

Health Care
Affordability Lab
at Yale

VIA ELECTRONIC SUBMISSION

October 1, 2026

Senator Ron Wyden
Ranking Member
Senate Committee on Finance
Washington, D.C. 20510

Re: Response to Request for Information, “Health Coverage That Works for Everyone”

Dear Ranking Member Wyden:

The Health Care Affordability Lab at Yale University welcomes the opportunity to respond to your recent Request for Information (RFI), *Health Coverage That Works for Everyone*, released on July 30, 2026.

The Health Care Affordability Lab (“the Lab”) at Yale is dedicated to producing research and evidence that can help policymakers and other stakeholders with efforts to lower health care costs without sacrificing quality. The Lab also prioritizes identifying practical, evidence-based solutions to inefficiencies in U.S. health care markets that can help ensure the system delivers greater value for patients and taxpayers alike.

The following comments are informed by the Lab’s broader body of work, including two flagship initiatives: **1% Steps for Health Care Reform**, which highlights findings of fellow economists and their targeted policy recommendations to reduce spending without sacrificing quality; and the **Just the Facts** memo series, which synthesizes the most methodologically rigorous research on pressing health policy matters for policymakers and the public.

Specifically, these comments respond to matters raised in Sections 1, 2, and 3 of the RFI, drawing on evidence concerning health care spending and insurance premiums among the privately insured; the effects of rising health care spending on wages and employment through employer-sponsored insurance; patient cost-sharing for insulin; integrating the individual and small group insurance markets; the structure of health insurance plan choice and standardized plan designs; commercial insurer network design; preferred pharmacy networks; and vertical integration and its interaction with the Medical Loss Ratio (MLR). The authors of the research in each of these areas are cited throughout, and the Lab would be happy to connect you or your team with them.

Section 1

Health Care Spending and Insurance Premiums Among the Privately Insured

Understanding the drivers of health insurance premium growth is essential to crafting mitigating policies. New research from our Lab shows that growing health care spending explains 91% of the growth in premiums from 2011 to 2024.¹ While premiums grew by 78% over that period, health spending grew by 84%. Insurer markups—the difference between premiums and health spending on enrollees—did increase in dollar terms, but they fell in percentage terms from 18.6% to 14.9% of premiums. In other words, insurer margins made up a declining share of premium revenue over this period. This highlights that to slow the growth in health insurance premiums, policymakers must slow the growth in health care spending.

Rising Health Care Spending Disrupts Labor Markets Through Employer-Sponsored Insurance

Most Americans get their health insurance coverage through an employer. Academic evidence shows that, in the presence of employer-sponsored health insurance, rising health care spending leads to job losses and slower economic growth outside the health care sector.² Brot-Goldberg et al. (2024), for example, find that after anticompetitive hospital mergers, each dollar increase in health care spending led to approximately \$1.33 in losses to the rest of the economy that were driven by reductions in incomes for non-health care workers.³ Research shows that if health care spending had grown at the rate of inflation, wages in the U.S. would have been approximately 10% higher today.⁴

Rising health insurance premiums make it more costly for companies to hire and retain workers. Because health insurance premiums account for a higher share of lower-wage workers' earnings, job losses when health spending increases have been shown to be concentrated among workers earning less than \$100,000 a year.⁵ For this reason, Finkelstein et al. (2023) found that rising health spending in the presence of employer-sponsored health insurance is

¹ Zack Cooper and Stuart V. Craig, "Health Care Spending and Insurance Premiums Among the Privately Insured," *JAMA Health Forum* 7, no. 9 (2026): e263005.

² Zarek Brot-Goldberg, Zack Cooper, Stuart Craig, Lev Klarnet, Ithai Lurie, and Corbin Miller, "Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers," NBER Working Paper No. 32613 (National Bureau of Economic Research, June 2024; revised December 2024), <https://doi.org/10.3386/w32613>; Jonathan Gruber and Alan Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," *Tax Policy and the Economy* 5 (1991): 111–143; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics* 24, no. 3 (2006); Janet Currie and Brigitte C. Madrian, "Health, Health Insurance and the Labor Market," in *Handbook of Labor Economics*, vol. 3, ed. Orley Ashenfelter and David Card (1999); Martin Gaynor, "Antitrust Applied: Hospital Consolidation Concerns and Solutions," statement before the Subcommittee on Competition Policy, Antitrust, and Consumer Rights, Committee on the Judiciary, U.S. Senate, May 19, 2021, https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf.

³ Brot-Goldberg et al., "Who Pays for Rising Health Care Prices?"

⁴ Brot-Goldberg et al., "Who Pays for Rising Health Care Prices?"

