**Elevance Health's March 27, 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**

**<u>The Honorable Troy Balderson (R-OH)</u>**

1. Ms. Boudreaux, I have become aware of a policy that providers are quite concerned about, in my district and beyond. This policy makes reimbursement for critical care more difficult, which I imagine is the intention.

   Beginning on April 1, 2026, Anthem will implement a new facility reimbursement policy titled Critical Care to Home. This new policy allows critical care services to be reimbursed except for—in what sounds to me like a very common situation— an individual presents in the emergency room in need of critical care - maybe they are showing signs of a heart attack or anaphylaxis. However, they are discharged once their condition has improved.

   I understand the emergency room is a very expensive care setting. I also understand not everyone is so lucky to be discharged following a medical event.

   a. Can you please walk me through the rationale behind [Anthem's new facility reimbursement policy "Critical Care to Home" beginning 4/1/26]? And, how are you balancing patient needs while curtailing the cost of health care?

**Elevance Health's Response to Question 1:**

Tackling affordability requires addressing the underlying cost drivers throughout the health care system—including hospital prices and prescription drug spending. While no single policy will solve the affordability problem, we support reforms that increase transparency and reduce waste across the system.

Our focus is on competition, transparency, and accountability across the system, and on addressing the biggest cost drivers, including hospital pricing power and high-cost drugs. Health care markets are local, and concentration varies by region - hospital systems or specialty providers that hold the greatest market power can, and do, drive higher prices because they are essential for access. By contrast, health insurance providers compete actively on premiums, benefits, networks, and service under extensive state and federal oversight. Elevance Health supports policies that strengthen competition and transparency wherever concentration exists to protect consumers. Our responsibility is to ensure people can access care, especially where a hospital system is essential for emergency or specialty services.

We support the intent of the No Surprises Act—to protect patients from unexpected medical bills and to create a fair, balanced process for resolving payment disputes. In principle, the Independent Dispute Resolution ("IDR") mechanism has the potential to resolve such disputes. However, a subset of out-of-network providers, particularly in high-cost planned elective specialties, are abusing the IDR process to seek payments multiple times higher than market rates.

The IDR process includes a third-party arbitration approach designed to resolve payment disputes between out-of-network care providers and the health insurance providers who represent patients and employers. In the "baseball-style" arbitration system enacted by Congress, each side submits a proposed payment amount, and the arbitrator must choose one offer – no negotiation. In practice, IDR outcomes have skewed heavily toward providers, with approximately 88% of determinations selecting provider offers—and some Independent Dispute Resolution Entities (IDREs) doing so more than 98% of the time—raising concerns about inconsistent application of statutory criteria and a departure from Congress's intent. This imbalance reflects both variability across IDREs and structural incentives within the process: because IDREs are compensated only when disputes are advanced and deemed eligible, there is a built-in incentive to move claims forward, including potentially ineligible ones. Coupled with limited eligibility screening and insufficient adherence to the Qualifying Payment Amount (QPA) as the central guiding benchmark—particularly where awards significantly exceed in-network rates without clear justification—these dynamics are driving volume and upward cost pressure.

As a result, the IDR process has been transformed into a powerful revenue generation tool that discourages in-network participation, interferes with market dynamics and drives up costs for employers and families. This is evident by the industry that has sprung up around regularly exploiting this pricy loophole – companies like the ironically named HaloMD.

The statistics related to IDR are concerning:

- More than 2.4 million IDR disputes were filed in 2025. That's about 150 times the government's initial projection.
- The Centers for Medicare & Medicaid Services (CMS) reported that in the first half of 2025, roughly 88% of IDR decisions sided with providers – with our data showing some IDR entities selecting provider offers over 98% of the time.
- For a routine hammertoe procedure, Medicare pays roughly $450 and employer-based insurance pays about $600. Through the IDR process, this routine procedure is resulting in average awards of $20,000.
- One emergency physician practice in Indiana submitted the same emergency medicine code to IDR 180 times. Our health plan offer was always $255, consistent with what we pay our in-network providers. The provider requested and was awarded $2,461 on all 180 disputes, approximately 10 times more than market norms.

A recent national survey of health plans conducted by AHIP and the Blue Cross Blue Shield Association found that nearly 40% of disputes submitted to IDR in 2024 were identified as ineligible under the rules Congress established. Yet many of these cases still moved through arbitration instead of being screened out. Providers and revenue management companies are often using IDR as a revenue strategy and taking advantage of limited enforcement of eligibility standards. IDREs, that are paid only when cases proceed to the payment determination stage, and who have a financial interest in a high volume of IDR disputes, have an incentive to allow these ineligible disputes to move forward, further distorting outcomes.

