

BRETT GUTHRIE, KENTUCKY
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ONE HUNDRED NINETEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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February 26, 2026

David Cordani
The Cigna Group
900 Cottage Grove Road
Bloomfield, CT 06002

Dear Mr. Cordani:

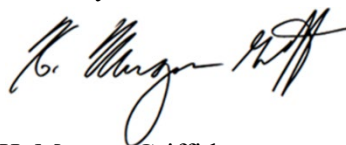
Thank you for appearing before the Subcommittee on Health on Thursday, January 22, 2026, to testify at the hearing entitled “Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability.”

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, March 12, 2026. Your responses should be mailed to Annabelle Huffman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Annabelle.Huffman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



H. Morgan Griffith
Chairman
Subcommittee on Health

cc: Diana DeGette, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Brett Guthrie (R-KY)

1. Please provide complete, detailed information and/or data, as appropriate, with respect to your group purchasing organization (Zinc, Ascent, Emisar), regarding:
 - a. The total number of employees presently working within each of your GPOs.
 - b. The current remuneration arrangements (such as fees or other forms of compensation paid to or retained by your GPO) with manufacturers, as well as health payors, including, but not limited to, health insurance plan sponsors, employers, or pharmacy benefit managers (PBM).
 - c. When your GPO began levying each fee or requiring such form of compensation.
 - d. An explanation of the services rendered for each of the fees charged or for which compensation was paid to or retained by your GPO, as well as whether any such fees are charged or compensation is required for similar classes of services also performed by your PBM.
 - e. Whether any such remuneration arrangements (such as fees or other forms of compensation paid to or retained by your GPO) are in any way linked to the list price of the drug.
 - f. How much of these fees or this compensation (as a percentage of total revenue) is retained by your parent company as profit, by year, since its establishment.

2. I have heard from healthcare providers who have raised serious concerns regarding vertically integrated health services businesses, including Optum Health, Caredon 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?
 - i. 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?

4. Several states have advanced legislation to institute 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?
 - 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?
5. 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?
6. 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?

The Honorable Diana Harshbarger (R-TN)

1. 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?
2. 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?
3. 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?
4. 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?

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

1. In ERISA self-funded dental plans you administer, who sets or controls: (a) coverage rules, (b) claim edits and payment policies, (c) downcoding and bundling logic, and (d) appeal outcomes, the plan sponsor or your organization?
 - a. Can you provide the Committee with the contractual language that allocates authority and responsibility?
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?

The Honorable John Joyce, M.D. (R-PA)

1. Reference Attachment A:
 - a. Please provide your policies and procedures your companies follow to adhere to the NSA and how you ensure patients are fully protected as the law intended.
 - b. Please confirm that your company holds patients harmless and does not balance bill patients for any outstanding eligible or ineligible NSA claims.
 - c. Do you support applying the same penalties to payers for non-compliance with the law’s patient protections that already apply to providers? If not, why not?

The Honorable Troy Balderson (R-OH)

1. Many commercial insurers have hesitated to cover Prescription Digital Therapeutics given the current patchwork of coding and reimbursement strategies used for these products.
 - a. Would a defined Medicare and Medicaid benefit category help to alleviate any confusion insurers may have around their ability to cover new and innovative therapies like PDTs?
2. Affordable health care is top of mind for patients and providers nationwide. A July 2025 study on anxiety and depression from the Peterson Health Technology Institute found that PDTs could generate annual net savings for commercial plans of \$8.7 million per million members.

- a. Do you view PDTs and other digital health technologies as effective opportunities to reduce health care costs?
3. 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?
4. Are there technical areas of federal law where minor statutory clarifications could improve consumer options to better align coverage with their financial needs?
5. 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?

The Honorable Kat Cammack (R-FL)

1. Physicians report that Cigna downcodes evaluation and management services after care has been delivered, often relying on automated systems.
 - a. Please describe the role automated tools or algorithms play in Cigna's downcoding of evaluation and management services, whether a licensed clinician reviews these determinations prior to payment reduction, and how Cigna addresses the administrative and financial burden on physicians and patients when downcoding decisions are overturned on appeal.