⁵ Brot-Goldberg et al., "Who Pays for Rising Health Care Prices?"

one of the leading causes of U.S. income inequality and has had an impact similar in magnitude to the effect of trade, outsourcing, and automation.⁶

Eliminating Cost-Sharing for Insulin

Strong academic evidence supports eliminating cost-sharing for insulin, including for people with Medicare or private health coverage. For drugs like insulin, patient cost-sharing does not steer patients toward cheaper, more cost-effective care. Rather, it drives patients to take less of medications they need—with measurable consequences for their health, including death.⁷

Even modest cost-sharing for insulin can reduce adherence and worsen glycemic control. In a new study, Brot et al. examine UnitedHealthcare’s Vital Medication Coverage program, which eliminated cost-sharing for preferred insulins beginning January 1, 2023. Eliminating that cost-sharing raised insulin use by 4% and lowered HbA1c—a measure of average blood glucose over the preceding months—by 0.05 percentage points, from a baseline of 7.4%. Notably, eliminating cost-sharing did not increase insulin uptake among patients with diabetes who were not already prescribed insulin, suggesting that provider decision-making is more central to driving initiation. Instead, it increased adherence among those already prescribed treatment. Even among this relatively economically secure population with employer-sponsored insurance, cost-sharing well below \$35 a month was enough to affect adherence and outcomes. The effects may be larger where financial barriers are steeper.

Other research shows that cost-sharing for medications treating chronic diseases can reduce medication adherence and worsen health. Using claims data that predate the \$35 monthly insulin cap enacted in the Inflation Reduction Act, Hollrah (forthcoming) studies low-income Medicare beneficiaries who lose the Low-Income Subsidy, which had limited their drug costs to a few dollars per fill.⁸ When these beneficiaries lose the subsidy and their costs rise, the quantity of insulin they fill falls by 35%—more than double the 16% reduction in the quantity they fill across their prescriptions overall, despite insulin’s clear clinical value. Hollrah’s central result is that a drug’s out-of-pocket price, not its clinical value, predicts how much patients cut back when costs rise. Chandra, Flack, and Obermeyer (2024) find the same pattern across a broader set of medications: when Medicare beneficiaries face abrupt out-of-pocket increases, they cut back on cardiovascular, diabetes, and respiratory drugs alike.⁹ Those with less room to spend consume fewer drugs and die at higher rates. Compared with lower-risk patients, patients at the

⁶ Amy Finkelstein, Casey McQuillan, Owen Zidar, and Eric Zwick, “The health wedge and labor market inequality,” The Brookings Institution, March 2023, <https://www.brookings.edu/articles/the-health-wedge-and-labor-market-inequality/>

⁷ Amitabh Chandra, Evan Flack, and Ziad Obermeyer, “The Health Costs of Cost Sharing,” *The Quarterly Journal of Economics* 139, no. 4 (2024): 2037–2082, <https://doi.org/10.1093/qje/qjae015>; Christopher Hollrah, “Prioritizing Benefit? How Low-Income Patients Respond to Prescription Cost-Sharing,” *American Economic Journal: Economic Policy*, forthcoming.

⁸ Hollrah, “Prioritizing Benefit?”

⁹ Chandra et al., “The Health Costs of Cost Sharing.”

highest risk of a heart attack or stroke cut back four times as much on high-value cardiovascular drugs like statins and blood pressure medications.

These findings are relevant to the Committee's question about which additional chronic care drugs merit cost-sharing caps. Patients do not reliably distinguish low-value from lifesaving treatment when they respond to cost sharing. When faced with a higher price, they cut back on both. These findings suggest that eliminating cost sharing would help patients across the income spectrum, with the greatest benefit for drugs that have high out-of-pocket costs, chronic use, no lower-cost substitute, and use that falls when prices rise. Beyond insulin, the cardiovascular, diabetes, and respiratory drugs Chandra et al. examine fit this profile most closely.

Integrating Individual and Small Group Health Insurance Markets to Reduce Premiums and Administrative Costs

Academic research highlights the opportunity to leverage CHOICE Arrangements (formerly known as ICHRAs) to expand small-firm employees' access to the individual market. Combining the small group and individual markets through these arrangements offers a potential way to lower premiums and government spending while reducing some of the administrative costs associated with small group coverage. To that end, we draw on Michael Dickstein's 1% Steps brief below.¹⁰

In 2024, approximately 32 million Americans received health insurance coverage through the individual and small group markets (22.3 million and 9.9 million, respectively). Most individual market enrollees rely on federal subsidies. While the Affordable Care Act (ACA) regulates the markets similarly, it allows insurers to price and sell plans separately in each market. The individual market is more exposed to adverse selection, in which the sickest enrollees choose the most generous plans and drive higher premiums. The small group market tends to experience higher administrative costs, likely due to greater broker involvement, less direct competition on premiums, and higher insurer markups.

