Health insurance execs shift blame for costly, confusing health care system

Drug prices, hospital care are responsible for high insurance costs, CEOs tell Congress

UnitedHealth Group CEO Stephen Hemsley, CVS Health Group President and CEO David Joyner, Elevance President and CEO Gail Boudreaux, Cigna Health Group President and CEO David Cordani, and Ascendiun President and CEO Paul Markovich testified at a House hearing on lowering health care costs Thursday.*Allison Robbert/AP*

By Bob Herman and Daniel Payne - STAT News

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Health insurance executives agree that the U.S. health care system is overpriced, wasteful, and confusing. And they also agree that those problems are someone else's fault.

On Thursday, the CEOs of America's largest health insurance companies appeared before Congress to both justify their current practices and push their visions for reshaping the health system. The leaders of UnitedHealth Group, CVS Health, Elevance Health, Cigna, and Ascendiun blamed the high prices of hospitals, doctors, and prescription drugs and reiterated their promises to make insurance approvals quicker and invest in "value-based care."

STORY

"We are dissatisfied with the status quo in health care, and know we must all do better," UnitedHealth CEO Steve Hemsley told members of the House Committee on Energy and Commerce. He then explained that health insurance is so expensive because hospital and drug spending "has soared at three times the rate of inflation."

Even before the hearing, hospital and pharmaceutical trade groups sent out statements that blamed insurers — and each other — for the country's affordability crisis.

The truth, of course, is that all parties find places to profit at the expense of patients, employers, and taxpayers.

Federal lawmakers, meanwhile, enjoy holding hearings to scold CEOs. And more of that occurred Thursday, with a handful of harangues focusing on care delays and denials — along with some detailed questioning on the companies' vertical integration.

But the health industry continues to evade seismic congressional changes to their practices. Companies still charge the highest prices in the world, aggressively lobby Congress to maintain most of the status quo, and dole out multimillion-dollar paychecks to top executives every year.

Still, the marathon bipartisan grilling of executives across two committee hearings comes as part of a new political dynamic for the health sector: one where traditionally laissez faire Republicans are increasingly skeptical of industry giants — and are considering how federal power should be used to lower costs and improve outcomes.

That's given them common cause with Democrats, who for years have looked to crack down on the health industry, such as through new drug price negotiation powers for Medicare. Earlier this week, Democrats and Republicans came together to unveil a health package that would add requirements for pharmacy benefit managers and hospital systems with the aim of lowering prices.

At the hearings, though, some Democrats spent time pillorying Republicans for allowing enhanced subsidies for ACA plans to lapse. President Trump in recent weeks has turned his focus to insurers, saying he hopes to negotiate with them, as he has with pharmaceutical companies, for lower prices. A White House spokesman did not respond to questions about whether insurance leaders have met with Trump.

Last week, the president asked Congress to update laws that govern health insurers, including changing how government subsidies for ACA plans are routed and creating new transparency requirements, including the wait times for care and denial rates for coverage. He also asked them to expand government power across the health system to lower costs. But suggestions from the White House and hearings are not guarantees of legislative changes. Congress has for years had difficulty passing even broadly backed updates in a timely fashion, much less major overhauls. Still, lawmakers on Thursday looked to untangle the core problems in America's health system.

The testimonies and responses from insurance leaders focused on the basics of how insurance actually works: Premiums reflect the amount of care that patients get and its price. Hospitals indeed are able to charge higher prices to commercial health plans — which includes those offered by employers and those sold on and off the ACA marketplaces. And the prices have risen well above inflation in the wake of the Covid-19 pandemic.

Drug companies and medical device firms, meanwhile, are the most profitable parts of health care. Patents give them time-limited monopolies on drugs and devices. Drug and device companies, which also find ways to extend those monopolies, are similarly able to charge insurers some of the highest prices in the world for their products.

UnitedHealth's Hemsley and Cigna CEO David Cordani emphasized how they and other insurers sit in the middle to bargain. "We negotiate lower costs for medical services and prescription drugs than individuals or employers could achieve on their own," Cordani said in prepared remarks.

However, the executives did not give a full picture of those negotiations. Some employers have sued these companies, alleging insurers don't provide access to claims data and fail to negotiate effectively. Health policy experts also have said insurers have a poor track record in negotiations.

Some members of Congress took time to highlight how the companies before them are providing a lot more than just health insurance now, which has raised concerns from antitrust officials. UnitedHealth, CVS, Cigna, and Elevance all own different parts of the industry that involve care delivery, pharmacy benefits, and technology services, which critics say contribute to the system's rising costs.

UnitedHealth, for example, has spent more than a decade acquiring physician practices, surgery centers, pharmacies, and other entities that directly do business with its UnitedHealthcare insurance arm. A STAT investigation in 2024 found UnitedHealth paid its own physician practices significantly above market rates for many common services, with independent research last year reaching a similar conclusion. This strategy has allowed insurers to meet federal "medical loss ratios" — the regulation that requires at least 80% to 85% of premiums to be spent on medical care — while also ensuring they keep more of the premiums.

"It is now in the insurer's interest to purchase as many health services that count towards that 80 or 85% medical spend requirement to ensure that Americans' premium dollars merely are just changing hands within your company's corporate structure," said Rep. John Joyce (R-Pa.), who chairs the Committee on Energy and Commerce's oversight and investigations subcommittee.

Joyce asked each of the companies to provide the names of affiliated provider subsidiaries that have gotten money from their insurance arms, how the negotiated prices compare for their own providers versus non-affiliated providers, and the percentage of premiums for each major type

of insurance that went toward their own providers. He asked for the companies to submit that information by the end of February.
Rep. Lori Trahan (D-Mass.) expressed skepticism that this vertical integration in companies like UnitedHealth is holding down costs. She hinted at future actions.

“When the same companies control the insurance, the doctors, and delivery of care, competition just breaks down, and families pay more,” Trahan said. “What’s clear right now is that this system is working very well for corporate profits, but this committee has a responsibility to fix a system that today isn’t working for patients.”