Elevance Health's March 13, 2026 Responses to House Energy & Commerce Committee Questions for the Record issued on February 26, 2026, hearing entitled, *Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability*, on January 22, 2026

The Honorable Brett Guthrie (R-KY)

1. I have heard from healthcare providers who have raised serious concerns regarding vertically integrated health services businesses, including Optum Health, Carelon Health, Evernorth Health Services, and others. Providers have reported that these businesses unilaterally imposed more restrictive and non-transparent clinical criteria that conflict with published and publicly available health plan medical policies for which they manage prior authorizations. With that responsibility in mind, I would like answers to the following questions.

    a. Does your health plan possess legal and operational authority to unilaterally overrule any clinical or coverage decision made by your company's health services line of business (or vice versa)?

    b. Does your company's health services line of business utilize any clinical algorithms or internal guidelines that result in a denial of service? If so, why?

    c. Does your parent company provide financial incentives or performance bonuses to your health services line of business based on meeting specific 'utilization management' targets or reduction in medical spend? If so, how are these bonuses defined?

    d. Does your company's health services line of business ever deny a claim that satisfies both a drug's FDA label instructions and your health plan affiliate's own published medical policy?

    e. Are the specific internal criteria used by your company's health services line of business to evaluate a claim made available to the provider and patient prior to the submission of a treatment request?

    f. As of today, has your company issued any formal directives requiring your company's health services line of business to eliminate any internal criteria that are more restrictive than the public-facing policies of your health plan business?

    g. Do your parent companies or health plan lines of business provide financial incentives or performance bonuses to your service business based on meeting specific 'utilization management' targets or reduction in medical spend? If so, how are those bonuses determined?

    h. Are internal criteria in any way communicated or made public to network providers and/or patients? If so, how?

2. CMS in August and December of 2025 notified PBMs and plans about the need to recognize the impact of the Inflation Reduction Act on pharmacies in negotiating pharmacy network agreements for 2026. The issue is particularly acute for long-term care (LTC) pharmacies who serve our nation's nursing homes and assisted living facilities and are uniquely exposed to Maximum Fair Price reductions in the Part D program.

    a. Have each of your plans adjusted reimbursement to LTC pharmacies to account for the impact to pharmacies of Maximum Fair Price changes that began on January 1, 2026? If so, how? If not, is this something you plan to do in the future?

3. Approximately 25 percent of Medicare beneficiaries have a mental health condition, yet many often do not receive treatment. Given the urgency of the behavioral health crisis in the United States, and in the older adult population in particular, care coordination for behavioral health needs to be prioritized.

    a. Where do you see opportunities for Medicare Advantage plans to enhance care navigation to better meet the behavioral health needs of the Medicare population, and how might technologies and innovations be leveraged in these efforts?

4. CMS recently issued the proposed rule for Contract Year 2027 for Medicare Advantage.

    a. Do you agree it is a positive development that the rule focuses on behavioral health and addressing the gaps for patients to achieve better outcomes?

    b. Are there ways that CMS could support Medicare Advantage plans in prioritizing care navigation, for behavioral health and other under-treated underlying health conditions?

5. The Energy and Commerce Committee is responsible for the expansion of technology in federal government programs – while stewarding taxpayer dollars. Many of the health innovations that the committee oversees, such as remote patient monitoring and enhanced chronic disease management, are intended to change the trajectory of chronic disease and improve outcomes while reducing costs by leveraging technology over multiple plan years.

    a. How does your business approach coverage and investments in innovative technologies (i.e. artificial intelligence, remote patient monitoring, wearables, chronic disease management innovations)?

    b. How does your business weigh long-term patient health improvements and taxpayer savings, which may not materialize over multiple plan years?

    c. How is your business leveraging health technology today to improve patient experience and outcomes; address waste, fraud and abuse; reduce administrative burdens; improve the provider experience; and otherwise improve the U.S. health care system? Please provide specific examples.

    d. Should Congress consider further opportunities to incentivize adoption of innovative technologies in the managed care space? If so, how?

6. Several states have advanced legislation to instituted some form of provider 'gold carding' programs, which exempts high-performing providers from certain prior authorization requirements.

    a. Do your companies operate any type of gold carding or prior authorization pass-types of programs? If so,

        i. Which lines of business do you operate these programs in?

        ii. How do you determine provider/service eligibility, as well as eligibility renewal?

        iii. How many providers qualify for your gold carding programs?

            1. If applicable, what percentage of qualifying providers are in some way affiliated with your parent company?

            2. What types of providers are most likely to qualify for these gold carding programs?

        iv. How do you advertise or otherwise educate your network participating providers regarding the existence of these programs?

    b. Do you plan to roll out any types of gold carding or prior authorization pass programs in the future?

7. Prior authorization can help control costs in both commercial insurance and Medicare Part D plans. HHS OIG has reported that major Medicare Part D plans are restricting timely access to life-saving cancer drugs.

    a. How does your company's utilization management criteria for cancer drugs align with published clinical guidelines and how does it differ?

8. How does your plan deploy utilization management strategies, like requiring primary care referrals ahead of specialist encounters?

    a. For certain specialists managing patients with chronic conditions (e.g. nephrologists managing patients with dialysis and vascular access services on a continuous basis), what steps does your company take to streamline utilization management, and its associated administrative burden, for these specific patients and providers?

Elevance Health's Response to Questions 1-8:

<u>Prior Authorization and Utilization Management</u>

Elevance Health is actively working to reduce the burden and delay often associated with prior authorizations, with the goal of improving members' access to treatment while ensuring care is

clinically appropriate and safe. Although prior authorization currently applies to only about 3% of our claims, and the vast majority of requests are approved, Elevance Health has taken significant steps to modernize and streamline this process. For instance, Elevance Health has eliminated prior authorization requirements for over 400 services since January 1, 2024. We are also adopting interoperability standards and working with providers to facilitate bidirectional data exchange that simplifies and speeds the process for electronic submissions, reducing paperwork and incomplete requests.

Today, approximately 32% of prior authorization requests to our plans are still submitted via traditional methods, such as fax, mail, or phone, which can cause delays. To facilitate further adoption of electronic prior authorization, Elevance Health is investing in technology to expand electronic submission pathways and enable real-time approvals, with approximately two-thirds of electronically submitted requests already being processed in real time. Additionally, Elevance Health will continue to review and streamline the overall volume of services subject to prior authorization while enhancing transparency in coverage determinations, including by providing clearer denial explanations and improved documentation guidance so providers know exactly what clinical information is required.

Elevance Health does not use artificial intelligence to deny prior authorization requests. Elevance Health conducts peer-to-peer reviews for prior authorization decisions by licensed clinicians, including physicians in the appropriate specialties, consistent with federal and state requirements. Elevance Health also honors existing authorizations during coverage transitions between plans for a period of 90 days to ensure continuity of care. Emergency care is never subject to prior authorization. When delays occur, they are often due to missing information – not denials – which is why Elevance Health is modernizing prior authorization processing with electronic tools and better data exchange to speed decisions and reduce burden. These reforms reflect Elevance Health's commitment to improving our members' access to care by promoting evidence-based treatment and reducing unnecessary delays.

Medicare Advantage Plan Practices

More than 34 million beneficiaries or nearly 55% of eligible beneficiaries, choose to enroll in Medicare Advantage plans. Medicare Advantage provides coordinated care, care management support, and an out-of-pocket maximum that traditional Medicare does not offer. In addition, Medicare Advantage bids average about 85% of fee-for-service costs, and independent analyses estimate Medicare Advantage costs about 10% less than fee-for-service on an apples-to-apples basis.

MA plans routinely bid below the benchmark set by the government and a portion of those savings go back to the Medicare Trust Funds. Up to 50% of the savings from bidding below the benchmark are required by statute to be returned to the Treasury; this happens before plans can even start to design the meaningful supplemental benefits that they provide to care for their members and to remain competitive in the market. Based on our estimates, approximately $39 billion in annual savings go back to the Medicare Trust Funds because of plan bids below the benchmark

Elevance Health's Medicare Advantage plans comply with all applicable federal coverage requirements, including the two-midnight rule, and we administer benefits consistent with CMS regulations and guidance. Medicare Advantage plans, like ours, operate in a highly regulated environment, and our coverage determinations are subject to CMS oversight, audit, and enforcement. When CMS updates guidance, we update our policies accordingly to ensure alignment.

We support improving Medicare Advantage, and as a first step, we encourage Congress to pass Congressman Aaron Bean (R-FL)'s Apples-to-Apples Comparison Act of 2025. This legislation would require CMS to release the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. Current analyses by MedPAC lack the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. We believe this will give Congress critical information with which to consider any possible reforms based on facts, not assumptions. We also support improving the Medicare Advantage Star Ratings system to focus on health outcomes like reducing hospital readmissions and slowing the progression of chronic diseases over administrative processes.

