

Date: May 22, 2026
To: NAIC Health Care Affordability and Mitigation (B) Workgroup
Drafting Group 2: Examine horizontal or vertical integration in health care, including using medical loss ratio data
From: AHIP - Kris Hathaway & LaCosta Wix
Re: AHIP Feedback & Resources

To support Drafting Group 2 in its work, AHIP would like to share the following information. At the outset, we think it is important that the Drafting Group address horizontal integration separate from vertical integration. We hope this resource will be helpful in informing the development of the brief.

When competition is appropriately balanced with patient protections, market-driven innovation can reduce healthcare costs while improving health outcomes. Common sense market reforms can encourage higher quality care at lower prices.

Horizontal Integration

Providing healthcare is very capital-intensive, and established players in provider markets can use their scale to purchase rivals and discourage new entrants. Appropriate oversight can ensure that local healthcare provider markets are more competitive and that providers cannot use monopoly power to overcharge patients and health plans. Mergers, expansions and new investments can all strengthen the healthcare system if they focus on and deliver quality and long-term success rather than local market consolidation and short-term profits. Patients and health plans must be protected from overbilling on services and medicines that can be readily provided at lower cost. With the right state and federal engagement, healthcare provider markets can become more competitive and affordable while providing high quality care.

NAIC has heard presentations pointing to the correlation between increased mergers across health systems and increased prices for consumers - by [Brown University](#), [Georgetown CHIR](#), [Blood Cancer United & United States of Care](#), [AHIP](#), [NASHP](#), and others' presentations have specifically pointed to facility fees from consolidated health systems as a contributing factor in rising healthcare costs. Presenters also highlighted how provider anti-steering and anti-tiering contract terms limit health plans' ability to negotiate with consolidated health systems based on cost and quality.

Site Neutral Payments: Hospital consolidation doesn't just raise prices for Americans; it impacts *where* care is delivered and *how* care is billed. Routine services are increasingly billed as coming from hospital outpatient departments – instead of physician offices or ambulatory surgical centers – which come with significantly higher prices. A 2025 [analysis](#) from the Health Care Cost Institute finds that for services commonly provided in both settings, prices in hospital outpatient departments were consistently higher than in physician offices, with price ratios ranging up to 13 times higher for the exact same services.

Anticompetitive Contract Terms: Health plans [create networks](#) to provide access to high-quality, affordable care for enrollees. Many plans experience significant difficulties in contracting due to anticompetitive practices like “all-or-nothing” contracting and anti-tiering clauses. These practices, when combined with network adequacy requirements, increase provider leverage in negotiations and drive up healthcare costs for consumers. Certain providers or facilities can use network adequacy rules to demand increased rates, additional network contracts for other system facilities, or inappropriate placement in a particular network tier. Provider consolidation amplifies these challenges, making negotiations extremely challenging despite good faith contracting efforts by plans.

Private Equity: Private equity's stake in healthcare has grown to more than [\\$1 trillion](#) over the past decade and continues to accelerate. A [recent study](#) found that, between 2013 and 2022, 82 private equity firms

acquired 423 cancer treatment practices across the country. That resulted in radiation therapy prices jumping 50% at PE-backed facilities compared to independent practices, and chemotherapy costs rising by 28%.

Private-equity funded providers and facilities have incentives that are separate from providing quality healthcare at an affordable price, and we see the results in costs going up across the healthcare system. One striking example is the ongoing misuse of the No Surprises Act's Independent Dispute Resolution (IDR) process by certain PE-backed provider groups. This concentrated exploitation of the IDR process is leading to higher payments for employers and health plans and driving up premiums

According to CMS [data](#), in the first half of 2024, 47% of all IDR cases originated from just four PE-backed organizations. Moreover, 45% of filed cases were challenged as ineligible, highlighting the systemic manipulation of the process by these entities. Overuse and gaming of the IDR process helped contribute to the [more than \\$5 billion](#) in added healthcare spending that accumulated in just the first two years the IDR process was open.

AHIP supports policies and reforms that promote [healthier markets for healthier people](#). When competition is appropriately balanced with patient protections, market-driven innovation can reduce healthcare costs while improving health. By improving competition, the healthcare system can become more affordable, more accessible and more responsive to patients' needs. Additional materials can be located on AHIP's [Cost Connection Initiative](#).