Pooling the two markets through CHOICE Arrangements can address both problems at once. Drawing on data from Oregon from 2014 to 2016 on enrollment, premiums, and spending, Dickstein et al. (2024) model how households would choose coverage and how insurers would price it, were small group enrollees moved into the individual market risk pool.¹¹ The central insight is that the gains from integration do not hinge on small group enrollees being healthier. Because small group households have stronger preferences for comprehensive coverage, they

¹⁰ Michael J. Dickstein, "Integrating Individual and Small Group Health Insurance Markets to Reduce Premiums and Administrative Costs," 1% Steps for Health Care Reform, September 2026, <https://www.onepercentsteps.com/policy-briefs/integrating-individual-and-small-group-health-insurance-markets-to-reduce-premiums-and-administrative-costs>.

¹¹ Michael J. Dickstein, Kate Ho, and Nathaniel Mark, "Market Segmentation and Competition in Health Insurance," *Journal of Political Economy* 132, no. 1 (2024).

can ease adverse selection by entering the risk pool, even when their costs resemble those of individual market enrollees.

The brief evaluates two approaches to pooling the individual and small group markets:

- **Encourage voluntary adoption of CHOICE Arrangements.** Lawmakers could strengthen the incentives for small employers to fund individual market coverage in place of a group plan. Indiana and Mississippi enacted tax incentives to that end, and nine other states have considered similar legislation as of mid-2026. The main risk from voluntary expansions, however, is selection: if employers with sicker workforces are the first to adopt CHOICE Arrangements to reduce their benefits costs, it leaves healthier employees in the small group pool and limits the improvement in the individual market pool.
- **Mandate enrollment through CHOICE Arrangements.** A more far-reaching approach would require small employers that offer coverage to replace their group plans with CHOICE Arrangement funding for individual market coverage, keeping their already-insured workers enrolled rather than letting them drop out. Congress could authorize state demonstrations to test this approach. The gains would be largest where the small group market carries higher markups and where small group enrollees are no sicker, and ideally healthier, than the individual market population; states with these characteristics would be natural demonstration sites.

If it became mandatory for small group employers that offer insurance to use CHOICE Arrangements to enroll their workers in plans on the individual market, gross premiums for the most adversely selected individual market plans (gold tier) would fall by about 60%, and small group enrollees' premiums would fall roughly 36% to 40% across tiers.¹² Federal spending on premium subsidies would fall by 22%, and implicit tax expenditures associated with small group coverage would fall by 30%.

Extrapolating these Oregon estimates nationally—scaling each state by the relative size of its small group market and the gap in health costs between its two segments—the brief projects savings of roughly \$3.9 billion to \$5.9 billion in individual market premium subsidies, or 11% to 16% of total premium tax credit spending in 2017.¹³

Section 2

Structuring Choice for Health Insurance Plans

Strong academic evidence supports standardizing health insurance plan designs and structuring the menus of plans from which consumers choose, as consumers frequently

¹² Dickstein, "Integrating Individual and Small Group Health Insurance Markets."

¹³ Dickstein, "Integrating Individual and Small Group Health Insurance Markets."

select plans that cost them more without providing additional benefits.¹⁴ Below, we draw on a 1% Steps brief authored by Jason Abaluck of Yale University and Jonathan Gruber of the Massachusetts Institute of Technology.¹⁵

Plan choice is a central feature of U.S. health insurance markets. Improving these choices can lower individuals' premiums and out-of-pocket costs, as well as strengthen competition among insurers by making it harder for lower-value plans to persist.¹⁶ Research across these markets consistently finds that consumers struggle to identify the plans that are best for them:

- **Consumers rarely select the lowest-cost plan available to them.** Research on Medicare Part D's early years found that only about 15% of seniors chose the lowest-cost plan in their choice set, and that the typical senior could have reduced their combined premiums and out-of-pocket costs by roughly one third by selecting it. These estimates compare what seniors would pay for the same prescriptions under different plans. The potential savings therefore come from choosing a plan that costs less for the medications they already take, not from switching medications or taking fewer of them.¹⁷
- **Many employees choose plans that are worse under every possible outcome.** In a study of 23,894 employees at a large U.S. firm, a majority chose "dominated" plans, meaning plans that cost more than an available alternative regardless of how much care the employee ultimately used. The resulting excess spending equaled 24% of chosen plan premiums, and low-income employees were significantly more likely to choose dominated plans.¹⁸
- **Larger plan menus produce worse choices.** Among school district employees in Oregon, the average employee could have saved \$600 per year by switching to a lower-cost plan, and employees made lower-cost choices when the menu was smaller.¹⁹ The 1% Steps brief reports that forgone savings rose from \$352 per employee when two plans were offered to \$1,118 when seven were offered.²⁰ A curated restriction of the menu improved choices more than the best available information intervention.²¹