The Honorable Erin Houchin (R-IN)

1. Because of shared savings fees, your company has a financial incentive to make physicians out of network. Have you been making new contracts with hospitals that exclude non-employed physicians as part of these new networks?
 - a. Have you started excluding any physicians that have routinely been part of your networks?
 - b. How much did your company collect on shared savings and program integrity fees in 2025? How much did you collect on these fees in 2024?
2. 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?
3. 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?

4. 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?
5. 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?
6. 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?
7. Insurance network adequacy, lack of specialists and long wait times for appointments are ongoing issues. What is your plan doing to address these concerns?
8. 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?
9. 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?
10. Independent physicians are the backbone of our healthcare system. What are your companies doing to help ensure that continues to be true?
11. 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?
12. Which regulations currently in place should be repealed in order to make plans more affordable?

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

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?
 - b. 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? How does that compare to patient out-of-pocket costs?
 - i. If manufacturers are providing larger rebates each year, why do patients continue to see rising out-of-pocket costs at the pharmacy counter?
 - ii. Do higher rebates sometimes result in higher list prices?
 - iii. 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?

The Honorable August Pfluger (R-TX)

1. In your testimony, you stated that you acquired Express Scripts specifically to enable “coordination across medical, behavioral, and pharmacy care” and to deliver “coordinated, whole-person, high-quality care that improves outcomes and reduces total costs.”
 - a. Is that accurate?
 - b. Is that what this integration is designed to deliver?
2. You acknowledged in your testimony that when a hospital system demanded a 30 percent rate increase, you settled for 20 percent because you couldn’t walk away. You also acknowledged that commercial rates are roughly 200 percent of Medicare rates.
 - a. If Cigna cannot say no to 20 percent increases and cannot get close to Medicare rates, what value is your market power providing to employers and consumers?
 - b. Does Express Scripts pay affiliated pharmacies higher reimbursement rates than unaffiliated pharmacies? If so, what is the percentage difference?
3. 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?

4. 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.
5. 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 Cigna 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?
6. 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 actuarial evidence justifies these increases to small employers?
 - i. How much reflects actual medical costs versus administrative overhead and profit?
 - b. 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?
7. Does your company require peer-to-peer reviews for prior authorizations? If so:
 - a. What are the qualifications of the physicians conducting these reviews?
 - i. 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?

- c. 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?
8. 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?
 9. 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?
 10. 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?
 11. 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?

The Honorable Diana DeGette (D-CO)

1. My constituent was diagnosed with stage IV intrahepatic cholangiocarcinoma in March 2025. Initial treatment with immunotherapy and chemotherapy showed no response. Genetic testing revealed a rare NRG1-Fusion mutation present in approximately 1 percent of tumors. This constituent is currently a member, through his employer, of a California-based plan administered by Cigna, though as a Colorado resident, he is seeking care in Colorado. Cigna denied coverage for the targeted therapy designed to treat this mutation, citing lack of medical necessity. After nearly a month of appeals and considerable out-of-pocket costs, he began treatment. The therapy has been successful in reducing the size of the tumor and made

him eligible for liver transplant evaluation. Following extensive evaluation, a multidisciplinary medical team cleared him for liver transplant. Cigna denied the transplant authorization within 48 hours of the request. Without transplant, his prognosis is poor. My constituent appealed to Cigna and tried to reach representatives of the company without avail. He also documented his experience on social media, where videos received over 14 million views. Following this attention, Cigna reversed the transplant denial. However, Cigna has since delayed responding to subsequent preauthorization requests from his oncologist for necessary amendments to his treatment plan, placing his transplant—and life—in jeopardy.