Elevance Health is deeply committed to improving Medicare Advantage offerings while maintaining a focus on affordability, access, and quality for beneficiaries, the government, and taxpayers.

Behavioral and Mental Health Care Access

Elevance Health is actively working to expand access to high-quality behavioral and mental health care across all markets. Recognizing the significant 40% increase in mental health diagnoses between 2019 and 2024, Elevance Health has taken proactive steps to address the growing need for services despite a nationwide shortage of behavioral health providers. These efforts include expanding its networks by adding over 50,000 behavioral health providers and leveraging telemental health and other digital solutions to improve accessibility. Elevance Health is also investing in integrated care models, peer support, and care coordination for individuals with more complex needs, such as by connecting behavioral health services with primary care and chronic condition management.

Elevance Health has made significant strides in improving care delivery by addressing barriers, reducing stigma, and fostering continuity of care. At the same time, we recognize that while the demand for behavioral health services has grown dramatically, the availability of providers has not kept pace with the demand, and too many providers choose to not accept insurance. Expanding access to behavioral health services sustainably requires system-level solutions, including workforce development, permanent telehealth flexibilities, integrated care models, and better data infrastructure.

Prescription Drug Coverage and Affordability

Elevance Health is taking proactive steps to enhance prescription drug coverage and affordability by implementing innovative tools and programs. That's why we built tools like EnsureRx, which automatically applies the lowest available price—covered or cash—on hundreds of medications at

the pharmacy counter, which has helped more than 3 million people save over $94 million in one year. We recognize the importance of real-time affordability tools in allowing individuals to access cost-sharing information for prescription drugs based on their specific benefits and pharmacy options. Additionally, Elevance Health prioritizes safety and quality by performing real-time checks when prescriptions are filled, ensuring appropriate usage within the benefit program.

Specialty drugs are one of the fastest-growing drivers of healthcare costs, and where they are administered matters. Hospital outpatient settings often charge significantly more for the same drugs than pharmacies. Specialty pharmacy and site-of-care programs, when clinically appropriate, can lower costs while maintaining safety and quality.

To tackle healthcare affordability more broadly, Elevance Health is committed to lowering costs through common-sense reforms, including fair hospital pricing, waste reduction, and improved drug price transparency. We acknowledge the frustration many families face due to rising premiums, co-pays, and out-of-pocket costs, and recognize our responsibility to deliver dependable coverage and protection against unexpected medical expenses. Our approach prioritizes affordability, aligning efforts to reduce administrative waste and fraud with policies designed to drive lasting cost reductions across the healthcare landscape.

Transparency and Communication with Members and Providers

Elevance Health is committed to meaningful healthcare transparency through personalized, actionable information that helps members make informed decisions. We provide clear explanations of coverage determinations, appeal rights, and clinical criteria to promote understanding of authorization and appeals processes. Members receive updated plan materials, determination notices, enhanced explanations of benefits, and timely notifications of pending changes through established channels.

Our Sydney Health App (Sydney) advances this commitment by providing convenient mobile access to real-time, personalized cost estimates based on a member's deductible, copays, provider selection, and prescription drug utilization. Through Sydney, members can review prices for provider visits, labs, and other procedures before scheduling care.

To reduce administrative barriers and avoid disruptions to treatment, we continue strengthening transparency in determinations and appeals pathways, aligning evidence-based clinical criteria with members' appeal rights to support trust and continuity of care

In addressing communication with healthcare providers, Elevance Health is similarly taking proactive steps to ensure greater transparency in prior authorization processes. Elevance Health has implemented several initiatives, such as providing clearer denial explanations to identify missing information, expanding real-time approval tools, and improving documentation guidance for providers.

Elevance Health is also committed to keeping providers up to date on changes to policies through provider bulletins, portal updates, webinars, and clinical policy documentation. By enhancing transparency in decision notices and appeal processes, Elevance Health helps providers navigate

prior authorization requirements more efficiently, fostering collaboration and delivering better care outcomes for our members. These measures demonstrate Elevance Health's focus on modernizing communication systems to strengthen the provider experience.

Technology and Innovation

Elevance Health is making significant investments in technology to enhance processes and improve experiences for both members and providers. As described above, we have made and continue to make investments in technology to improve the prior authorization experience for members and reduce the administrative burden on providers. We are also placing substantial resources into innovative technologies, like telehealth, to meet our members where they are and make it easier to receive access to high quality care when they need it. Additionally, Elevance Health makes sustained investments in cybersecurity across people, processes, and technology, including 24/7 monitoring, advanced security infrastructure, and regular testing and risk assessments. We treat cybersecurity as a continuous improvement discipline, not a one-time compliance exercise. Taken together, these investments aim to simplify healthcare administration, reduce barriers to care, and promote continuity of coverage while maintaining strong privacy and security protections.

Regulatory and Legislative Reform

Healthcare policy is set by elected officials and regulators, not by private companies. Our role is to share data, operational experience, and member impact considerations to help policymakers make informed decisions. There is no single solution to improving affordability across all health insurance markets, which is why we support bipartisan policy solutions that improve healthcare affordability, access, and quality. For example, we support a short-term extension of the enhanced ACA tax credits with guardrails; creating additional coverage options like expanding HSA eligibility and enhanced Association Health Plans; and Congress appropriating funding for cost-sharing reduction subsidies.

We also welcome a conversation on making reforms to the individual market Medical Loss Ratio (MLR). At the same time, from our perspective, the existing MLR safeguards are robust. The current 80% standard already provides strong consumer protection, and there's no evidence that raising it would meaningfully lower premiums or healthcare costs. Premiums are driven by the underlying cost of care—not health insurance carriers' margins—and increasing the MLR could impede product innovation and discourage investments in care management and quality improvement while increasing market volatility that reduces competition and choice. Ultimately, we recognize that lowering the cost of health care is the most effective path to affordability.

Provider Networks and Contracting

Elevance Health is taking proactive steps to enhance transparency, efficiency, and affordability with respect to provider networks and contracting. In addressing broader challenges in provider networks, Elevance Health emphasizes the importance of competition and value-driven reforms in concentrated provider markets. We advocate for policies that prioritize affordability, including

site-neutral payment structures, increased hospital pricing transparency, and incentives for high-quality care delivery. We also underscored our commitment to reducing administrative burdens and enabling reinvestment in value-based care by enhancing system efficiency and transparency in contract negotiations. These initiatives reflect our continued focus on ensuring that our members receive high-quality, affordable care, while also addressing structural issues that exist within the healthcare market.

We are also advocating for reforms to the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process. The No Surprises Act is protecting patients from surprise medical bills, but some healthcare providers – many owned by private equity and venture capital firms – are abusing the IDR arbitration process, which is driving up health insurance premiums. IDR filings exceeded 2.2 million cases in 2025—compared to an initial projection of about 17,000 annually—and median awards reached 459% of the QPA benchmark. Those costs ultimately raise premiums and out-of-pocket costs for families.

Consider a Spinal fusion (CPT 22612), one of the most expensive procedures based on arbitration awards, performed in Los Angeles, CA, where we have a robust offering of in-network providers performing the procedure:

- Medicare pays approximately $1,500 for a spinal fusion.
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- Nothing about the procedure or market changed, only the incentive structure did.

Under baseball-style arbitration, where higher numbers can prevail, providers rationally raise their offers and submit more cases. Meanwhile, the IDR Entities rely on arbitration fees for revenue, creating a system that rewards volume rather than efficient, market-based resolution.

The Honorable Diana Harshbarger (R-TN)

2. The 340B program allows eligible hospitals to purchase certain medicines at steeply discounted prices — sometimes for as little as a penny — while charging insurers and patients hundreds or thousands of dollars. MedPAC reports that more than half of all hospitals participate in 340B, and analysis has shown that these large margins encourage hospitals to buy up physician practices so they can extend 340B discounts to more patients, further fueling consolidation. These incentives also push hospitals to steer patients toward higher cost medicines to maximize revenue from the spread.

    a. As an insurer, do you believe it is fair for large hospital systems to acquire life saving medicines at essentially no cost and then bill insurers and patients at exponentially higher rates?

    b. And in your view, is the consolidation driven by these 340B incentives contributing to higher premiums for employers and families?

