is comprehensive and timely. This includes expanding CMS authority to assess and report quality measures across all MA populations, not just those used for Star Ratings.

We appreciate the opportunity to offer our perspective and look forward to working with the Subcommittee as it considers policies that affect the nation's health care system, medical education, and public health. For further questions, please contact Ally Perleoni, AAMC director, government relations at aperleoni@aamc.org.

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[12] Id.
[13] Guardado, Jose R. American Medical Association. Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2024 Update. https://www.ama-assn.org/system/files/prp-pbm-shares-hhi-2024.pdf
[14] Kakani P, et al. Use of and Steering to Pharmacies Owned by Insurers and Pharmacy Benefit Managers in Medicare. JAMA Health Forum. 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC11724340/.