UNITEDHEALTH GROUP®

HEARING BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS & MEANS

Testimony of Stephen J. Hemsley
Chairman & Chief Executive Officer, UnitedHealth Group

January 22, 2026

Chairman Smith, Ranking Member Neal, Members of the Committee, thank you for inviting me to testify. I am Steve Hemsley, and I am here today on behalf of my colleagues—our doctors, nurses, pharmacists, data scientists, and so many more—who come to work each day with a shared mission: to help people live healthier lives and make the health system work better for everyone.

Health care is deeply personal, and we are privileged to serve millions of individuals and families at every stage of life.

Employers, including small businesses, state and local governments, and unions, choose us to manage their employee health plans and pharmacy coverage. We also work on behalf of 32 states across more than 100 programs to ensure their most vulnerable have access to high-quality care through Medicaid.

We serve nearly 10 million seniors through Medicare Advantage, prudently managing costs on behalf of taxpayers and offering superior benefits to seniors. This year, our customers will also include about one million people enrolled in Affordable Care Act ("ACA") exchange plans.

Given this role, we recognize and embrace the profound responsibility to approach our work with integrity, humility, and compassion. Like all of you, we are dissatisfied with the status quo in health care. It isn't as good as it should be, and for that I am very sorry.

We share responsibility for the way things are today, and we are determined to make the system work much better, using our capabilities, expertise, and ingenuity to improve it, not only for the people and communities we serve but for all Americans. In fact, last year alone we invested $5 billion in innovations to improve experiences and outcomes for providers and payers alike.

Working closely with a variety of stakeholders—hospital systems, benefits providers, unions, governments, care providers, policy experts, and employers of all sizes—we are innovating to make high-quality health care easier to find, simpler to navigate, and, most importantly, more accessible and more affordable.

Our goal, as a company, is to offer health care that works better. Better outcomes. Better experiences. Lower costs.

While this aim is hardly controversial, achieving these goals requires a candid discussion about *why* the price of health care is high and continues to rise. Only then can policymakers and companies like ours determine what more we can do to restrain these trends and provide relief for American families.

We can start with a common set of facts about how health insurance costs are determined.

We compete aggressively with the companies here today and many others to provide health plan options at prices people can afford. The undeniable reality, though, is that premiums are rising, and Americans are feeling it.

The cost of health insurance is driven by the cost of health care. It is a symptom, not a cause. Premium rates are based on two key factors: how much care is used and how much is charged for that care. When the price of care goes up and care activity increases, the cost of health coverage necessarily follows.

We try to limit these pressures as much as possible, using negotiations, data, and better care coordination to moderate cost growth, improve outcomes, and protect access. We focus on preventive care, so people get care before a condition worsens or before becoming sick at all. And we advocate for broader system changes that address the underlying drivers of health care costs.

Last year alone, we negotiated nearly $300 billion in discounts on behalf of customers. Without those efforts, recent premium increases would have easily been at least two times higher.

Our industry is one of the few stakeholders in the health care ecosystem incentivized to keep the cost of care as low as possible while still maintaining high-quality health outcomes for people and helping them avoid getting sick in the first place. And it is a virtuous circle. Generally, the healthier people are, the fewer health resources they need.

Additionally, we have made notable progress in areas such as value-based care, which simplifies care and incentivizes better health outcomes, and Medicare Advantage, which provides value to taxpayers through lower total costs than traditional Medicare with more benefits and lower overall costs to seniors, a majority of whom choose it.

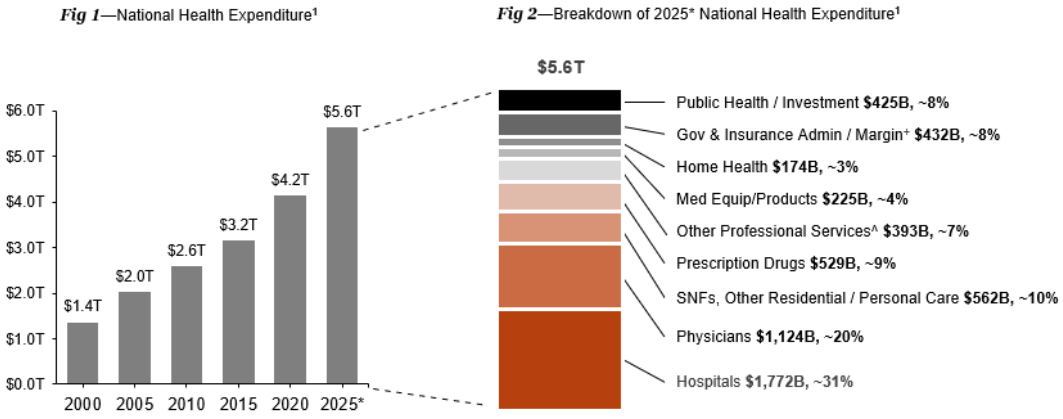
How people experience our products and services is important, too. We know there are aspects that are still too complicated. We are actively working with independent reviewers to identify areas for enhancement, and we are intensely focused on setting a new standard of transparency, simplicity, and ongoing improvement as we continue taking costs out of the system.