3. In behavioral health care, clinicians recommend treatment plans based on a patient's individual clinical needs. However, your plans frequently impose "fail first" requirements — insurance rules that deny coverage for a clinician-recommended treatment unless a patient first tries and fails one or more insurer-preferred options. These policies substitute insurer cost preferences for medical judgment, forcing patients to endure delays, medication changes, or ineffective care before accessing the treatment their doctor has already determined is appropriate. In mental health and substance use treatment, such forced delays and switches can destabilize patients and place their health and safety at serious risk.

    a. Why does a health insurance carrier such as yours continue to substitute insurer judgment for that of treating clinicians by requiring patients to "fail first" before receiving clinically appropriate care?

    b. Does your company require patients to try and fail first before you'll cover what their doctor originally prescribed?

    c. In mental health and substance use treatment, what happens to patients when you force them to wait and try treatments that their own doctor already determined likely won't work? Do they get better? Or do they get worse?

    d. When patients fail and perhaps relapse, does that cost more or less than covering the right treatment the first time?

    e. In effect, are you requiring patients to fail first to save money in the short term, even though it harms patients and costs more overall?

4. Can you explain how your company's Medicare Advantage claim denial rates compare to those for traditional Medicare, and what steps are you taking to ensure that denials do not disproportionately and severely burden at-risk rural hospitals already facing imminent financial collapse from delayed or reduced payments in underserved, low-wage index communities?

5. In light of reports showing that Medicare Advantage plans often receive significantly higher payments from the government through risk adjustment practices, how does your organization ensure that these additional funds translate into fair, timely, and adequate reimbursements for at-risk rural providers serving vulnerable, high-need populations in low-wage index regions?

6. What specific measures has your company implemented to address persistent complaints from at-risk rural hospitals about the use of proprietary algorithms that override treating physician judgments on medical necessity, potentially leading to dangerously extended patient stays, sharply increased costs, and heightened closure risks for those facilities?

7. Given the widening and unsustainable disparities in Medicare payments between urban and rural communities, how does your Medicare Advantage program account for the severe and unique challenges of low-wage index regions and other disadvantaged communities,

including dramatically higher operational costs relative to reimbursements that threaten the survival of essential community hospitals?

8. Could you detail your company's policies on post-acute care approvals for Medicare Advantage enrollees, and how these policies prevent unnecessary and harmful denials that burden at-risk rural hospitals with prolonged and costly inpatient care responsibilities in underserved areas?

9. How does your organization collaborate with at-risk rural hospitals to resolve payment disputes in Medicare Advantage claims, and what concrete metrics do you use to track resolution times in order to prevent further exacerbation of severe financial pressures on providers already at imminent risk of closure?

10. In areas where at-risk rural hospitals face imminent closure due to chronically inadequate reimbursements, what meaningful reforms to your Medicare Advantage payment models would you support to promote long-term financial stability and preserve essential access to care for vulnerable beneficiaries?

11. What data can you provide on the impact of your Medicare Advantage prior authorization requirements on at-risk rural hospitals, particularly regarding significant delays in patient discharges and the resulting devastating strain on already limited resources in underserved communities?

12. How does your company address concerns about retroactive downcoding of claims, which significantly reduces payments for services already provided and imposes crippling financial pressure on at-risk rural hospitals with minimal operating reserves?

13. What data can you provide on the frequency and financial impact of downcoding adjustments in Medicare Advantage claims submitted by at-risk rural hospitals, and what steps are you taking to ensure such adjustments are accurate, timely, and do not accelerate closure risks in low-wage index regions?

14. Considering the heavy reliance of underserved rural communities on Medicare Advantage for elderly and vulnerable care, what firm commitments can your organization make to reform denial, prior authorization, and downcoding practices that directly contribute to severe hospital financial instability and the potential loss of essential services?

15. With rural hospitals nationwide facing $1 billion in annual losses from declining reimbursement rates, what immediate actions will your company take to adjust Medicare Advantage policies and ensure equitable support for at-risk providers serving high proportions of Medicare and Medicaid patients in low-wage index communities?

16. KFF data reveal that only 11.7 percent of Medicare Advantage denials were appealed in 2023, with 82 percent overturned. What reforms is your organization pursuing to reduce initial denial rates and lessen the administrative burden on at-risk rural hospitals contesting these decisions?

17. With OIG estimates showing $7.5 billion in Medicare Advantage overpayments from unsupported diagnoses in 2023, what internal audits does your company conduct to prevent such waste while supporting the viability of at-risk rural hospitals?

Elevance Health's Response to Questions 2-17:

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workforce development, permanent telehealth flexibilities, integrated care models, and better data infrastructure.

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Provider Networks and Contracting

Elevance Health is taking proactive steps to enhance transparency, efficiency, and affordability with respect to provider networks and contracting. In addressing broader challenges in provider networks, Elevance Health emphasizes the importance of competition and value-driven reforms in concentrated provider markets. We advocate for policies that prioritize affordability, including site-neutral payment structures, increased hospital pricing transparency, and incentives for high-quality care delivery. We also underscored our commitment to reducing administrative burdens and enabling reinvestment in value-based care by enhancing system efficiency and transparency in contract negotiations. These initiatives reflect our continued focus on ensuring that our members receive high-quality, affordable care, while also addressing structural issues that exist within the healthcare market.

We are also advocating for reforms to the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process. The No Surprises Act is protecting patients from surprise medical bills, but some healthcare providers – many owned by private equity and venture capital firms – are abusing the IDR arbitration process, which is driving up health insurance premiums. IDR filings exceeded 2.2 million cases in 2025—compared to an initial projection of about 17,000 annually—and median awards reached 459% of the QPA benchmark. Those costs ultimately raise premiums and out-of-pocket costs for families.

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Under baseball-style arbitration, where higher numbers can prevail, providers rationally raise their offers and submit more cases. Meanwhile, the IDR Entities rely on arbitration fees for revenue, creating a system that rewards volume rather than efficient, market-based resolution.

Rural and Underserved Provider Support

Access to healthcare in rural areas, including doctors, hospitals, and pharmacies, is one of our top priorities. Rural healthcare providers are facing several challenges, including workforce shortages and increasing overhead costs. Elevance Health is committed to partnering with rural healthcare providers to ensure access to doctors, hospitals, and pharmacies for the consumers we serve. Our rural programs also reduce administrative burden and strengthen provider capacity through providing hands-on support and technology. We invest in scholarships, training, housing, and workforce development programs to build a sustainable rural healthcare pipeline. For example, we have committed $1 million to Texas Tech University Health Sciences Center to support workforce programs serving some of the most rural areas of the Permian Basin and West Texas.

Elevance Health recognizes that independent and rural pharmacies are essential to member care, particularly in underserved areas. We work with a broad range of pharmacies to ensure affordable access, supporting independent rural pharmacies while PBM-affiliated pharmacies help fill access gaps through home delivery and specialized services. We are also placing significant resources into innovative technologies, like telehealth, to meet members where they are and make it easier to receive access to high quality care when they need it.

The Honorable Earl L. "Buddy" Carter (R-GA)

2. After care is received, patients are the ones to face the repercussions of billing errors and overcharges without recourse due to a lack of price transparency. All too often, this ends in medical debt lawsuits, foreclosures, and wage garnishments.

    a. Are you confident in the accuracy and completeness of your Transparency in Coverage (TiC) Machine-Readable Files (MRFs)?

    b. Would you sign an attestation of such?

c. Would you oppose a requirement that a senior executive attest to the accuracy of your transparency data?

Elevance Health's Response to Question 2:

Transparency and Communication with Members and Providers

Elevance Health is committed to meaningful healthcare transparency through personalized, actionable information that helps members make informed decisions. We provide clear explanations of coverage determinations, appeal rights, and clinical criteria to promote understanding of authorization and appeals processes. Members receive updated plan materials, determination notices, enhanced explanations of benefits, and timely notifications of pending changes through established channels.

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To reduce administrative barriers and avoid disruptions to treatment, we continue strengthening transparency in determinations and appeals pathways, aligning evidence-based clinical criteria with members' appeal rights to support trust and continuity of care

In addressing communication with healthcare providers, Elevance Health is similarly taking proactive steps to ensure greater transparency in prior authorization processes. Elevance Health has implemented several initiatives, such as providing clearer denial explanations to identify missing information, expanding real-time approval tools, and improving documentation guidance for providers.

Elevance Health is also committed to keeping providers up to date on changes to policies through provider bulletins, portal updates, webinars, and clinical policy documentation. By enhancing transparency in decision notices and appeal processes, Elevance Health helps providers navigate prior authorization requirements more efficiently, fostering collaboration and delivering better care outcomes for our members. These measures demonstrate Elevance Health's focus on modernizing communication systems to strengthen the provider experience.

The Honorable Troy Balderson (R-OH)

2. I have heard concerns from healthcare providers about Third Party Administrators like Carelon Healthcare, a wholly owned subsidiary of Elevance Health. These concerns relate directly to patient access, clinical transparency, and adherence to Blue Cross Blue Shield's and the FDA-approved standards of care and established clinical guidelines.