- a. What are possible reasons for issuing initial denials of care like that described above?
 - b. How many prior authorization requests were made to Cigna for oncology care in 2024?
 - c. Of such requests, how many were initially denied?
 - d. Of such denials, how many were appealed?
 - e. Of such appeals, how many ultimately resulted in an approval?
 - f. Since learning of this individual's situation, has Cigna:
 - i. Conducted an analysis of what it could have done differently to avoid administrative burden for this individual? If so, what did that analysis find?
 - ii. Initiated any corrective actions to its staff training or processes? If so, what are those corrective actions?
 - g. Does Cigna monitor social media for complaints about denials or other issues with the company?
 - h. Is there a threshold of any metric (e.g. views, likes, comments, reposts) of a complaint post that triggers internal review at Cigna? If so, what are those thresholds?
 - i. How does Cigna assign reviewers to prior authorization cases?
 - j. What mechanisms exist to match reviewers with cases within their area of expertise?
2. How much of each premium dollar does Cigna spend on preventive services? In your answer, please list the services included in your calculation.
 3. What is Cigna'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?

4. Absent a recommendation from ACIP, does Cigna have a policy or procedure in place to evaluate coverage of a new vaccine or a vaccine for which new evidence becomes available?
5. FDA has approved an increasing number of cell and gene therapies in recent years and many more are expected in the coming years. Many of these therapies will treat and potentially cure chronic illnesses for which there was previously no cure. Some of these illnesses, such as type 1 diabetes, may be appropriate for larger patient populations than previous high-cost curative therapies.
 - a. Please describe your company's current coverage of cell and gene therapies.
 - b. Please describe any financial mechanism that your company has instituted to manage the risk associated with coverage of cell and gene therapies.
 - c. Please describe how your company is planning for a future environment in which more curative but high-cost cell and gene therapies are available and indicated for a broader population.
 - d. Please discuss whether legislation or any other U.S. Government policy change is needed to address access to cell and gene therapies as more are approved by FDA, and any recommendations you might have for such legislation.
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.
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? 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.

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?
 - i. 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?

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 lets 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?
3. Twelve months ago, the Food and Drug Administration approved the first in class novel non-opioid painkiller for moderate to severe pain in 20 years.
 - a. Do you believe that, as health insurers, you have a responsibility to work with providers to keep your plan members as healthy as possible and prevent seniors from adverse events associated with opioids, such as falls, dizziness, and addiction?
 - b. Would avoiding these adverse events save you and the overall Medicare system money?

The Honorable Kim Schrier (D-WA)

1. I’ve heard many stories from providers about how when they go to the Independent Dispute Resolution (IDR) process under the No Surprises Act (NSA), they have to wait through the backlog, and then even when they win and are supposed to be paid within 30 days, insurance companies aren’t paying; insurers are sitting on the money, waiting weeks, months, and sometimes over a year, to pay on claims, all while collecting interests and leaving providers on the hook for meeting payroll and rent while they wait. Is your company failing to pay IDR decisions on time?
 - a. What percentage of IDR decisions against your company have a payment made within the 30-days required by the NSA?
 - b. Will you commit to ensuring all payments resulting from IDR decisions are paid within 30 days?
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. How has your rate of in-network and out-of-network care changed since implementation of the law?

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

The Honorable Jake Auchincloss (D-MA)

1. An investigative report found substantial evidence that group purchasing organizations (GPOs) are a cynical semantic exercise designed to allow Cigna, UnitedHealth Group, and CVS to continue making profits in the face of increasing pressure and regulatory reform directed at pharmacy benefit managers. In essence, the insurers have created these shell companies with few or no employees that charge manufacturers “fees” instead of “rebates” and established them overseas for tax and opacity reasons. This enables the insurers to nominally comply with PBM reforms and contractual obligations, while not impacting their bottom line.