¹⁴ Jason Abaluck and Jonathan Gruber, "Less Is More: Structuring Choice for Health Insurance Plans," 1% Steps for Health Care Reform, February 2021, <https://onepercentsteps.com/policy-briefs/less-is-more-structuring-choice-for-health-insurance-plans/>.

¹⁵ Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

¹⁶ Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

¹⁷ Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review* 101, no. 4 (2011): 1180–1210, <https://doi.org/10.1257/aer.101.4.1180>; Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

¹⁸ Saurabh Bhargava, George Loewenstein, and Justin Sydnor, "Choose to Lose: Health Plan Choices from a Menu with Dominated Option," *The Quarterly Journal of Economics* 132, no. 3 (2017): 1319–1372, <https://doi.org/10.1093/qje/qjx011>.

¹⁹ Jason Abaluck and Jonathan Gruber, "When Less Is More: Improving Choices in Health Insurance Markets," *The Review of Economic Studies* 90, no. 3 (2023): 1011–1040, <https://doi.org/10.1093/restud/rdac050>.

²⁰ Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans." These figures are reported in the brief, which draws on an earlier working-paper version of Abaluck and Gruber (2023).

²¹ Abaluck and Gruber, "When Less Is More: Improving Choices in Health Insurance Markets."

These patterns reflect predictable frictions. Enrollees rarely switch plans even when their medical needs change or better options are added. They pay more attention to differences in monthly premiums than to the out-of-pocket costs they will face. When they do consider out-of-pocket costs, they focus on general plan features, such as the size of the hospital deductible, rather than the features that matter for their own expected care use.²²

Evidence also indicates that standardizing plan designs changes what consumers choose. When the Massachusetts Connector, the first public insurance exchange, opened in 2006, insurers could set cost-sharing freely within each coverage tier, resulting in 25 different plan designs across six insurers. In 2010, in response to public dissatisfaction with the confusing array of options, the Connector standardized offerings to seven plan designs.²³ Before the change, consumers overwhelmingly chose low-premium plans; after standardization, they were more likely to choose plans with more generous coverage.²⁴ Average premiums paid increased, but the plans consumers selected had lower estimated out-of-pocket costs. Consumers paid more for insurance but received greater protection against medical bills.²⁵

The 1% Steps brief offers three recommendations for policymakers and employers seeking to improve the environments in which individuals select insurance plans.²⁶

First, eliminate the lowest-performing plans while preserving meaningful choice.

Administrators should favor adding plans that are better on average than existing options, rather than plans that appeal only to small segments of the market. Many of the enrollees who would benefit from a niche plan do not choose it, while others for whom it is worse do. To preserve competition while offering fewer plans, the brief proposes a bidding process in which insurers compete for the opportunity to offer plans on an exchange. Consumers would then choose among the selected plans.²⁷

Second, pair decision support tools with skilled agents who help individuals select products. Each helps only modestly on its own. Decision support tools go largely unused when simply made available, and agents working without them exhibit many of the same choice inconsistencies as consumers choosing alone. In one large private Medicare exchange, agents' unaided guidance cost enrollees an average of approximately \$1,260 relative to better available choices. Equipping those agents with a decision support tool, and requiring its use, improved

²²Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

²³Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

²⁴Keith M. Marzilli Ericson and Amanda Starc, "How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange," *Journal of Health Economics* 50 (2016): 71–85; Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

²⁵Keith M. Marzilli Ericson and Amanda Starc, "How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange," *Journal of Health Economics* 50 (2016): 71–85; Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

²⁶Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

²⁷Abaluck and Gruber, "Less Is More: Structuring Choice for Health Insurance Plans."

outcomes by an average of \$278 per enrollee and substantially reduced variation in performance across agents.²⁸

Third, introduce defaults when they do not impose large switching costs and when individuals first enter a market. A default is the plan a person is automatically enrolled in unless they choose another. Defaults are most appropriate when switching does not entail costly disruptions, such as changes to provider networks. For example, in general medical plans, beneficiaries might be defaulted only into plans that keep all of their existing providers in network. In prescription drug plans, defaults might target the beneficiaries with the most to gain, such as those who stand to save \$500 or more per year.²⁹