We appreciate the focus on affordability here in Congress and by President Trump and are committed to helping identify and implement solutions that improve affordability and expand the availability of quality care. We recognize there are steps on the policy front that will make care more affordable, and we welcome the opportunity to participate in this important national conversation.

The Drivers of Rising Costs: The Price of Hospitals, Specialty Services, and Prescription Drugs

Today, nearly one out of every five dollars spent in our country goes toward health care. Forty years ago, it was half that rate, and it steadily climbs each decade. Overall health care spending reached approximately $5.6 trillion in 2025, up from $4.9 trillion just three years ago. The pace of spending also continues to accelerate. During the last 25 years, health care on a per person basis has gone up 242%, climbing from $4,845 in 2000 to a projected $16,570 for 2025.

National Health Expenditures



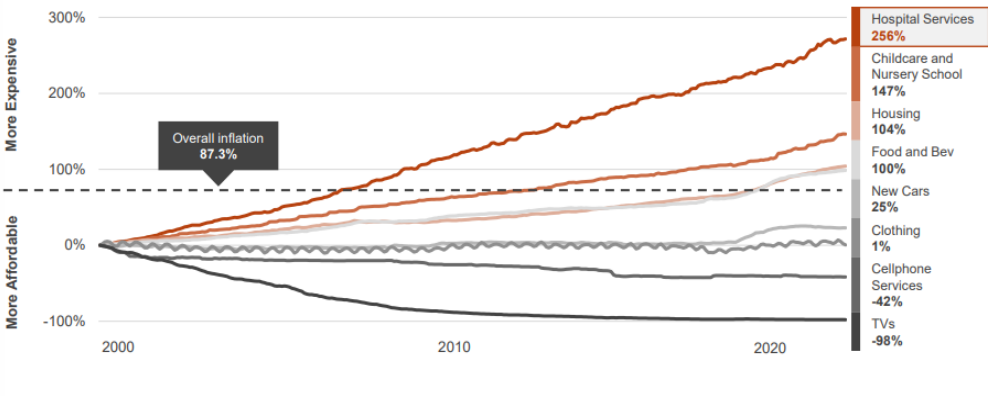
During the same 25-year period, overall inflation has risen about 87%, and, in that time, consumer goods such as clothing and consumer electronics have all gotten more affordable on a relative basis.

Hospital Pricing

America is fortunate to have some of the finest hospitals and care providers in the world. They often deliver extraordinary work in caring for people while also dealing with a range of constraints and challenges.

Yet the reality today is that hospital prices have increased nearly three times faster than inflation over the past 25 years and account for more than 30% of what America spends on health care each year.

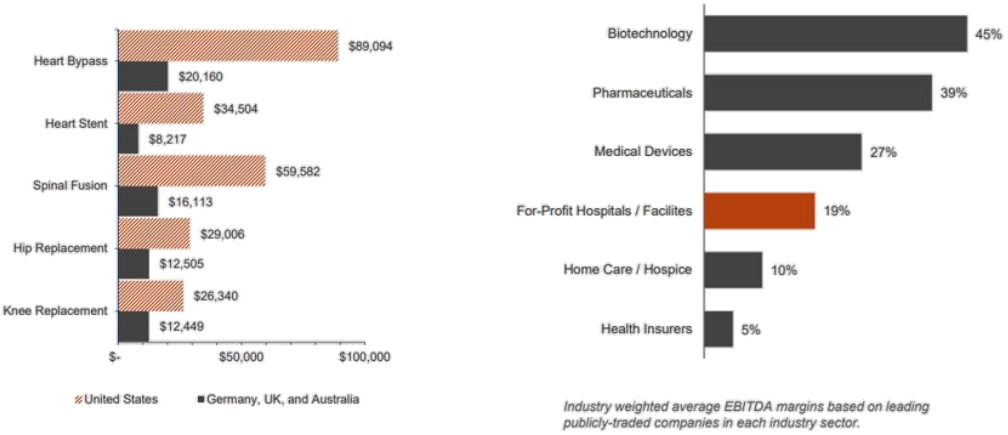
Prices Compared with Overall Inflation



At for-profit hospitals, pricing increases for services, not higher rates of care activity, have been the primary driver of higher overall hospital spending. And for many not-for-profit hospitals, revenue growth and multi-billion-dollar investment portfolios leave them better positioned than operating margins suggest, even as others struggle.