Insurer	CVS/Aetna	UHG	Cigna	Elevance	BS-CA
PBM	CVS Caremark	OptumRx	Express Scripts	CarelonRx	N/A
PBM-GPO	Zinc Health Services	EMISAR Pharma Services	Ascent Health Services	N/A	N/A
Where?	Bloomington, MN	Dublin, Ireland	Schaffhausen, Switzerland		
When?	Est. 2020	Est. 2019	Est. 2019		

The investigation alleges that the GPOs operate as “shell companies” with few or no employees. After reviewing LinkedIn profiles, team photos, corporate filings, and job listings to determine the staffing at all three entities, the investigators identified fewer than 150 employees total (as of October 10, 2025) — about 88 at Ascent, 29 at EMISAR, and 24 at Zinc. How many people work at Zinc, EMISAR, and Ascent?

- a. Do they work in-person or remotely?
 - b. Why do Zinc and EMISAR not have a website?
 - c. Is the role played by the GPOs (Zinc, EMISAR, Ascent) disclosed to PBM plan clients?
 - i. How?
 - ii. By name?
 - iii. If not, why not?
2. Neither the PBM GPOs nor their parent companies report financial information for these specific entities, but the limited data available suggests these businesses are improbably lucrative. A 2023 report estimates PBMs earned \$7.6 billion in fees related to their GPOs in 2022. With fewer than 150 employees across all three entities, these PBM GPOs generate more than \$50 million in revenue per employee. What does the GPO (Zinc, EMISAR, Ascent) do differently than what the PBM (CVS Caremark, OptumRx, Express Scripts) does?
- a. What proof do you have to demonstrate that PBM GPOs save patients money?
 - b. What is the number of covered lives that the GPO (Zinc, EMISAR, Ascent) covers?
 - i. What is the number of covered lives the respective PBMs (CVS Caremark, OptumRx, Express Scripts) serve?
 - c. Assuming the delta is small, how does the GPO aggregate purchasing power any more than the existing PBM?
 - d. Job postings raise questions about how independent an operation the GPOs really are. Why did several job postings for the GPO appear on the PBM and parent company websites?
3. A 2024 Federal Trade Commission (FTC) report states, "...since the PBMs spun off their rebate aggregators, they have extracted from drug manufacturers billions of dollars in additional fees." The investigation notes that the exponential revenue increases flow through a "labyrinth of payment categories" that are carefully engineered to avoid transparency: entity administration fees, prescription data services, data portals, enterprise fees, and other charges that PBMs insist are not rebates and therefore don't require pass-through to health plans. "These revenue streams exist on top of the PBM's typical administrative service fees of about 3 to 5 percent of the wholesale price of each drug, further inflating healthcare costs." Why do the GPOs (Zinc, EMISAR, and Ascent) label manufacturer payments as 'fees' rather than 'rebates'?
- a. What fees earned by PBM GPOs are passed through to health plans?

- b. What is the total annual value of the contracts [Emisar/Zinc/Ascent] have negotiated with drugmakers?
 - i. How much of that money does each retain, either in the form of fees from the drugmakers or fees/reimbursements from the PBMs?
4. Two of the three GPOs investigated are headquartered abroad. EMISAR (UnitedHealth) is located in Dublin, Ireland, and Ascent (Cigna) is located in Schaffhausen, Switzerland.
- a. Why are UnitedHealth and Cigna using an offshore entity to collect fees that are never seen by the American patients paying for these drugs?

The Honorable Troy A. Carter (D-LA)

1. Can you share your company's step therapy policy?
2. How are your companies ensuring that coverage decisions for HIV prevention drugs, including long acting agents like lenacapavir, do not undermine the President initiated Ending the HIV Epidemic in the U.S. (EHE) by 2030 goal—particularly for communities that have historically faced barriers to access like Louisiana’s 2nd congressional district?
 - a. If the answer is yes, please explain how your coverage policies will ensure timely, affordable, and equitable access to long acting HIV prevention therapies like lenacapavir.
 - b. If the answer is no, please explain how that position aligns with the national goal of ending the HIV/AIDS epidemic by 2030.
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. 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?
 - a. Are you aware that studies show removing prior authorization in behavioral health increases treatment initiation and reduces emergency department visits?