These findings bear directly on the Committee's interest in standardized benefits and plan designs that help consumers choose coverage that best meets their needs. Standardization and curated menus make plans comparable. Decision support and skilled agents help consumers act on that comparability, and well-designed defaults protect those who do not act. Because low-income enrollees are the most likely to select plans that cost more than an available alternative regardless of how much care they use, improving the choice environment may also help address disparities in what families pay for coverage.³⁰

The potential savings are meaningful. Using enrollment figures at the time of the brief's publication, the authors offer a back-of-the-envelope calculation: if each enrollee saved \$100 per year through improved choices, savings would total approximately \$4.5 billion per year in Medicare Part D, \$2.2 billion in Medicare Advantage, and \$15.8 billion in employer-sponsored insurance. This amounts to \$22.5 billion in aggregate, approximately 1% of total Medicare spending and 1.3% of total commercial health insurance spending.³¹

Designing Smart Commercial Insurer Networks

Academic research indicates that “smart networks”—which cap reimbursements for shoppable, non-differentiated services while preserving broad, more generous networks for specialized care—can enable commercial insurers to cut spending on shoppable services, many of which show high price variation without differences in quality. Below, we draw on a 1% Steps brief authored by Jonathan Gruber of the Massachusetts Institute of Technology.³²

²⁸ Jonathan Gruber, Benjamin R. Handel, Samuel H. Kina, and Jonathan T. Kolstad, “Managing Intelligence: Skilled Experts and AI in Markets for Complex Products,” NBER Working Paper No. 27038, April 2020, <https://www.nber.org/papers/w27038>; Abaluck and Gruber, “Less Is More: Structuring Choice for Health Insurance Plans.”

²⁹ Abaluck and Gruber, “Less Is More: Structuring Choice for Health Insurance Plans.”

³⁰ Bhargava, Loewenstein, and Sydnor, “Choose to Lose: Health Plan Choices from a Menu with Dominated Option.”

³¹ Abaluck and Gruber, “Less Is More: Structuring Choice for Health Insurance Plans.”

³² Jonathan Gruber, “Designing Smart Commercial Insurer Networks,” 1% Steps for Health Care Reform, 2021, <https://onepercentsteps.com/policy-briefs/designing-smart-commercial-insurer-networks/>.

While certain health care procedures may differ in price due to substantial differences in quality, others remain reliably consistent in quality across settings. MRI scans, for instance, do not vary much from provider to provider in terms of quality, due to the nature of the procedure. Services like these are considered “shoppable” by the Centers for Medicare & Medicaid Services (CMS); all such services can be scheduled in advance, routinely provided in non-urgent settings, and expected to be consistent in quality. Yet research has shown that significant price variation exists even for these services.^{33,34} This price variation drives up spending for commercial insurers, leading to higher premiums for their enrollees.³⁵

Smart networks, like some reference price plans, allow commercial insurers to reduce spending on these shoppable services. To create savings, smart networks reimburse up to a reference price for certain services where shopping is possible. Any costs that exceed a service’s reference price must be covered by enrollees. Insurers can base these rates on different standards, such as Medicare reimbursement rates, but the brief recommends that insurers set each reference price at the median negotiated amount per service in a hospital referral region. Academic research has shown that reference prices, when used for shoppable services and combined with price transparency and patient information, create a cascading effect in which patients are diverted away from higher-priced providers, who then lower their prices accordingly, and overall commercial health spending decreases.³⁶

The brief recommends the following:

- **Commercial insurers can introduce smart networks for the 70 different services deemed shoppable by CMS.** Reference prices under such networks would apply only to services that remain consistent in quality across care settings and are routinely provided in non-urgent settings.³⁷
- **Insurers creating smart networks should set reference prices equal to the median commercial reimbursement amount in each hospital referral region.** Rather than tying prices to a national indicator like Medicare, relying on local markets would allow insurers to account for genuine inter-region differences in market dynamics.³⁸

The most prominent example of reference pricing and its efficacy has come from the California Public Employees’ Retirement System (CalPERS). CalPERS began using reference pricing in 2011, and research has shown the program’s success in redirecting enrollees toward more

³³ Alexander P. Philips and Christopher M. Whaley, “Commercial Price Variation for Common Services in General Surgery,” *JAMA Network Open* 8, no. 6 (2025): e2517818, <https://doi.org/10.1001/jamanetworkopen.2025.17818>.

³⁴ Michael Chernew, Zack Cooper, Eugene Larsen-Hallock, and Fiona Scott Morton, “Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans,” NBER Working Paper No. 24869 (National Bureau of Economic Research, 2018), <https://doi.org/10.3386/w24869>.