3. Providers across the nation report that Carelon has unilaterally imposed more restrictive and non-transparent clinical criteria, created by the sole discretion of Carelon, that conflict with the published and publicly available BCBS medical policies for which they manage prior authorizations. This is often over the objections of treating physicians and their

patients. These actions have resulted in repeated denials, prolonged appeals, delayed treatment, and, in some cases, unnecessary patient risk and added cost.

Given Carelon's influence over access to FDA-approved therapies and its operation under financial models that may incentivize cost containment over patient access and outcomes, it is important to examine whether adequate oversight, safeguards, and accountability exist at the parent-company level.

With that responsibility in mind, I would like answers to the following questions.

a. Yes or no: Does Elevance Health provide financial incentives or performance bonuses to Carelon based on meeting specific 'utilization management' targets or

b. Yes or no: Can a policyholder be considered 'fully informed' if their coverage can be denied based on internal criteria that were not disclosed to them at the time of enrollment?

4. When individuals and families are comparing coverage options, how important is flexibility in plan design to helping them manage financial risk over the course of a year?

5. Are there technical areas of federal law where minor statutory clarifications could improve consumer options to better align coverage with their financial needs?

6. Thirty percent of adults with a mental health condition say they didn't get care because of problems with their health insurance.

   a. When your company makes it hard to find or denies recommended treatment, what happens to those patients--are the costs simply shifted to emergency rooms, public systems, and taxpayers?

Elevance Health's Response to Questions 2-6:

<u>Prior Authorization and Utilization Management</u>

Elevance Health is actively working to reduce the burden and delay often associated with prior authorizations, with the goal of improving members' access to treatment while ensuring care is clinically appropriate and safe. Although prior authorization currently applies to only about 3% of our claims, and the vast majority of requests are approved, Elevance Health has taken significant steps to modernize and streamline this process. For instance, Elevance Health has eliminated prior authorization requirements for over 400 services since January 1, 2024. We are also adopting interoperability standards and working with providers to facilitate bidirectional data exchange that simplifies and speeds the process for electronic submissions, reducing paperwork and incomplete requests.

Today, approximately 32% of prior authorization requests to our plans are still submitted via traditional methods, such as fax, mail, or phone, which can cause delays. To facilitate further adoption of electronic prior authorization, Elevance Health is investing in technology to expand electronic submission pathways and enable real-time approvals, with approximately two-thirds of

electronically submitted requests already being processed in real time. Additionally, Elevance Health will continue to review and streamline the overall volume of services subject to prior authorization while enhancing transparency in coverage determinations, including by providing clearer denial explanations and improved documentation guidance so providers know exactly what clinical information is required.

Elevance Health does not use artificial intelligence to deny prior authorization requests. Elevance Health conducts peer-to-peer reviews for prior authorization decisions by licensed clinicians, including physicians in the appropriate specialties, consistent with federal and state requirements. Elevance Health also honors existing authorizations during coverage transitions between plans for a period of 90 days to ensure continuity of care. Emergency care is never subject to prior authorization. When delays occur, they are often due to missing information – not denials – which is why Elevance Health is modernizing prior authorization processing with electronic tools and better data exchange to speed decisions and reduce burden. These reforms reflect Elevance Health's commitment to improving our members' access to care by promoting evidence-based treatment and reducing unnecessary delays.

Prescription Drug Coverage and Affordability

Elevance Health is taking proactive steps to enhance prescription drug coverage and affordability by implementing innovative tools and programs. That's why we built tools like EnsureRx, which automatically applies the lowest available price—covered or cash—on hundreds of medications at the pharmacy counter, which has helped more than 3 million people save over $94 million in one year. We recognize the importance of real-time affordability tools in allowing individuals to access cost-sharing information for prescription drugs based on their specific benefits and pharmacy options. Additionally, Elevance Health prioritizes safety and quality by performing real-time checks when prescriptions are filled, ensuring appropriate usage within the benefit program.

Specialty drugs are one of the fastest-growing drivers of healthcare costs, and where they are administered matters. Hospital outpatient settings often charge significantly more for the same drugs than pharmacies. Specialty pharmacy and site-of-care programs, when clinically appropriate, can lower costs while maintaining safety and quality.

To tackle healthcare affordability more broadly, Elevance Health is committed to lowering costs through common-sense reforms, including fair hospital pricing, waste reduction, and improved drug price transparency. We acknowledge the frustration many families face due to rising premiums, co-pays, and out-of-pocket costs, and recognize our responsibility to deliver dependable coverage and protection against unexpected medical expenses. Our approach prioritizes affordability, aligning efforts to reduce administrative waste and fraud with policies designed to drive lasting cost reductions across the healthcare landscape.

Transparency and Communication with Members and Providers

Elevance Health is committed to meaningful healthcare transparency through personalized, actionable information that helps members make informed decisions. We provide clear explanations of coverage determinations, appeal rights, and clinical criteria to promote

understanding of authorization and appeals processes. Members receive updated plan materials, determination notices, enhanced explanations of benefits, and timely notifications of pending changes through established channels.

Our Sydney Health App (Sydney) advances this commitment by providing convenient mobile access to real-time, personalized cost estimates based on a member's deductible, copays, provider selection, and prescription drug utilization. Through Sydney, members can review prices for provider visits, labs, and other procedures before scheduling care.

To reduce administrative barriers and avoid disruptions to treatment, we continue strengthening transparency in determinations and appeals pathways, aligning evidence-based clinical criteria with members' appeal rights to support trust and continuity of care

In addressing communication with healthcare providers, Elevance Health is similarly taking proactive steps to ensure greater transparency in prior authorization processes. Elevance Health has implemented several initiatives, such as providing clearer denial explanations to identify missing information, expanding real-time approval tools, and improving documentation guidance for providers.

Elevance Health is also committed to keeping providers up to date on changes to policies through provider bulletins, portal updates, webinars, and clinical policy documentation. By enhancing transparency in decision notices and appeal processes, Elevance Health helps providers navigate prior authorization requirements more efficiently, fostering collaboration and delivering better care outcomes for our members. These measures demonstrate Elevance Health's focus on modernizing communication systems to strengthen the provider experience.

Regulatory and Legislative Reform

Healthcare policy is set by elected officials and regulators, not by private companies. Our role is to share data, operational experience, and member impact considerations to help policymakers make informed decisions. There is no single solution to improving affordability across all health insurance markets, which is why we support bipartisan policy solutions that improve healthcare affordability, access, and quality. For example, we support a short-term extension of the enhanced ACA tax credits with guardrails; creating additional coverage options like expanding HSA eligibility and enhanced Association Health Plans; and Congress appropriating funding for cost-sharing reduction subsidies.

We also welcome a conversation on making reforms to the individual market Medical Loss Ratio (MLR). At the same time, from our perspective, the existing MLR safeguards are robust. The current 80% standard already provides strong consumer protection, and there's no evidence that raising it would meaningfully lower premiums or healthcare costs. Premiums are driven by the underlying cost of care—not health insurance carriers' margins—and increasing the MLR could impede product innovation and discourage investments in care management and quality improvement while increasing market volatility that reduces competition and choice. Ultimately, we recognize that lowering the cost of health care is the most effective path to affordability.

Behavioral and Mental Health Care Access

Elevance Health is actively working to expand access to high-quality behavioral and mental health care across all markets. Recognizing the significant 40% increase in mental health diagnoses between 2019 and 2024, Elevance Health has taken proactive steps to address the growing need for services despite a nationwide shortage of behavioral health providers. These efforts include expanding its networks by adding over 50,000 behavioral health providers and leveraging telemental health and other digital solutions to improve accessibility. Elevance Health is also investing in integrated care models, peer support, and care coordination for individuals with more complex needs, such as by connecting behavioral health services with primary care and chronic condition management.

Elevance Health has made significant strides in improving care delivery by addressing barriers, reducing stigma, and fostering continuity of care. At the same time, we recognize that while the demand for behavioral health services has grown dramatically, the availability of providers has not kept pace with the demand, and too many providers choose to not accept insurance. Expanding access to behavioral health services sustainably requires system-level solutions, including workforce development, permanent telehealth flexibilities, integrated care models, and better data infrastructure.

The Honorable Erin Houchin (R-IN)

2. Do your company's Medicare Advantage plans comply with the two-midnight rule as required by federal law?

    a. If so, would you oppose legislation imposing penalties or impacting star ratings for plans that do not comply?

3. How frequently do your company's Medicare Advantage plans use prior authorization requests compared to ten years ago?

4. Can you commit that, in peer-to-peer review processes, a provider can speak with a physician in the appropriate specialty to make a medical determination about a patient's care?

5. What are program fees intended for and what are they based on? These fees incentivize your company to inappropriately deny payments to doctors and hospitals for appropriately performed exams and procedures.

    a. Why are these fees not part of the routine services covered by the premiums paid to you to administer self-insured health plans?