Surgical Procedures: Historically, the same surgical procedures cost two to four times more in the U.S. than they do in other industrialized countries, helping to generate profit margins nearly four times greater than health insurers and twice those of home care and hospice providers.

U.S. Prices for Surgeries vs. Rest of World; For-Profit Hospital Margins



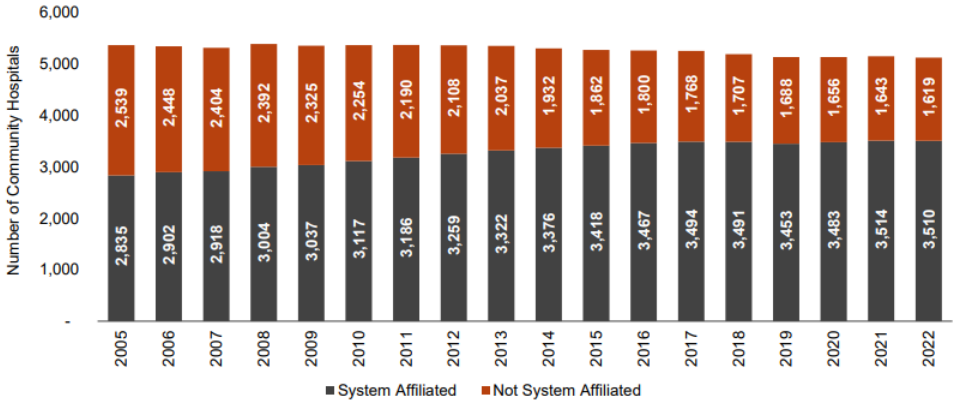
Site of Service: Where these procedures are performed can be a significant driver of cost as well. Increasingly, they are taking place in lower-cost outpatient settings—especially hospital outpatient departments and ambulatory surgery centers—given the broad differentials in cost.

For example, about 1.5 million hip and knee replacements were conducted in the U.S. in 2025. The average cost of a knee replacement in a hospital setting for a person with commercial insurance was $38,000 in 2023. The average cost for the same procedure in a hospital-owned outpatient setting was about $10,000 less, while the average cost

at an ambulatory surgery center was $21,800, or about 40% less overall. Research shows that shifting just these joint replacement surgeries alone into lower-cost sites of care would save the health system about $6 billion per year and about $70 billion over a decade.

Hospital Consolidation: Consolidation is further boosting hospitals' pricing power. Between 2005 and 2022, the number of independent hospitals decreased by 36%.

U.S. Hospital Consolidation 2005–2022



Today, multi-hospital systems own roughly 95% of all hospital beds in the U.S., up from 89% in 2016. In markets where ownership is highly consolidated, prices are rising even faster.

For example, in the Houston and Seattle markets, where the top three hospital systems have at least 70% of the market share, UnitedHealthcare's costs have increased 19% and 13%, respectively, between 2020 and 2024. By contrast, in less consolidated markets like Chicago and Kansas City, our costs have increased more modestly, between 4% and 7%, respectively.

This difference in market structure translates directly into higher costs for consumers, employers, and the health care system overall. If pricing in the more consolidated markets had trended like Chicago, Houston would have seen about $618 million less in hospital spend during the same four years, and hospital spending in Seattle would have been about $142 million less during the same period.

Pricing Transparency: Other market forces, including poor transparency, make it hard to figure out what hospitals and doctors actually charge for care. In New York City, where the three largest hospital systems account for 41% of the market share, delivering a baby by C-section costs $42,000 more at one hospital than the average cost of other academic hospitals in our UnitedHealthcare network in the same market.

These types of pricing discrepancies are unfortunately all too common and often lead patients to inadvertently choose high-cost care settings. Further, hospital acquisitions, including provider groups, lead to higher costs when consumers see those physicians but without meaningful improvement in the quality of care.

Specialty Services

Specialty services, most notably diagnostic testing, have become an essential resource in helping clinicians accurately identify medical conditions and detect diseases early, when they are most treatable. They also guide personalized treatment decisions and reduce unnecessary or ineffective interventions. In fact, today, care providers rely on diagnostic tests to inform about 70% of all medical decisions.

Yet, like hospital prices, the costs for these services continue to rise, driven in part by the overuse of diagnostic testing.

Service Volume & Price Variation: Certain tests, like CT scans, are ordered between two and three times more often in the U.S. than in other countries. Americans also spend substantially more on these services, largely due to higher prices for hospital care, physician services, and advanced diagnostics.

The costs of scans and tests also range considerably. The price for a heart ultrasound varies between $210 to as much as $1,830, and a CAT scan of the neck spans from $320 to $2,440, according to a recent study.