³⁵ Brot-Goldberg et al., “Who Pays for Rising Health Care Prices?”

³⁶ James C. Robinson and Timothy T. Brown, “Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery,” *Health Affairs* 32, no. 8 (2013): 1392–97, <https://doi.org/10.1377/hlthaff.2013.0188>.

³⁷ Gruber, “Designing Smart Commercial Insurer Networks.”

³⁸ Gruber, “Designing Smart Commercial Insurer Networks.”

affordable options for shoppable services. In just the first year after the program's implementation, surgical volume for CalPERS members increased by 21% at low-price facilities and decreased by 34% at high-price ones, while prices charged at those facilities to CalPERS members decreased by 4.6% at low-price and 18% at high-price facilities.³⁹

Gruber's brief estimates that if all shoppable procedures being paid above the price median were instead paid at the median, commercial health spending would decrease by 2.8%, generating savings of over \$30 billion.⁴⁰

Promoting Preferred Pharmacy Networks

Academic evidence supports expanding the use of preferred pharmacy networks in commercial insurance, which lower prescription drug spending while maintaining consumers' access to convenient pharmacies.⁴¹ Below, we draw on a 1% Steps brief authored by Amanda Starc of Northwestern University and Ashley Swanson of the University of Wisconsin–Madison.⁴²

Prices for identical drugs vary substantially across pharmacies. Prices for Crestor, a popular branded drug, can vary by up to 34% across pharmacies, and prices for levothyroxine, a widely used generic thyroid medication, can vary by up to 40%.⁴³ Variation on this scale means that payers and consumers can save significant amounts when prescriptions are filled at lower-priced locations. A preferred pharmacy network is a plan design tool for capturing those savings: the insurer contracts selectively with a subset of pharmacies and sets lower cost sharing at those preferred locations. Steering members toward preferred pharmacies, in turn, gives the insurer greater bargaining leverage in price negotiations, which can lower the prices it pays for its members' prescriptions.⁴⁴ These findings do not mean that all pharmacy steering lowers costs. As discussed below in Section III, when an insurer or pharmacy benefit manager (PBM) directs patients toward pharmacies it owns, it can raise total drug spending if it pays those pharmacies more for the same drugs, even when patients' own costs fall.

Evidence from Medicare Part D illustrates how preferred pharmacy networks lower spending:

- **Lower cost sharing successfully steers patients.** Enrollees in Part D plans with preferred networks generally pay \$6 to \$8 less out of pocket per prescription at preferred pharmacies than for identical products at non-preferred locations.⁴⁵

³⁹ Robinson and Brown, "Increases in Consumer Cost Sharing," 1392–97.

⁴⁰ Gruber, "Designing Smart Commercial Insurer Networks."

⁴¹ Amanda Starc and Ashley Swanson, "Promoting Preferred Pharmacy Networks," 1% Steps for Health Care Reform, February 2021, <https://onepercentsteps.com/policy-briefs/promoting-preferred-pharmacy-networks/>.

⁴² Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁴³ Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁴⁴ Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁴⁵ Starc and Swanson, "Promoting Preferred Pharmacy Networks."

- **Steering translates into lower negotiated prices.** Part D plans that use preferred pharmacy networks negotiate prices that are 1.9% to 2.3% lower, and preferred networks reduce Part D prescription drug spending by approximately 2%.⁴⁶
- **Effects on access appear minimal on average.** The closest preferred pharmacy is, on average, four minutes farther from a Part D beneficiary than the closest in-network pharmacy. However, the average beneficiary does not travel farther when their plan adopts a preferred network, and the average enrollee is better off due to reduced out-of-pocket costs at preferred pharmacies.⁴⁷

One caveat is that these savings depend on enrollees actually facing the cost-sharing differential. Enrollees whose cost sharing is subsidized, and who are therefore insulated from the copayment differences between preferred and non-preferred pharmacies, respond less to preferred networks, which reduces the savings plans can achieve.⁴⁸

Preferred pharmacy networks are now standard in Medicare Part D, where the share of plans using them rose from 13% in 2011 to 95% in 2019. By contrast, only about half of employer-sponsored plans use limited or preferred pharmacy networks.⁴⁹ The 1% Steps brief accordingly encourages employers to pursue, and commercial insurers to adopt, preferred pharmacy networks.⁵⁰ Preferred networks are consistent with the Committee's interest in plan designs that drive competition based on value: they preserve broad pharmacy access while rewarding the pharmacies that offer lower prices.