6. Physician insurance payments have not kept pace with inflation and Medicare physician payments have stagnated over the past 20 years. How will your company ensure that rising health care costs will not result in downstream physician reimbursement cuts?

7. Insurance company contracting with Utilization Management vendors, like Optum, has resulted in an increase in denials for physician services. Payers are increasingly using

machine learning models to auto-deny high-cost encounters based only on claims and without any review of clinical documentation. "Downcoding" practices such as this coupled with prior authorization requirements, arbitrary codes, and modifier edits drive up prices, burden physician practices, and threaten small practice viability and access to care for patients.

a. How will insurers ensure fair medical review of clinician documentation for each patient and appropriate appeals processes and timelines?

8. Insurance carrier consolidation leads to fewer insurance plans competing in the marketplace, and the potential for rising premiums. How many competitors exist within your market and what restrictions on insurance company consolidations would you recommend?

9. Insurance network adequacy, lack of specialists and long wait times for appointments are ongoing issues. What is your plan doing to address these concerns?

10. As carriers increasingly rely on third party vendors such as Availity, Cotivity, Evicore, and Optum for claims reviews, prior authorizations, coding integrity, how are you monitoring third party vendors to ensure that their determinations are consistent with the plan member's benefits coverage and the physician contracts?

11. Physicians report that when appealing carrier denials, they are told the third party made the decision based on the vendor's algorithm. Shouldn't insurers have a responsibility much like employers' fiduciary responsibility on the behaviors of their contracted vendors?

12. The Medpac March 2025 report informed Congress that there are issues with Medicare Advantage (MA) plans related to coding intensity (upcoding), favorable selection, and market concentration. They estimated that Medicare Advantage plans have overcharged Medicare by at least $615 billion. Information like this makes the general public look at their unaffordable health care costs and wonder where all the money goes. What can you say about Medicare Advantage companies overcharging the government, and therefore the taxpayers?

13. Independent physicians are the backbone of our healthcare system. What are your companies doing to help ensure that continues to be true?

14. Administrative burdens from insurers are taking hours and hours from physicians and their staff every day contributing to their moral injury and burnout and taking away precious time that could be used for direct patient care. What are your companies doing to address this?

15. Which regulations currently in place should be repealed in order to make plans more affordable?

Elevance Health's Response to Questions 2-15:

<u>Prior Authorization and Utilization Management</u>

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Medicare Advantage Plan Practices

More than 34 million beneficiaries or nearly 55% of eligible beneficiaries, choose to enroll in Medicare Advantage plans. Medicare Advantage provides coordinated care, care management support, and an out-of-pocket maximum that traditional Medicare does not offer. In addition, Medicare Advantage bids average about 85% of fee-for-service costs, and independent analyses estimate Medicare Advantage costs about 10% less than fee-for-service on an apples-to-apples basis.

MA plans routinely bid below the benchmark set by the government and a portion of those savings go back to the Medicare Trust Funds. Up to 50% of the savings from bidding below the benchmark are required by statute to be returned to the Treasury; this happens before plans can even start to design the meaningful supplemental benefits that they provide to care for their members and to

remain competitive in the market. Based on our estimates, approximately $39 billion in annual savings go back to the Medicare Trust Funds because of plan bids below the benchmark
Elevance Health's Medicare Advantage plans comply with all applicable federal coverage requirements, including the two-midnight rule, and we administer benefits consistent with CMS regulations and guidance. Medicare Advantage plans, like ours, operate in a highly regulated environment, and our coverage determinations are subject to CMS oversight, audit, and enforcement. When CMS updates guidance, we update our policies accordingly to ensure alignment.

We support improving Medicare Advantage, and as a first step, we encourage Congress to pass Congressman Aaron Bean (R-FL)'s Apples-to-Apples Comparison Act of 2025. This legislation would require CMS to release the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. Current analyses by MedPAC lack the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. We believe this will give Congress critical information with which to consider any possible reforms based on facts, not assumptions. We also support improving the Medicare Advantage Star Ratings system to focus on health outcomes like reducing hospital readmissions and slowing the progression of chronic diseases over administrative processes.

Elevance Health is deeply committed to improving Medicare Advantage offerings while maintaining a focus on affordability, access, and quality for beneficiaries, the government, and taxpayers.

Regulatory and Legislative Reform

Healthcare policy is set by elected officials and regulators, not by private companies. Our role is to share data, operational experience, and member impact considerations to help policymakers make informed decisions. There is no single solution to improving affordability across all health insurance markets, which is why we support bipartisan policy solutions that improve healthcare affordability, access, and quality. For example, we support a short-term extension of the enhanced ACA tax credits with guardrails; creating additional coverage options like expanding HSA eligibility and enhanced Association Health Plans; and Congress appropriating funding for cost-sharing reduction subsidies.

We also welcome a conversation on making reforms to the individual market Medical Loss Ratio (MLR). At the same time, from our perspective, the existing MLR safeguards are robust. The current 80% standard already provides strong consumer protection, and there's no evidence that raising it would meaningfully lower premiums or healthcare costs. Premiums are driven by the underlying cost of care—not health insurance carriers' margins—and increasing the MLR could impede product innovation and discourage investments in care management and quality improvement while increasing market volatility that reduces competition and choice. Ultimately, we recognize that lowering the cost of health care is the most effective path to affordability.

Provider Networks and Contracting

Elevance Health is taking proactive steps to enhance transparency, efficiency, and affordability with respect to provider networks and contracting. In addressing broader challenges in provider networks, Elevance Health emphasizes the importance of competition and value-driven reforms in concentrated provider markets. We advocate for policies that prioritize affordability, including site-neutral payment structures, increased hospital pricing transparency, and incentives for high-quality care delivery. We also underscored our commitment to reducing administrative burdens and enabling reinvestment in value-based care by enhancing system efficiency and transparency in contract negotiations. These initiatives reflect our continued focus on ensuring that our members receive high-quality, affordable care, while also addressing structural issues that exist within the healthcare market.

We are also advocating for reforms to the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process. The No Surprises Act is protecting patients from surprise medical bills, but some healthcare providers – many owned by private equity and venture capital firms – are abusing the IDR arbitration process, which is driving up health insurance premiums. IDR filings exceeded 2.2 million cases in 2025—compared to an initial projection of about 17,000 annually—and median awards reached 459% of the QPA benchmark. Those costs ultimately raise premiums and out-of-pocket costs for families.

Consider a Spinal fusion (CPT 22612), one of the most expensive procedures based on arbitration awards, performed in Los Angeles, CA, where we have a robust offering of in-network providers performing the procedure:

- Medicare pays approximately $1,500 for a spinal fusion.
- In-network commercial rates cluster around $1,900.
- Anthem's payment offers are approximately $2,000.
- By contrast, the median provider reimbursement request in arbitration is approximately $100,000 per case—nearly 40 times the in-network market rate.
- Nothing about the procedure or market changed, only the incentive structure did.

Under baseball-style arbitration, where higher numbers can prevail, providers rationally raise their offers and submit more cases. Meanwhile, the IDR Entities rely on arbitration fees for revenue, creating a system that rewards volume rather than efficient, market-based resolution.

Technology and Innovation

Elevance Health is making significant investments in technology to enhance processes and improve experiences for both members and providers. As described above, we have made and continue to make investments in technology to improve the prior authorization experience for members and reduce the administrative burden on providers. We are also placing substantial resources into innovative technologies, like telehealth, to meet our members where they are and make it easier to receive access to high quality care when they need it. Additionally, Elevance Health makes sustained investments in cybersecurity across people, processes, and technology, including 24/7 monitoring, advanced security infrastructure, and regular testing and risk assessments. We treat cybersecurity as a continuous improvement discipline, not a one-time

compliance exercise. Taken together, these investments aim to simplify healthcare administration, reduce barriers to care, and promote continuity of coverage while maintaining strong privacy and security protections.

The Honorable Richard Hudson (R-NC)

1. North Carolina is home to one of the most vibrant life sciences ecosystems in the world. Tens of thousands of North Carolinians work in research, development and advanced manufacturing, ultimately affecting whether the next breakthrough therapy makes it from the lab to the people who need it.

    a. How do your coverage practices account for the long-term value of innovative therapies that may reduce hospitalizations or cure diseases?

    b. Do unpredictable formulary access and rebate demands discourage investment in new therapies, particularly for rare or complex diseases? In turn, costing more per patient in the long run?