The combination of higher prices and the increasingly pervasive nature of these services has become another significant cost driver for the health system. For example, Medicare Part B spending on genetic tests increased nearly four-fold between 2014 and 2023 and by then accounted for almost 25% of all Part B laboratory spending.

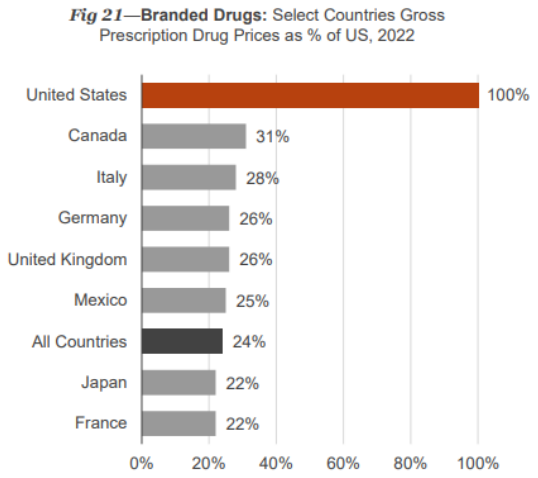
Drug Pricing

The American people have benefitted enormously from the advances and innovations delivered by pharmaceutical companies. In many cases, they have been transformative.

At the same time, prescription drug spend has increased 269% since 2000 and continues to meaningfully outpace inflation year after year, climbing about 9% annually during the past decade and 13% in the past two years.

Americans pay nearly three times more for the same drugs as in other countries, and the gap is even larger—almost four times—for name brands.

U.S. Branded Drug Prices vs. Rest of World



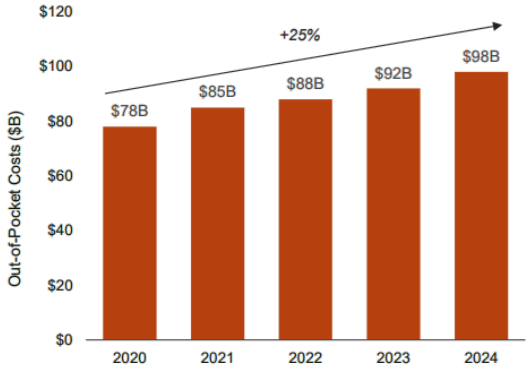
Cost to Consumers: Since 2009, the average retail price of brand-name prescription drugs has more than doubled in inflation-adjusted dollars, and the average annual price of specialty drugs has tripled over the last 10 years from nearly $18,000 to more than $52,000.

While much attention has been paid to prices of specialty drugs, we see similar pricing trends in drugs Americans use every day. Anti-inflammatory, auto immune, and other regularly used medications are very much driving costs. And while the Trump Administration has made great progress closing the gap, recent reports indicate that drugmakers plan to raise U.S. prices for at least 350 branded prescription drugs this year.[1]

[1] Michael Erman, *Exclusive: Drugmakers Raise US Prices on 350 Medicines Despite Pressure from Trump*, Reuters (Jan. 1, 2026), https://www.reuters.com/business/healthcare-pharmaceuticals/drugmakers-raise-us-prices-350-medicines-despite-pressure-trump-2025-12-31/.

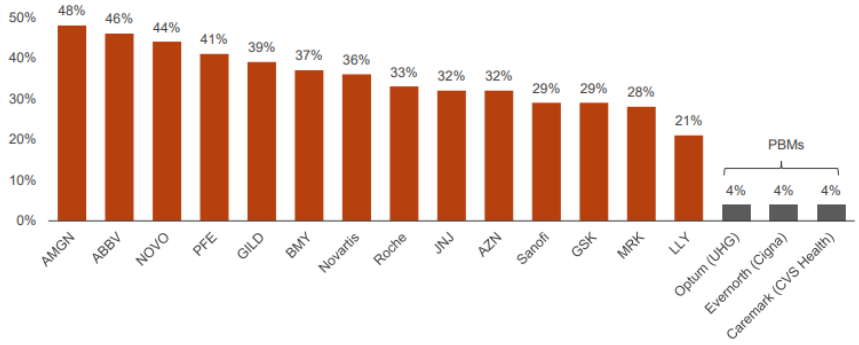
Consumers are also consistently paying more for their medications, with out-of-pocket costs rising about 25% since 2020.

Patient Out-of-Pocket Costs for Medicines Dispensed



Margin Differential: At the same time, manufacturers enjoy margins as much as 10 times greater than the pharmacy benefit managers that negotiate lower prices on behalf of consumers and employers.

Pharma Margin vs. PBM Margin



Our Role

The fact is the prices for care are just too high. Each of these drivers of higher costs is complex, but the outcome for consumers is the same: spending more on the health care they and their families need.