MLR Data & Vertical Integration

The NAIC played a central role in developing and implementing the MLR under the ACA. The ACA requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the MLR. The ACA requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the rate review provisions also imposing limits on health insurance rate increases. If an issuer fails to meet the applicable MLR standard in any given year, as of 2012, the issuer is required to provide a rebate to its customers.

Notably, industry-wide average MLRs are substantially above the required ratios for each market type, demonstrating robust premium price competition. For example, KFF [reports](#) the industry average simple MLR in the individual market was 85% in 2024, 5 percentage points greater than the required 80%. If a health plan increased its premium to reduce the MLR to the required 80%, that premium would likely be less competitive to enrollees and result in decreased enrollment. The consistent trend of MLRs substantively above regulatory requirements demonstrates robust premium competition. Furthermore, in the individual market, premium subsidies are calculated based on the relevant second lowest cost silver plan. This further drives premium competition, discouraging plans from offering higher-cost plans at the regulatory-minimum MLR. Premium subsidies in the Medicare Advantage and Medicare Part D markets are calculated relative to benchmarks or national average bids, encouraging plans to submit lower premium bids to encourage enrollment even though that means that lower amounts of profit because they are above the regulatory-minimum MLR.

Both MLRs and any rebates paid under MLR requirements are publicly available:

- MLR data submitted is public and linked on the [CMS webpage](#).
- State regulators have access to most health plan data which populates the MLR form.
- Kaiser Family Foundation [publishes](#) annual MLR rebates by state.

Both [KFF](#) and [Healthinsurance.org](#) estimate close to \$13 Billion will have been paid by health plans to people and businesses who have purchased coverage starting in 2012, when the MLR took effect, through 2024.

Dr. Lynn Hua [presented](#) on vertical integration (VI) as part of the NAIC CIPR Research Fellows Talk in March 2026. She addressed the correlation of quality ratings and MLRs when comparing vertically integrated plans and traditional commercial health plans. Dr. Hua noted that vertically integrated plans may serve different

populations and markets, but that was considered as part of the analysis. In her study, she found average MLRs in vertically integrated plans were five percentage points above the statutory minimum and that these plans also had higher quality ratings than other plans. This suggests vertically integrated health plans are not obtaining additional profits, highlighting the existence and importance of premium competitiveness in plan bids.

An [article](#) in Health Affairs published in 2025 raised questions on whether vertical integration was potentially weakening the effectiveness of MLR requirements on health plans. The article did not include any evidence or data to support their hypothetical theory and AHIP's [response](#) reminds interested parties that health plans compete for employer and individual purchasers, with the deciding factor being premium and cost sharing by the policyholder. Artificially inflating provider payments to provider affiliates would undermine plan competitiveness because it would lead to higher premiums or reduced benefits. In short, a plan would be less attractive to beneficiaries and employers compared with competitors if the speculated "gaming" was occurring.

HHS Office of Inspector General released a [Data Snapshot](#) this month on the "Impacts of Vertical Integration in Medicare Part D on Sponsors' Drug Costs, Pharmacy Reimbursement, and Enrollee Cost Sharing." For the purpose of the study, vertically integrated referred to the consolidation of Part D sponsors with PBMs. The OIG report found:

- Monthly premiums for plans offered by vertically integrated organizations were substantially lower than premiums for plans offered by other sponsors... but for select drugs, higher drug out of pocket costs.
- Overall, the net cost of drugs was similar for vertically integrated Part D sponsors and other Part D sponsors.
- Vertically integrated sponsors paid their own pharmacies a little less than they paid other pharmacies... but the report could not account for later payment adjustments.

Legal: In 2025, Arkansas passed legislation (HB 1150) which restricts PBMs from owning pharmacies. Soon after its passage, a number of lawsuits were filed in federal court challenging the new law. AHIP filed an [amicus brief](#) in the consolidated case to explain to the court the significant impact the law has on health plans and those who rely upon health plans for high quality, affordable, and accessible pharmacy services. In that brief, we emphasize the need for more pharmacies – not fewer – in order to avoid pharmacy deserts and to leverage competition among pharmacies to promote affordable care. The brief explains how banning PBM-affiliated pharmacies in Arkansas will threaten access to affordable healthcare, both in Arkansas and beyond.

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