2. Research showed that in 2025, more than 1,400 medicines were excluded from at least one of the three largest PBMs' standard commercial formularies.

    a. Given this trend, are PBMs driving higher spending for patients and employers by prioritizing products that yield the PBM more profit over those that offer lower net costs?

        i. It seems insurance companies frequently cite drug list prices as the cause of affordability issues. Can you state in general what manufacturers actually receive – net of rebates – for your top drugs?

        ii. How does that compare to patient out-of-pocket costs?

        iii. If manufacturers are providing larger rebates each year, why do patients continue to see rising out-of-pocket costs at the pharmacy counter?

        iv. Do higher rebates sometimes result in higher list prices?

        v. How much of the rebate revenue generated by manufacturers is retained by your PBM rather than used to reduce patient costs?

3. The research institute RTI International found patients must go out of network for mental health care three-and-a-half times more often than for physical health care—showing that providers exist, but they aren't in your networks. RTI also found that, compared to Medicare, insurers pay physical health clinicians 22 percent more than behavioral health providers. When you underpay mental health providers and layer on burdensome insurer requirements, clinicians leave your networks. That leaves your policyholders with too few in-network options and forces families to pay far more out of pocket—or go without care.

a. Why are the reimbursements so much lower for mental health providers resulting in inadequate networks?

b. Would this saddle more out-of-pocket costs for families?

c. Would this shift costs to emergency rooms, public systems and taxpayers?

d. What steps will your companies take to stop these cost shifts?

e. What do you all cover compared to Medicare, Medicaid and TRICARE as it relates to mental health services?

Elevance Health's Response to Questions 1-3:

Behavioral and Mental Health Care Access

Elevance Health is actively working to expand access to high-quality behavioral and mental health care across all markets. Recognizing the significant 40% increase in mental health diagnoses between 2019 and 2024, Elevance Health has taken proactive steps to address the growing need for services despite a nationwide shortage of behavioral health providers. These efforts include expanding its networks by adding over 50,000 behavioral health providers and leveraging telemental health and other digital solutions to improve accessibility. Elevance Health is also investing in integrated care models, peer support, and care coordination for individuals with more complex needs, such as by connecting behavioral health services with primary care and chronic condition management.

Elevance Health has made significant strides in improving care delivery by addressing barriers, reducing stigma, and fostering continuity of care. At the same time, we recognize that while the demand for behavioral health services has grown dramatically, the availability of providers has not kept pace with the demand, and too many providers choose to not accept insurance. Expanding access to behavioral health services sustainably requires system-level solutions, including workforce development, permanent telehealth flexibilities, integrated care models, and better data infrastructure.

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Elevance Health is taking proactive steps to enhance prescription drug coverage and affordability by implementing innovative tools and programs. That's why we built tools like EnsureRx, which automatically applies the lowest available price—covered or cash—on hundreds of medications at the pharmacy counter, which has helped more than 3 million people save over $94 million in one year. We recognize the importance of real-time affordability tools in allowing individuals to access cost-sharing information for prescription drugs based on their specific benefits and pharmacy options. Additionally, Elevance Health prioritizes safety and quality by performing real-time checks when prescriptions are filled, ensuring appropriate usage within the benefit program.
Specialty drugs are one of the fastest-growing drivers of healthcare costs, and where they are administered matters. Hospital outpatient settings often charge significantly more for the same

drugs than pharmacies. Specialty pharmacy and site-of-care programs, when clinically appropriate, can lower costs while maintaining safety and quality.

To tackle healthcare affordability more broadly, Elevance Health is committed to lowering costs through common-sense reforms, including fair hospital pricing, waste reduction, and improved drug price transparency. We acknowledge the frustration many families face due to rising premiums, co-pays, and out-of-pocket costs, and recognize our responsibility to deliver dependable coverage and protection against unexpected medical expenses. Our approach prioritizes affordability, aligning efforts to reduce administrative waste and fraud with policies designed to drive lasting cost reductions across the healthcare landscape.

Technology and Innovation

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The Honorable August Pfluger (R-TX)

1. You are one of the largest purchasers of health care in America with massive data analytics capabilities. Despite your market dominance, your vertical integration, and your claims about negotiating power, costs keep rising faster than the underlying medical expenses.

    a. If your business models are designed to reduce costs, why are premium increases running at rates three times faster than hospital cost increases?

    b. What value are you providing to employers and families paying these premiums?

    c. What are the top three things your company does to rein in underlying gross premium increases across the commercial marketplace? Please quantify their impact in any way you can.

    d. How do your companies currently or are planning to deploy technology to increase patient affordability?

2. What are the specific federal regulations or policies that you believe contribute to rising health care costs?

a. What regulatory changes would you support to improve affordability for consumers?

i. Additionally, some argue the Medical Loss Ratio creates perverse incentives, specifically that capping profit as a percentage means the only way to grow profits is to grow total spending. Do you agree with that criticism? If not, explain how MLR doesn't incentivize premium inflation.

3. You are receiving payments from the federal government that are benchmarked to Traditional Medicare rates. Where is that money going if it is not going to the rural hospitals providing care?

4. Can you explain why you believe it is appropriate to pay rural hospitals—which already operate on razor-thin margins and are closing at alarming rates—less than Traditional Medicare?

5. What specific, concrete actions are your company and affiliates taking—or willing to commit to taking—to ensure that your Medicare Advantage plans support rural hospitals rather than drive them out of business?

a. Will you commit to payment parity with Traditional Medicare for Critical Access Hospitals?

b. Will you commit to 24-hour turnaround times on prior authorizations for rural providers?

c. Will you commit to reducing administrative burdens on rural providers? If so, how?

6. Ground ambulance services are often out-of-network, even though they are the only emergency option for rural patients. Rural hospitals report payment delays and below-cost reimbursement, contributing to closures. Will Elevance Health commit to:

a. Standardized reimbursement for emergency services that patients cannot shop for?

b. Transparent payment methodologies with denial rate caps and interest on late payments to stabilize rural providers?

7. A 12-employee community bank in my district faced a $100,000 annual premium increase. Small employers across TX-11 report double-digit increases without improved access or outcomes. Many are dropping coverage.

a. What are you doing to ensure that small employers—who lack the negotiating power of large corporations—are not priced out of offering health insurance to their employees?

8. Does your company require peer-to-peer reviews for prior authorizations? If so:

a. What are the qualifications of the physicians conducting these reviews? Are they required to be board-certified in the same specialty as the treating physician?

b. What is the average length of a peer-to-peer review call?

i. Do you track how many of these calls are terminated by the treating physician due to time constraints?

a. Do you allow treating physicians to designate a qualified staff member to participate in peer-to-peer reviews on their behalf, or do you require the treating physician to personally participate in peer-to-peer reviews?

9. How many and what percentage of total prior authorization requests are denied each year specifically because the treating physician was "unavailable" or "refused to discuss" the case during a peer-to-peer review?

a. What percentage of these denials are later overturned on appeal?

10. Do you track the time burden your peer-to-peer review process places on treating physicians?

a. Have you studied whether this process delays medically necessary care?

11. When a rural hospital with limited staff submits a prior authorization request for a patient who is medically ready for discharge, how long does that process take on average?

a. Do you track denial rates and processing times by geographic location—specifically, are rural providers treated differently than urban providers?

12. Will you commit to:

a. Requiring that peer-to-peer reviews be conducted by physicians board-certified in the same specialty as the treating physician?

b. Allowing treating physicians to designate qualified staff to participate in peer-to-peer reviews?

c. Establishing reasonable time limits for peer-to-peer reviews and not penalizing physicians who must end calls to see patients?

d. Publicly reporting prior authorization approval rates and processing times, broken down by rural versus urban providers?

e. Publicly reporting the number of prior authorizations denied due to physician "unavailability" and the overturn rate on appeal?

Elevance Health's Response to Questions 1-12:

<u>Prior Authorization and Utilization Management</u>

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Elevance Health is deeply committed to improving Medicare Advantage offerings while maintaining a focus on affordability, access, and quality for beneficiaries, the government, and taxpayers.

Rural and Underserved Provider Support

Access to healthcare in rural areas, including doctors, hospitals, and pharmacies, is one of our top priorities. Rural healthcare providers are facing several challenges, including workforce shortages and increasing overhead costs. Elevance Health is committed to partnering with rural healthcare providers to ensure access to doctors, hospitals, and pharmacies for the consumers we serve. Our rural programs also reduce administrative burden and strengthen provider capacity through providing hands-on support and technology. We invest in scholarships, training, housing, and workforce development programs to build a sustainable rural healthcare pipeline. For example, we have committed $1 million to Texas Tech University Health Sciences Center to support workforce programs serving some of the most rural areas of the Permian Basin and West Texas.

Elevance Health recognizes that independent and rural pharmacies are essential to member care, particularly in underserved areas. We work with a broad range of pharmacies to ensure affordable access, supporting independent rural pharmacies while PBM-affiliated pharmacies help fill access gaps through home delivery and specialized services. We are also placing significant resources into innovative technologies, like telehealth, to meet members where they are and make it easier to receive access to high quality care when they need it.