The fee-for-service system substantially incentivizes hospitals, specialists, and pharmaceutical companies to charge higher rates and prices, provide more care, order more labs and scans, and sell as many drugs as possible. They also face other factors like increased utilization and the need to adapt to shifting policy changes.

Health insurers sit on the opposite side of that cost equation. We are incentivized to keep the cost of care as low as possible while keeping people as healthy as possible. By doing so, we are able to keep our benefit offerings stable from year to year and maintain lower premiums and out-of-pocket costs.

Health insurance is also the only industry where profits are essentially capped. By law, about 80–85% of each dollar collected must be spent on medical costs. In some Medicaid programs, the ratio is closer to 90%. Furthermore, insurers are required to maintain significant reserves to protect the financial long-term viability of the insurance programs they offer.

Given these fundamental constraints, coupled with the rising costs of drugs, hospital, and specialty care, the costs coming into the insurance pool continue to exceed annual inflation despite our efforts to hold the line on behalf of consumers, employers, and taxpayers.

Our Focus: Access, Affordability, and Consumer Choice

We are committed to using all available tools to help keep health care affordable and accessible. We negotiate with hospitals, physicians, and drug companies on behalf of our customers, working hard to ensure providers are reimbursed at fair and competitive rates, knowing higher rates lead to higher out-of-pocket costs and higher costs for employers and government sponsors. We also generate cost savings by helping to identify fraud, waste, abuse, and low-value care within the system, for example, saving about $35 billion last year through our program integrity efforts.

Additionally, we have made notable progress on prevention, doubling down on innovation and aligning incentives across the health system. That last element is especially critical because it changes the current incentive structure from paying for volume to rewarding doctors and health systems for keeping patients healthy and well.

Toward Value-Based Care

The U.S. health care system is the most expensive in the world, yet it delivers inconsistent quality, uneven outcomes, and significant waste. A major contributor to high costs and low-value care is the system's reliance on fee-for-service payment models, which reward providers for the volume of products and services. It is a system built on intensely treating people when they are sick, rather than one focused proactively on keeping them healthy.

We believe, and real-world data support the idea, that moving from a transactional health system rooted in episodic patient interactions to one that prioritizes preventive, holistic care over the longer term will deliver better outcomes to the people who use it, at a lower overall cost.

For patients, this means simplifying the health care experience and focusing on whole-person health. For care providers, it is about creating greater capacity for patient care, ensuring physicians have the time, technology, data, and insights they need to keep patients well. And for payers, it helps every health care dollar go further by making high-quality care more accessible and affordable and making it easier to keep chronic conditions in check.

We serve more than four million people in comprehensive value-based care models across dozens of geographies, including older adults as well as those in Medicaid and commercial health plans. Many people in these care models have lower incomes and live in rural parts of the country where access to medical care can be challenging. Others are managing multiple chronic and complex conditions, making care coordination even more critical for their long-term health.

The people we serve in value-based care models are more likely to receive preventive screenings, less likely to be admitted or readmitted to the hospital, and have better control of diabetes and hypertension than people in fee-for-service models.

Value-based care allows our physicians to spend more dedicated time with each patient, rather than rushing through high patient volumes. This reduces physician burnout and stress.[2] [3] And importantly, it gives them greater focus on prevention and whole-person care, allowing them to practice medicine in a way that is more fulfilling, sustainable, and aligned with the health outcomes they want for their patients.

Medicare Advantage patients served by our value-based care models have better health outcomes than those in fee-for-service models. This includes up to 21% fewer hospital admissions overall; 35% fewer hospital admissions for

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[2] Kim, Premkumar et al., *Do Compensation Models Affect Family Physician Job Satisfaction? Scoping Review*, Can. Fam. Physician (Jun. 2025), https://pubmed.ncbi.nlm.nih.gov/40523730/.

[3] *Evaluating Value Based Payment in Reducing Administrative Burden*, AAFP (Oct. 24, 2023), https://drive.google.com/file/d/1ntigIXzOiYne6yI7QH3aBekUMS9KH-9A/edit.

those with hypertension; and up to 44% fewer hospital admissions among those with COPD, asthma, and other acute and chronic conditions. In addition, 70% of Medicare Advantage diabetic patients under our care have control of their A1c levels, up seven percentage points year over year, and approximately 75% of Medicare Advantage patients in our value-based care models were screened for breast cancer and colorectal cancer. [4]

Moreover, the managed care structure of Medicare Advantage allows the program to provide value to the government with lower total costs than traditional Medicare and lower overall cost to beneficiaries. All told, Medicare Advantage costs the federal government 9% less than traditional Medicare, and Medicare Advantage out-of-pocket costs are 53%, or $4,139, less annually than in traditional Medicare for a non-dual eligible aged-in beneficiary with a PDP and Medigap Plan G.[5]

While we know there is certainly significant work ahead, we are proud to be at the forefront of the transformation of U.S. health care as we help to build a simpler, more connected system that delivers higher-quality care at a lower cost.