The potential savings are meaningful. Total U.S. spending on retail prescription drugs in 2018 was \$335 billion, of which \$134.3 billion was attributable to the commercially insured. Applying the approximately 2% reduction observed in Medicare Part D to the half of commercial plans that do not currently use preferred networks would lower drug spending by more than \$1.34 billion per year, approximately 0.4% of U.S. retail prescription drug spending.⁵¹

Section 3

The comments in this section draw on the Lab's Just the Facts memo reviewing the academic literature on vertical integration in health care.⁵²

⁴⁶ Amanda Starc and Ashley Swanson, "Preferred Pharmacy Networks and Drug Costs," *American Economic Journal: Economic Policy* 13, no. 3 (2021): 406–446, <https://doi.org/10.1257/pol.20180489>; Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁴⁷ Starc and Swanson, "Promoting Preferred Pharmacy Networks"; Starc and Swanson, "Preferred Pharmacy Networks and Drug Costs."

⁴⁸ Starc and Swanson, "Preferred Pharmacy Networks and Drug Costs."

⁴⁹ Starc and Swanson, "Promoting Preferred Pharmacy Networks." The brief cites A. J. Fein, "Yes, Commercial Payers Are Adopting Narrow Retail Pharmacy Networks," Drug Channels Institute, 2017.

⁵⁰ Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁵¹ Starc and Swanson, "Promoting Preferred Pharmacy Networks."

⁵² Zack Cooper et al., "Review of Expert and Academic Literature Assessing Vertical Integration in Health Care," Health Care Affordability Lab at Yale, June 9, 2026.

Vertical Integration Among Insurers, PBMs, and Pharmacies

Academic evidence supports reevaluating the MLR requirement for vertically integrated insurers. Researchers have found that vertical integration among insurers and pharmacies may allow integrated insurers to tunnel profits to circumvent the MLR rule, with the side effect of raising prescription drug prices for enrollees.⁵³ Insurer-PBM integration can weaken competition among PBMs, raising premiums for enrollees in non-integrated plans.⁵⁴

Because MLR rules apply to the health plan itself rather than to its broader corporate structure, an integrated insurer can raise the reimbursement prices it pays its own pharmacies for filling prescriptions. That spending counts toward the applicable MLR minimum, so the insurer satisfies the requirement on paper while the resulting profit stays inside the corporate family, at the pharmacy rather than the insurer. A 2026 study found that, in the three years after MLR implementation, prices paid by insurers to their affiliated pharmacies increased by 9.5% relative to non-integrated pharmacies. Furthermore, this price increase was concentrated among insurers most at risk of MLR noncompliance: price increases from insurers whose MLR was below 90% were six times greater than those from insurers with MLR above 90%.⁵⁵

Because Medicare Part D's cost-sharing and subsidy formulas are calculated as a share of reimbursement prices, increasing payments to integrated pharmacies also raises costs for patients and the federal government. Moreover, vertical integration could grant insurers greater control over pharmacy choice, letting them steer enrollees toward integrated pharmacies and away from lower-cost alternatives. This process reduces patient volume at competing, non-integrated pharmacies and places higher costs directly onto enrollees through cost-sharing.

Researchers estimated that if vertically integrated insurers divested their affiliated pharmacies, average Medicare drug prices would fall by 7.3%, annual consumer surplus in Medicare Part D would rise by 8.1%, and annual government spending on Medicare Part D subsidies and reinsurance would decrease by \$5.3 billion—with the largest gains for rural consumers, who have fewer non-integrated pharmacy options.⁵⁶ However, divestiture would also raise premiums because integrated insurers currently use profits from inflated pharmacy prices to subsidize lower premiums.⁵⁷ The research suggests the price and consumer-surplus gains outweigh the resulting premium increase, leaving consumers better off overall.

Insurers are also becoming vertically integrated with PBMs. By integrating with PBMs, insurers can leave competitors with fewer alternatives for PBM services, which raises their costs and, in turn, their premiums. The 2015 merger between UnitedHealthcare and Catamaran, the last significant standalone PBM at the time, caused non-integrated plans to raise their premiums by

⁵³ Zack Cooper et al., "Review of Expert and Academic Literature Assessing Vertical Integration in Health Care."

⁵⁴ Zack Cooper et al., "Review of Expert and Academic Literature Assessing Vertical Integration in Health Care."

⁵⁵ Kakani et al., "Profit Regulation and Strategic Transfer Pricing by Vertically Integrated Firms: Evidence from Health Care," NBER Working Paper No. 35043 (National Bureau of Economic Research, 2026), https://www.nber.org/system/files/working_papers/w35043/w35043.pdf.

⁵⁶ Yde, "Vertical Integration and Regulated Profits in Pharmacy Benefits Markets," job market paper, University of Virginia, Charlottesville, VA, 2025, <https://www.ydeeric.com/>.