Prescription Drug Coverage and Affordability

Elevance Health is taking proactive steps to enhance prescription drug coverage and affordability by implementing innovative tools and programs. That's why we built tools like EnsureRx, which

automatically applies the lowest available price—covered or cash—on hundreds of medications at the pharmacy counter, which has helped more than 3 million people save over $94 million in one year. We recognize the importance of real-time affordability tools in allowing individuals to access cost-sharing information for prescription drugs based on their specific benefits and pharmacy options. Additionally, Elevance Health prioritizes safety and quality by performing real-time checks when prescriptions are filled, ensuring appropriate usage within the benefit program.

Specialty drugs are one of the fastest-growing drivers of healthcare costs, and where they are administered matters. Hospital outpatient settings often charge significantly more for the same drugs than pharmacies. Specialty pharmacy and site-of-care programs, when clinically appropriate, can lower costs while maintaining safety and quality.

To tackle healthcare affordability more broadly, Elevance Health is committed to lowering costs through common-sense reforms, including fair hospital pricing, waste reduction, and improved drug price transparency. We acknowledge the frustration many families face due to rising premiums, co-pays, and out-of-pocket costs, and recognize our responsibility to deliver dependable coverage and protection against unexpected medical expenses. Our approach prioritizes affordability, aligning efforts to reduce administrative waste and fraud with policies designed to drive lasting cost reductions across the healthcare landscape.

Technology and Innovation

Elevance Health is making significant investments in technology to enhance processes and improve experiences for both members and providers. As described above, we have made and continue to make investments in technology to improve the prior authorization experience for members and reduce the administrative burden on providers. We are also placing substantial resources into innovative technologies, like telehealth, to meet our members where they are and make it easier to receive access to high quality care when they need it. Additionally, Elevance Health makes sustained investments in cybersecurity across people, processes, and technology, including 24/7 monitoring, advanced security infrastructure, and regular testing and risk assessments. We treat cybersecurity as a continuous improvement discipline, not a one-time compliance exercise. Taken together, these investments aim to simplify healthcare administration, reduce barriers to care, and promote continuity of coverage while maintaining strong privacy and security protections.

Regulatory and Legislative Reform

Healthcare policy is set by elected officials and regulators, not by private companies. Our role is to share data, operational experience, and member impact considerations to help policymakers make informed decisions. There is no single solution to improving affordability across all health insurance markets, which is why we support bipartisan policy solutions that improve healthcare affordability, access, and quality. For example, we support a short-term extension of the enhanced ACA tax credits with guardrails; creating additional coverage options like expanding HSA eligibility and enhanced Association Health Plans; and Congress appropriating funding for cost-sharing reduction subsidies.

We also welcome a conversation on making reforms to the individual market Medical Loss Ratio (MLR). At the same time, from our perspective, the existing MLR safeguards are robust. The current 80% standard already provides strong consumer protection, and there's no evidence that raising it would meaningfully lower premiums or healthcare costs. Premiums are driven by the underlying cost of care—not health insurance carriers' margins—and increasing the MLR could impede product innovation and discourage investments in care management and quality improvement while increasing market volatility that reduces competition and choice. Ultimately, we recognize that lowering the cost of health care is the most effective path to affordability.

Provider Networks and Contracting

Elevance Health is taking proactive steps to enhance transparency, efficiency, and affordability with respect to provider networks and contracting. In addressing broader challenges in provider networks, Elevance Health emphasizes the importance of competition and value-driven reforms in concentrated provider markets. We advocate for policies that prioritize affordability, including site-neutral payment structures, increased hospital pricing transparency, and incentives for high-quality care delivery. We also underscored our commitment to reducing administrative burdens and enabling reinvestment in value-based care by enhancing system efficiency and transparency in contract negotiations. These initiatives reflect our continued focus on ensuring that our members receive high-quality, affordable care, while also addressing structural issues that exist within the healthcare market.

We are also advocating for reforms to the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process. The No Surprises Act is protecting patients from surprise medical bills, but some healthcare providers – many owned by private equity and venture capital firms – are abusing the IDR arbitration process, which is driving up health insurance premiums. IDR filings exceeded 2.2 million cases in 2025—compared to an initial projection of about 17,000 annually—and median awards reached 459% of the QPA benchmark. Those costs ultimately raise premiums and out-of-pocket costs for families.

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Under baseball-style arbitration, where higher numbers can prevail, providers rationally raise their offers and submit more cases. Meanwhile, the IDR Entities rely on arbitration fees for revenue, creating a system that rewards volume rather than efficient, market-based resolution.

The Honorable Diana DeGette (D-CO)

7. Individuals with chronic conditions like type 1 diabetes rely on drugs and medical devices to effectively manage their condition. Many such individuals report unaffordable and increasing cost sharing for items and services that are used to manage their condition.

    a. For calendar years 2024 and 2025, what was the total out-of-pocket spend by your plan members on managing a chronic condition?

        i. In terms of percentage of total out-of-pocket spending?

    b. Do individuals who do not adhere to chronic disease management regimens prescribed by their health care providers tend to consume more or fewer health care resources than those who do (i.e., are non-adherent patients more expensive)?

    c. Please describe the process to determine cost-sharing for chronic disease management items and services.

    d. Please describe any effort by your company to ensure cost-sharing is affordable for items and services prescribed to an individual with a chronic disease for the purposes of managing that disease.

Elevance Health's Response to Question 7:

Prescription Drug Coverage and Affordability

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To tackle healthcare affordability more broadly, Elevance Health is committed to lowering costs through common-sense reforms, including fair hospital pricing, waste reduction, and improved drug price transparency. We acknowledge the frustration many families face due to rising premiums, co-pays, and out-of-pocket costs, and recognize our responsibility to deliver dependable coverage and protection against unexpected medical expenses. Our approach prioritizes affordability, aligning efforts to reduce administrative waste and fraud with policies designed to drive lasting cost reductions across the healthcare landscape.

The Honorable Robin L. Kelly (D-IL)

1. Investigative reporting by ProPublica, based on interviews with hundreds of behavioral health providers, documents widespread delayed payments, aggressive retrospective audits, and post-payment clawbacks — sometimes years after care was delivered. Providers report that these practices are pushing them out of insurance networks, which shrinks in-network mental health access, and forces patients to pay more out of pocket or go without care.

    a. Given the impact on patients' access and affordability, does your company do retrospective audits that claw back payment for services that have already been delivered and paid for?

    b. If so, how many mental health and substance use disorder patients had claims that were clawed back last year?

2. ASCO's national surveys show that more than 95 percent of oncology practices report treatment delays due to prior authorization, with many delays measured in weeks.

    a. Will you commit, on the record, that no patient with a confirmed cancer diagnosis should experience a delay in evidence-based treatment because of prior authorization—and if not, why?

Elevance Health's Response to Questions 1 & 2:

Prior Authorization and Utilization Management

Elevance Health is actively working to reduce the burden and delay often associated with prior authorizations, with the goal of improving members' access to treatment while ensuring care is clinically appropriate and safe. Although prior authorization currently applies to only about 3% of our claims, and the vast majority of requests are approved, Elevance Health has taken significant steps to modernize and streamline this process. For instance, Elevance Health has eliminated prior authorization requirements for over 400 services since January 1, 2024. We are also adopting interoperability standards and working with providers to facilitate bidirectional data exchange that simplifies and speeds the process for electronic submissions, reducing paperwork and incomplete requests.

Today, approximately 32% of prior authorization requests to our plans are still submitted via traditional methods, such as fax, mail, or phone, which can cause delays. To facilitate further adoption of electronic prior authorization, Elevance Health is investing in technology to expand electronic submission pathways and enable real-time approvals, with approximately two-thirds of electronically submitted requests already being processed in real time. Additionally, Elevance Health will continue to review and streamline the overall volume of services subject to prior authorization while enhancing transparency in coverage determinations, including by providing clearer denial explanations and improved documentation guidance so providers know exactly what clinical information is required.

Elevance Health does not use artificial intelligence to deny prior authorization requests. Elevance Health conducts peer-to-peer reviews for prior authorization decisions by licensed clinicians, including physicians in the appropriate specialties, consistent with federal and state requirements. Elevance Health also honors existing authorizations during coverage transitions between plans for a period of 90 days to ensure continuity of care. Emergency care is never subject to prior authorization. When delays occur, they are often due to missing information – not denials – which is why Elevance Health is modernizing prior authorization processing with electronic tools and better data exchange to speed decisions and reduce burden. These reforms reflect Elevance Health's commitment to improving our members' access to care by promoting evidence-based treatment and reducing unnecessary delays.