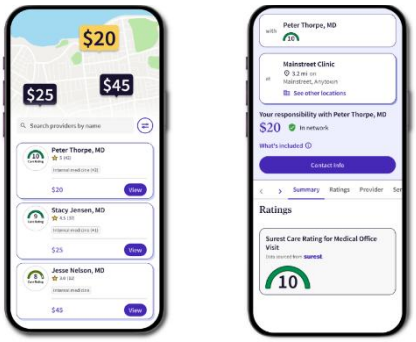
Investing in Improved, More Affordable Customer Experiences

Consumers expect health care to function like any other industry they interact with in their daily life. When they sign up for their health benefits for the next year, they want those benefits to meet their needs and fit their budgets. When they need care, they want to know what it will cost and which doctor is the best option for them. And when their needs change throughout the course of their life, they want their health coverage to flex to those needs. We are focused on improving those kinds of experiences to give our members the choice, personalization, and simplicity they want, and the efforts are making a difference: for example, UnitedHealthcare had the #1 payer app on the Apple Store most often in 2025.

We are also leading the charge in modernizing commercial benefits for people with the introduction of Surest, a modern health plan designed to bring greater simplicity and certainty to care. Surest simplifies the process of choosing where to receive care by offering members the information they need upfront, enabling them to comparison shop for care. The plan has no deductible and no coinsurance that patients are billed for weeks after receiving care.

Using the Surest app or website, members can check and compare prices and quality ratings in advance of seeking care, with lower prices indicating providers have a track record of delivering effective, cost-efficient care. This upfront pricing also helps avoid the surprise of a medical bill that, with a traditional health plan, might show up weeks or months after a service or procedure.

Surest Experience: Transparency & Certainty



[4] *See also* Cohen, Vabson et al., *Health Outcomes Under Full-Risk Medicare Advantage v. Traditional Medicare*, Amer. Journal of Managed Care (May 9, 2025), *https://doi.org/10.37765/ajmc.2025.89740*.

[5] Heinrich and Smetek, *Value of Medicare Advantage to the Federal Government: 2025*, Milliman (Jan. 2026), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/1-9-26_Value-of-MA-to-the-federal-government.pdf; Heinrich and Scherer, *Comparison of Annual Beneficiary Health Care Costs Across Medicare Coverage Options 2025*, Milliman (Jan. 2026), https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/1-16-26_Comparison-of-beneficiary-costs-across-Medicare-coverage-options.pdf.

Surest members pay 54% less out of pocket, on average, compared to those in traditional plans. Employers that offer Surest also see lower total costs of care year-over-year. We are committed to extending these consumer-centric features wherever we can to allow consumers more choice, control, certainty, and value.

Improving Affordability: Potential Solutions to Lower Premiums and Out-of-Pocket Costs

We are deeply committed to improving care and embracing the opportunities to make it better for the American people. We take the immensity and complexity of this responsibility very seriously, and we appreciate the chance to share some of our ideas about how Congress and others can help as part of today's hearing.

Policy Solutions

We appreciate that there are bipartisan discussions underway in Congress to determine how to extend the enhanced ACA premium tax credits and improve the program in ways to address a range of issues, including affordability and fraud, waste, and abuse. Though UnitedHealthcare is a relatively small participant in the individual ACA market, we will voluntarily eliminate and rebate our profits this year for these coverages, as Congress continues to work toward more long-term solutions.

We also believe there are additional steps policymakers can take to strengthen the stability, affordability, and sustainability of these plans for consumers.

- **Broadening Consumer Choice**. Access to the lowest-cost plans, often referred to as catastrophic plans, is restricted under current law, and these plans are not eligible for premium tax credits. Expanding eligibility for these plans and allowing premium tax credits to be applied to them would give consumers, particularly younger and healthier individuals and those seeking lower monthly premiums, additional affordable coverage options while maintaining essential protections.

- **Standardizing Broker Compensation**. Unlike in the Medicare Advantage program, broker compensation in the ACA market is not standardized, creating incentives for brokers to steer consumers toward plans that pay higher commissions rather than those that best meet an individual's needs. Standardizing compensation would better align broker incentives with consumer interests, promote more objective plan selection, and help consumers choose coverage based on value, affordability, and access to care rather than commission differentials.

We also look forward to working with you and our industry partners to identify ways to bring down costs beyond the ACA market.