Consider a Spinal fusion (CPT 22612), one of the most expensive procedures based on arbitration awards, performed in Los Angeles, CA, where Elevance Health plans 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.

We are fully engaged, and we have made significant investments in technology and staffing to support implementation of the IDR process. In addition, we are making offers in IDR that are consistent with market pricing. Our offers are based on real market data, reflecting typical in-network rates. Even so, arbitrators regularly side with care providers, for amounts that are several times higher than typical in-network rates, Medicare rates, or the QPA and, in some cases, exceed the requesting provider's own billed charges.

These dynamics increase costs for employer-funded health plans and ultimately drive higher premiums and out-of-pocket costs for consumers, undermining affordability and the intent of the law. Elevance Health is pleased to assist the Committee in developing legislation to ensure that the IDR mechanism works as intended.

While we continue to advocate for changes and improvements to the IDR process with Congress and CMS, we are taking action, including with an administrative policy, to protect our customers from the abusive behavior that is driving up the cost of their health insurance premiums and out-of-pocket costs.

Elevance Health implemented a facility administrative policy, effective January 1, 2026, that applies a 10% payment adjustment to in-network hospitals that use out-of-network clinicians for scheduled, non-emergency care. The policy addresses a loophole in the current system where out-of-network clinicians participate in scheduled care at in-network facilities and then use the IDR process to secure payments well above in-network rates, even when in-network options are available. The policy applies only in these scheduled, non-emergency situations and does not apply to emergency care under any circumstances.

Additionally, this policy excludes critical access hospitals, designated rural facilities, safety net hospitals, emergency services, when a patient has a prior authorization for out-of-network services, and when an in-network provider of the same specialty is not available within the geographic area. This policy ensures patients have access to care they need at a cost that families and employers can afford.

Our policy is not about penalties or mandates – it's about asking our in-network hospitals to be part of the solution to this abuse of the IDR process. Our intent is not to restrict access to high quality care, but to address a payment dynamic that's pushing healthcare costs significantly higher.

**Rep. Erin Houchin (R-IN)**

1. Your company has recently unilaterally decided in 11 states to cut hospital reimbursement for hospital claims that involve any out of network provider. This is a serious problem for small rural hospitals that are dependent on independent physicians and physician practices to help provide services. Regarding shared savings fees, will you be charging shared saving fees on the 10 percent reductions to hospital billings that you are making if any out-of-network provider was involved in the care?

    a. What is the annual amount you pay in hospital claims each year?

    b. Because of shared savings fees, your company has a financial incentive to make physicians out of network.

        i. Have you been making new contracts with hospitals that exclude non-employed physicians as part of these new networks?

        ii. Have you started excluding any physicians that have routinely been part of your networks?

    c. How much did your company collect on shared savings and program integrity fees in 2025?

        i. How much did you collect on these fees in 2024?

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**Rep. Tom Kean, Jr. (R-NJ)**

1. Earlier this month, the CDC made changes to the vaccine schedule. I appreciate the September statement made by America's Health Insurance Plans that plans will continue covering all immunizations that were recommended by the ACIP as of September 1, 2025, with no cost-sharing for patients through 2026.

    a. Beyond 2026, will you commit that your company will continue to cover all previously ACIP-recommended vaccines that were listed in September 2025?

        i. Will you commit to covering these prevention measures without cost-sharing or additional utilization management practices like prior authorization?

**Elevance Health's Response to Question 1:**

Elevance Health covers vaccines as required by law, and according to benefit mandates supported by a broad set of clinical evidence. We will continue to follow our medical policy, which is currently aligned with the most recent recommendations of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and/or the affirmative recommendations of the Advisory Committee on Immunization Practices (ACIP). Our medical policy is guided by these societies' recommendations around the latest medical research and clinical best practice recommendations. Vaccine safety is evaluated through rigorous trials and ongoing monitoring by federal health agencies.

Ultimately, decisions regarding vaccine use should be made between patients and physicians. We administer coverage consistent with federal and state preventive service requirements. Where vaccines are required to be covered without cost-sharing, we implement those requirements as designed.

**Diana DeGette (D-CO)**

1 Last fall, Elevance plans issued a policy in 11 states, including Colorado, that its plans would impose a 10 percent payment reduction on in-network hospital claims that involve an out-of- network provider. Elevance also threatened termination of hospitals that repeatedly used out-of-network physicians.

    a. Has any Elevance plan terminated an in-network agreement with any hospital in any of the 11 states (CO, CT, GA, IN, KY, ME, MO, NV, NH, OH, and WI) affected by the policy?

        i. If so, was the hospital in violation of the policy?

    b. Has any hospital in any of the 11 states terminated its relationship with Elevance since the policy was announced?

c. Please describe your observations about the use of out-of-network physicians in in-network hospitals in the 11 affected states since January 1, focusing on whether the use of out-of-network physicians has declined

d. Through January 22, 2026, across the 11 states, what is the total dollar value of the discount applied to hospital claims since the policy was implemented?

e. What are Elevance's observations of the types of hospitals that use out-of-network physicians in some services?

i. Do they tend to share certain characteristics, such as geography, size, or for-or non-profit status?