⁵⁷ Yde, "Vertical Integration."

42% relative to integrated plans. Because UnitedHealthcare's own enrollees saw no decrease in their premiums, the premium increase among rival insurers likely reflects higher costs imposed on them because of the merger, rather than efficiencies.⁵⁸

Vertical Integration Between Insurers and Providers

Academic evidence suggests that insurer acquisitions of physician practices can enable regulatory gaming, though the evidence base is still developing and, in the U.S., concentrated on a single firm. This limits what can be said with confidence about how these transactions affect competitors and patients market-wide. The most rigorous causal evidence on insurer-provider integration comes from Chile: insurer-hospital integration led insurers to skew networks toward their own hospitals, weakening competition and raising prices in a way that outweighed efficiency gains.⁵⁹

When an insurer owns the practices it pays, the MLR can be circumvented on the provider side by raising payments to affiliated physicians, counting them as medical spending, and keeping the profit within the corporate family. Using CMS payer transparency data for the employer-sponsored and individual markets, a descriptive study finds that UnitedHealthcare pays its Optum-affiliated providers 17% more than non-affiliated providers, relative to what competing insurers pay the same practices.⁶⁰ Where UnitedHealthcare holds at least 25% market share, that gap rises to 61%. This study describes correlations rather than causal effects, but the authors raise concerns over the potential for regulatory gaming of the MLR and the disadvantaging of competing physician practices.

Insurer-provider integration appears to have mixed effects depending on the health insurance segment. While some evidence suggests that it can lead to higher spending in the Medicare Advantage market, it has also been found to lead to more efficient care provision in the commercial market. After Optum acquired physician practices, risk scores for UnitedHealthcare's Medicare Advantage enrollees rose about 6%, implying roughly \$265 million in additional federal spending from more intensive coding without accompanying changes in measured quality.⁶¹ Because the coding changes spilled over to physicians' non-UnitedHealth patients, UnitedHealth captured only about 37% of the additional risk adjustment revenue while 63% flowed to rival Medicare Advantage insurers. The cost is ultimately borne by taxpayers, given how Medicare Advantage payments are publicly financed. Grasley and Guido (2025) study a single 2017 Optum acquisition of a primary care practice in Colorado, and they find

⁵⁸ Gray et al., "Disadvantaging Rivals: Vertical Integration in the Pharmaceutical Market," *American Economic Journal: Applied Economics* 18, no. 1 (2026): 286–304, <https://doi.org/10.1257/app.20240011>.

⁵⁹ José Ignacio Cuesta et al., "Vertical Integration and Plan Design in Healthcare Markets," NBER Working Paper No. 32833 (National Bureau of Economic Research, 2025), <https://doi.org/10.3386/w32833>.

⁶⁰ Daniel R. Arnold and Brent D. Fulton, "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers," *Health Affairs* 44, no. 11 (2025): 1395–1403, <https://doi.org/10.1377/hlthaff.2025.00155>.

⁶¹ Jeffrey Marr, Christopher M. Whaley, and Xiaoxi Zhao, "From Payer to Provider: Impacts of Insurer Vertical Expansion into Physician Services," Brown University Center for Advancing Health Policy Through Research, April 14, 2026, <https://doi.org/10.26300/9xte-nh94>.

similar evidence of greater Medicare Advantage coding intensity.⁶² However, they also find that the acquisition improved efficiency in the commercial market by increasing referrals to less expensive specialists, which reduced costs by about \$300 per inpatient referral. As the authors note, assessing the net impact of the acquisition requires weighing this potential efficiency against the taxpayer costs of increased Medicare Advantage coding. Whether these findings generalize beyond this single acquisition is an open question.

Thank you for the opportunity to provide ideas and feedback on ways to strengthen health coverage in the U.S. If you have questions about the information in this letter, please reach out to Andrea Harris, Managing Director of the Health Care Affordability Lab at Yale, at andrea.harris@yale.edu.

Sincerely,

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CC:

Senator Mark Warner
Senator Jon Ossoff
Senator Raphael Warnock
Senator Lisa Blunt Rochester
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Senator Sheldon Whitehouse
Senator Jeff Merkley
Senator Elissa Slotkin
Senator Elizabeth Warren
Senator Tina Smith
Senator Peter Welch
Senator Maggie Hassan
Senator Mazie Hirono
Senator Maria Cantwell
Senator Richard Blumenthal
Senator Michael Bennet

⁶² Nick Grasley and Mariana Guido, "Aligning Incentives or Gaming the System? The Impact of Insurer-Physician Acquisitions," working paper, 2025, <https://marianaguido.github.io/assets/papers/jmp/mgjmp.pdf>.