- **Lowering Health Savings Account ("HSA") Thresholds and Broadening the Scope of Covered Services for High-Deductible Health Plans ("HDHPs")**. HSAs are currently available to individuals covered by HDHPs with deductibles of at least $1,700, and HDHPs generally restrict the types of preventive services (e.g., annual physicals, vaccines) that can be covered at zero dollars in the pre-deductible phase. Congress could consider lowering the deductible threshold for HSA eligibility and allowing a broader range of services, such as routine office visits and mental health care, to be covered pre-deductible at no cost. As part of a broader affordability agenda, expanding access in this way would help lower out-of-pocket costs for consumers, reduce financial barriers to routine and preventive care, and encourage earlier engagement with primary and behavioral health services—supporting better health outcomes while preserving consumer choice and affordability.

- **Addressing Site of Service**. Patients regularly seek care at sites that are unnecessarily expensive given their acuity level, driving up health care costs across the board. Ensuring that patients seek care at the site that is clinically appropriate for their condition would meaningfully reduce premiums and out-of-pocket expenses. Congress should consider applying site neutral payments to align reimbursement across care settings for services that can be delivered safely and equivalently outside the hospital. This policy would remove the Part B differential across outpatient settings by aligning hospital outpatient departments with lower physician-

office reimbursement rates. The Congressional Budget Office ("CBO") estimates this would save the federal government $157 billion over ten years.

- **Expanding Flexibility for Association Health Plans ("AHPs")**. Small businesses today are limited in forming or joining AHPs based on factors like industry or geography. Expanding eligibility and loosening these restrictions would give small businesses more flexibility to pool together, access more affordable coverage, and reduce overall health care spending burdens.

- **Reforming Patent Law to Lower Drug Costs and Boost Competition**. Similarly, Congress can foster a more competitive prescription drug market by curbing patent abuses by pharmaceutical manufacturers. Under current law, manufacturers take advantage of loopholes to prolong patent protections. Tactics such as product hopping, patent thickets, and pay-for-delay agreements have been used to preserve market dominance and postpone the introduction of more affordable generic and biosimilar alternatives—sometimes for decades. One analysis estimated that, for just five drugs in a single year, these practices cost the health care system between $1.8 and $7.6 billion.[6] Patent reforms would produce significant savings and ensure that competition is driven by clinical value rather than a manufacturer's ability to manipulate the patent system.

- **Restricting Direct-to-Consumer Advertising**. Congress can generate federal government savings by eliminating or restricting direct-to-consumer ("DTC") pharmaceutical advertising. The CBO estimates that a 10% increase in DTC advertising expenditures is associated with a 1% to 2.3% increase in prescription drug spending, demonstrating that reduced advertising could lower overall drug costs.[7] Federal government savings would be even greater when accounting for tax revenues: banning pharmaceutical advertising or treating advertising expenditures as taxable income could increase U.S. tax payments by approximately $1.5 to $1.7 billion annually from the ten largest pharmaceutical companies.[8] In 2022, drugmakers spent about $7.6 billion on DTC advertising, with nearly $1.7 billion devoted to just 10 drugs, underscoring how marketing dollars are concentrated behind the most expensive products. Research also finds that these ads often steer patients toward higher-cost, less effective brand-name drugs instead of cheaper alternatives.[9]

- **Addressing Disparities Between Domestic and Foreign Drug Prices**. We commend efforts by the Trump Administration and Congress to negotiate with pharmaceutical manufacturers to bring prices in the U.S. down and in line with other OECD nations. Congress can continue to play an important role in addressing disparities between prescription drug prices in the U.S. and those paid in other countries by modernizing policies that shape how drugs are priced and reimbursed.

* * *

There are few things as vital to the human condition as good health. Every day, millions of people count on UnitedHealth Group not just to care for them when they are sick, but to keep them healthy and well at every stage of their lives. As we undertake this important work, we know there is much more to be done to make health care more accessible and affordable for all Americans.

We believe the conversation about how to improve the health care system is important and necessary. The best way to achieve that is to ensure that all people in our health care system—patients, hospitals, doctors, pharmaceutical companies, health insurers, regulators and policymakers—are part of the conversation and working together towards a common goal of building a system that works for everyone.

Again, thank you for the opportunity to be here today. I am happy to answer any questions.

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[6] Brill and Robinson, *Patent Thickets and Lost Drug Savings*, Matrix Global Advisors (Jan. 2023), https://getmga.com/wp-content/uploads/2023/01/Patent_Thickets_Jan_2023.pdf.

[7] *Alternative Approaches to Reducing Prescription Drug Prices*, CBO (Oct. 2024), https://www.cbo.gov/publication/60812.