2. How much of each premium dollar does Elevance spend on preventive services? In your answer, please list the services included in your calculation.

3. What is Elevance's current policy on coverage of vaccines that were recommended by ACIP as of September 1, 2025?

a. Will you commit to maintaining no-cost access to vaccines that were recommended by ACIP as of September 1, 2025 through calendar year 2027?

6. Patients with chronic conditions like type 1 diabetes routinely report delays or denials for clinically necessary treatments such as insulin, continuous glucose monitors, and insulin pumps.

a. Please describe your coverage policies for the following, including any prior authorization, step therapy, or other utilization management requirements:

i. Insulin

ii. Continuous glucose monitors

iii. Insulin pumps

b. Please describe any utilization management requirements that are in place on any item or service to treat or manage diabetes that is recommended as the standard of care in clinical guidelines issued by physician professional societies.

**Elevance Health's Response to Question 1-3 and 6:**

**<u>Hospital Contracting and Out-of-Network Payment Policies</u>**

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**Vaccine Coverage**

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Ultimately, decisions regarding vaccine use should be made between patients and physicians. We administer coverage consistent with federal and state preventive service requirements. Where vaccines are required to be covered without cost-sharing, we implement those requirements as designed.

**Diabetes Medicines and Devices Coverage Policies**

Ensuring access to the treatment of diabetes, including affordable insulin, is a top priority of the company and we have implemented a range of measures across our lines of business to support our members.

In the Medicare market, we cap insulin cost-sharing at $35 per month, including during the deductible phase.

In our fully insured commercial offerings, we promote affordability through point-of-sale rebates, placement of lower-cost insulins on preferred formulary tiers and coverage of biosimilar insulins on lower tiers or at parity with their reference products. We also offer preventive drug lists that include insulin products at low or no cost. As a result, average member cost-sharing for a 30-day supply of insulin is approximately $31 in the fully insured market.

In the self-insured market, we offer an array of formulary options that include point-of-sale rebates, biosimilar insulin options on lower tiers or at parity with reference products, and preventive drug lists that may provide insulin at low or no cost depending on the member's benefit.

We are also focused on improving transparency and empowering members to make informed decisions about their treatment options. Our Price-a-Med tool provides members with personalized, real-time information on medication coverage and out-of-pocket costs. In addition, we are a member of CivicaScript, which is working to manufacture more affordable insulin options, including long-acting insulin glargine-yfg, and these products are covered on select formularies.

Elevance Health supports coverage of both continuous glucose monitors (CGMs) and insulin pumps for our members. Coverage generally requires a confirmed diagnosis of diabetes, use of insulin to manage blood glucose levels, and evidence of inadequate glycemic control. This may include persistent hyperglycemia, recurrent hypoglycemia, or hypoglycemia unawareness.

Elevance Health also ensures access to coverage, supports, and services for members with End-Stage Renal Disease (ESRD) through low-barrier primary and preventive care, built-in drug coverage, and supplemental benefits, such as transportation for dialysis treatments. We believe policy solutions should balance access with actuarially sound protections that sustain a competitive and viable market.

Together, these efforts reflect our commitment to expanding access, improving affordability, and supporting better health outcomes.

**Rep. Kim Schrier (D-WA)**

3. The U.S. Preventive Services Task Force is a scientifically independent, volunteer panel of national experts in disease prevention and evidence-based medicine. The Task Force works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services. The USPSTF has enabled millions of Americans access preventive services without a copay to promote and maintain their health, most without even realizing the USPSTF was to thank. While the Supreme Court has ruled affirmatively on the legitimacy of the recommendations, recently, Secretary Kennedy has slowed down the pace of approving new recommendations and created uncertainty and political pressure on the members of the task force and their recommendations.

    a. Will the insurance companies represented by this panel commit to honoring the recommendations as they exist today if Sec. Kennedy rolls back any of the recommendations?

**Elevance Health's Response to Question 3:**

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Physicians (AAFP), the American Academy of Pediatrics (AAP), and/or the affirmative recommendations of the Advisory Committee on Immunization Practices (ACIP). Our medical policy is guided by these societies' recommendations around the latest medical research and clinical best practice recommendations. Vaccine safety is evaluated through rigorous trials and ongoing monitoring by federal health agencies.

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