Behavioral and Mental Health Care Access

Elevance Health is actively working to expand access to high-quality behavioral and mental health care across all markets. Recognizing the significant 40% increase in mental health diagnoses between 2019 and 2024, Elevance Health has taken proactive steps to address the growing need for services despite a nationwide shortage of behavioral health providers. These efforts include expanding its networks by adding over 50,000 behavioral health providers and leveraging telemental health and other digital solutions to improve accessibility. Elevance Health is also investing in integrated care models, peer support, and care coordination for individuals with more complex needs, such as by connecting behavioral health services with primary care and chronic condition management.

Elevance Health has made significant strides in improving care delivery by addressing barriers, reducing stigma, and fostering continuity of care. At the same time, we recognize that while the demand for behavioral health services has grown dramatically, the availability of providers has not kept pace with the demand, and too many providers choose to not accept insurance. Expanding access to behavioral health services sustainably requires system-level solutions, including workforce development, permanent telehealth flexibilities, integrated care models, and better data infrastructure.

The Honorable Nanette D. Barragán (D-CA)

1. Analyses show that copay accumulators are not keeping premiums low, and eliminating copay accumulators isn't raising drug prices.

    a. Given the evidence, what is the justification for continuing copay accumulator programs?

    b. If you can't point to patient benefit or premium savings, why should Congress not move to prohibit them, seeing as they cause harm to patients?

    c. Would you commit to take steps to remove these policies from your health plans?

2. A ProPublica investigation into Cigna found that the company built a system that let its doctors reject claims 'without opening the patient file' — with one former Cigna doctor

saying, 'We literally click and submit.' Over just two months, Cigna doctors denied more than 300,000 claims this way, spending about 1.2 seconds on each. Claims are not just numbers; they represent a loved one's treatment for cancer, opioid addiction, autoimmune diseases, and depression. While these practices predate artificial intelligence (AI), AI now allows insurers to deny care at unprecedented speed and scale.

a. Given that reality, would you support 1) a clear ban prohibiting AI from denying care and 2) a requirement that any denial be based on an individualized review by a licensed clinician with appropriate training and experience in that specific type of care—especially when only 16 percent of physicians report that insurer "peer reviewers" have the appropriate qualifications?

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Medicare Advantage Plan Practices

More than 34 million beneficiaries or nearly 55% of eligible beneficiaries, choose to enroll in Medicare Advantage plans. Medicare Advantage provides coordinated care, care management support, and an out-of-pocket maximum that traditional Medicare does not offer. In addition, Medicare Advantage bids average about 85% of fee-for-service costs, and independent analyses estimate Medicare Advantage costs about 10% less than fee-for-service on an apples-to-apples basis.

MA plans routinely bid below the benchmark set by the government and a portion of those savings go back to the Medicare Trust Funds. Up to 50% of the savings from bidding below the benchmark are required by statute to be returned to the Treasury; this happens before plans can even start to design the meaningful supplemental benefits that they provide to care for their members and to remain competitive in the market. Based on our estimates, approximately $39 billion in annual savings go back to the Medicare Trust Funds because of plan bids below the benchmark

Elevance Health's Medicare Advantage plans comply with all applicable federal coverage requirements, including the two-midnight rule, and we administer benefits consistent with CMS regulations and guidance. Medicare Advantage plans, like ours, operate in a highly regulated environment, and our coverage determinations are subject to CMS oversight, audit, and enforcement. When CMS updates guidance, we update our policies accordingly to ensure alignment.

We support improving Medicare Advantage, and as a first step, we encourage Congress to pass Congressman Aaron Bean (R-FL)'s Apples-to-Apples Comparison Act of 2025. This legislation would require CMS to release the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. Current analyses by MedPAC lack the necessary data to perform an accurate cost comparison of Medicare Advantage and original Medicare. We believe this will give Congress critical information with which to consider any possible reforms based on facts, not assumptions. We also support improving the Medicare Advantage Star Ratings system to focus on health outcomes like reducing hospital readmissions and slowing the progression of chronic diseases over administrative processes.

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The Honorable Kim Schrier (D-WA)

2. Through the No Surprises Act, Congress sought to maintain a level playing field between insurance companies and health care providers – giving both sides a reason to pursue in-network contracts, to prevent out-of-network care. I have heard concerns that some providers who offer care covered under the No Surprises Act have had their contracts terminated by insurance companies, increasing the out-of-network care they provide. While patients are protected from certain out-of-network bills under the No Surprises Act, I am concerned that network adequacy may suffer as a result of cancelled contracts.

    a. How has your rate of in-network and out-of-network care changed since implementation of the law?

    b. What steps are you taking to bring more providers in-network, which would reduce the need for the payment resolution provisions of the No Surprises Act?

    c. Given what is known about payment dispute resolution outcomes, is this information being used to inform in-network contract negotiations?

4. Anthem has implemented a policy that financially penalizes hospitals for the use of out-of-network providers and has threatened network exclusion if hospitals do not compel affiliated medical groups to accept Anthem's contracting terms. I am deeply concerned about how this policy could impact patient access to care. How does threatening to remove hospitals from the network improve patient access to care?

    a. How has Anthem evaluated whether these policies reduce access to timely care and/or limit patient choice?

    b. Would you agree that contract negotiations should be done in a balanced, good faith manner?

c. Does threatening a doctor's hospital seem like a balanced, good faith approach? The No Surprises Act already has a dispute resolution mechanism for out-of-network care received at in-network hospitals. However, this policy appears to be an effort to bypass the federally-legislated solution to resolve payment disputes such as this.

Elevance Health's Response to Questions 2 and 4:

Provider Networks and Contracting

Elevance Health is taking proactive steps to enhance transparency, efficiency, and affordability with respect to provider networks and contracting. In addressing broader challenges in provider networks, Elevance Health emphasizes the importance of competition and value-driven reforms in concentrated provider markets. We advocate for policies that prioritize affordability, including site-neutral payment structures, increased hospital pricing transparency, and incentives for high-quality care delivery. We also underscored our commitment to reducing administrative burdens and enabling reinvestment in value-based care by enhancing system efficiency and transparency in contract negotiations. These initiatives reflect our continued focus on ensuring that our members receive high-quality, affordable care, while also addressing structural issues that exist within the healthcare market.

We are also advocating for reforms to the No Surprises Act (NSA) Independent Dispute Resolution (IDR) process. The No Surprises Act is protecting patients from surprise medical bills, but some healthcare providers – many owned by private equity and venture capital firms – are abusing the IDR arbitration process, which is driving up health insurance premiums. IDR filings exceeded 2.2 million cases in 2025—compared to an initial projection of about 17,000 annually—and median awards reached 459% of the QPA benchmark. Those costs ultimately raise premiums and out-of-pocket costs for families.

Consider a Spinal fusion (CPT 22612), one of the most expensive procedures based on arbitration awards, performed in Los Angeles, CA, where we have a robust offering of in-network providers performing the procedure:

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Under baseball-style arbitration, where higher numbers can prevail, providers rationally raise their offers and submit more cases. Meanwhile, the IDR Entities rely on arbitration fees for revenue, creating a system that rewards volume rather than efficient, market-based resolution.

The Honorable Lizzie Fletcher (D-TX)

1. Some of the proposals to lower health care costs include shifting people onto non-Affordable Care Act insurance products—also known as junk insurance—that can discriminate against people with pre-existing conditions and fail to cover basic health care needs. Junk insurance plans also pull younger, generally healthier people away from the ACA Marketplaces— further increasing costs for everyone. In Elevance's Q3 quarterly earnings call last year— your company explained this problem, stating "If the enhanced advanced premium tax credits were to expire at year-end. We'd expect a material contraction in the ACA Marketplace. We've seen some of those independent estimates from the Congressional Budget Office which indicate meaningfully lower enrollments and a much higher morbidity risk pool into 2026 ... [a] smaller, more acute pool does mean fewer enrollees just spray risk and sharper premium increases. And that's really what we're seeing."

    a. Do you expect that healthier individuals will drop ACA coverage this year?

    b. And what do you expect that to do to premiums for ACA coverage into the future?

Elevance Health's Response to Question 1:

<u>Provider Networks and Contracting</u>

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The Honorable Troy A. Carter (D-LA)

3. Prior authorization and step therapy in behavioral health frequently disrupts ongoing care, wastes critical time, and creates dangerous gaps in treatment. More than 90 percent of physicians have reported that prior authorization negatively impacts patients' health. Removing prior authorization in behavioral health has been shown by numerous studies to increase treatment initiation, reduce relapse rates, and prevent emergency department visits.

    a. Given that evidence, does your plan continue to require prior authorization and/or step therapy for behavioral health services—despite knowing it destabilizes patients, increases downstream costs, and ultimately shifts those costs to taxpayers through emergency care and public programs?

    b. Are you aware that studies show removing prior authorization in behavioral health increases treatment initiation and reduces emergency department visits?

Elevance Health's Response to Questions 3:

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