[8] *Direct-to-Consumer (DTC) Pharmaceutical Advertising Spending, Tax Implications and Impact on Prescription Drug Costs in the U.S.*, Campaign for Sustainable Rx Pricing (Mar. 2025), https://www.csrxp.org/wp-content/uploads/2025/04/CSRxP-Analysis-Direct-to-Consumer-Advertising-Report.pdf.

[9] Patel, Hwang et al., *Therapeutic Value of Drugs Frequently Marketed Using Direct-to-Consumer Television Advertising*, JAMA Network Open (Jan. 13, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800405.

APPENDIX: SUMMARY FACTS & STATISTICS

Overall U.S. Health Care Spending

- About $5.6 trillion in 2025 vs. $4.9 trillion in 2023
- Per person spending rose 242% since 2000, from $4,845 to $16,570 for 2025
- During this period, health care spending outpaced inflation by nearly ~3X (overall inflation: 87% 2000-present)

Hospitals

Pricing:

- Hospital prices increased ~3x rate of inflation since 2000, now +30% of all health care spending
- Common surgeries cost ~2x–4x in U.S. vs. other countries

Margins:

- Hospital margins are about ~4x higher than health insurers and about ~2x greater than home health services

Site of Service:

- Knee replacement for commercially insured patient: ~$38k in hospital vs.~ $22k in ambulatory surgical center (~40% less)

Consolidation:

- In 2022 there were ~36% fewer independent hospitals in the U.S. than in 2005
- Multi-hospital systems own ~95% of beds vs. ~89% in 2016
- In markets like Houston and Seattle, where the top 3 hospitals account for +70% of the market share, UnitedHealthcare's costs have risen about 19% and 13%, respectively, compared with 4% to 7% in less concentrated markets like Chicago and Kansas City

Transparency:

- In New York City, where 3 hospitals account for 40% of the market, a C-section costs $42,000 more at one hospital vs. average cost of other hospitals in the UnitedHealthcare network

Drug Prices

Drug Spending & Pricing:

- U.S. drug spending rose 269% since 2000, growing ~9% annually during the past decade and ~13% in the last two years
- Out-of-pocket drug costs rose ~25% since 2020
- U.S. pays 3x more for drugs than international, up to 4x for some brand-name drugs
- Average price for specialty drugs +3x in 10 years ($18,000 to $52,000)
- Pharmaceutical manufacturers planning to raise prices on 350 brand-name drugs this year

Margins:

- Pharmaceutical margins +10x PBM margins; 44–48% for top 3 drugmakers vs. 4% for top 3 PBMs

Specialty Services

Diagnostic Tests:

- Diagnostic tests inform ~ 70% of medical decisions
- These tests are ordered ~2–3x more often in the U.S. vs. other countries

Pricing Variation:

- Higher prices at hospitals and lower prices at ambulatory centers
- Heart ultrasounds range from $210 to $1,830
- Neck CAT scans range from $320 to $2,440

Growing Prevalence:

- Medicare Part B spending on genetic tests increased ~ 4x from 2014–2023
- Genetic tests now account for ~25% of all Part B lab spending

Negotiated Savings

- In 2025, UnitedHealth Group negotiated ~ $300 billion in discounts on behalf of customers
- Without these efforts, premium increases would easily have been 2x higher
- $35 billion in savings via payment/program integrity (waste, fraud, abuse)

Value-Based Care

Value-based care focuses on prevention, innovation, and aligning incentives—fundamental transition from paying for volume to rewarding doctors and health systems for keeping patients healthy and well.

UnitedHealth Group serves more than four million patients in comprehensive value-based care models across dozens of geographies, including older adults and people with Medicaid and commercial benefits.

Benefits for Patients:

- Simplified health care experiences
- Greater care coordination and whole-person health

Benefits for Physicians:

- More dedicated time with each patient
- Less burnout and stress; allows for a practice that is more fulfilling and more closely aligned with the outcomes they want for their patients.

Better Health Outcomes (Medicare Advantage + Value-Based Care in UnitedHealth Group Models):

- Up to 21% fewer hospital admissions overall
- About 35% fewer hospital admissions for hypertension
- Up to 44% fewer hospital admissions among those with COPD, asthma, and other acute and chronic conditions
- About 70% have control of their A1c levels, up 7 percentage points year over year
- About 75% are screened for breast cancer and colorectal cancer

Medicare Advantage

- UnitedHealth Group serves more than 10 million people enrolled in Medicare Advantage, which delivers demonstrably better health outcomes at a lower cost for patients and taxpayers
- More than half of people who are eligible for Medicare choose Medicare Advantage
- 95% senior satisfaction
- Medicare Advantage costs the federal government 9% less than traditional Medicare; out-of-pocket costs are 53%, or $4,139, less annually than in traditional Medicare for a non-dual eligible aged-in beneficiary with a prescription drug plan and Medigap Plan G

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