Before the Senate Finance Committee Minority Staff

Response to Request for Information: Health Coverage That Works For Everyone

Written Comments from the American Economic Liberties Project, Alliance of Independent Dentists, Doctors for America, Pharmacists United for Truth and Transparency, Psychotherapy Action Network, Searchlight Investigative Journalism Foundation, and Small Business Majority

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Introduction & Summary

The American Economic Liberties Project (AELP),[1] Alliance of Independent Dentists,[2] Doctors for America,[3] Pharmacists United for Truth and Transparency,[4] Psychotherapy Action Network PSiAN),[5] Searchlight Investigative Journalism Foundation,[6] and Small Business Majority[7] submit these written comments in response to the Senate Finance Committee Minority Staff's request for information (RFI) regarding "Health Coverage That Works For Everyone."[8]

We appreciate Senate Democrats' efforts to reform private insurance. As the RFI acknowledges, the Committee must address the structural root causes of rapidly rising coverage costs amid rapidly declining coverage quality. These causes include decades of neoliberal federal policymaking by both political parties based on the flawed premise that empowering private insurers to manage, or ration, care would effectively contain costs. Instead, these policies resulted in extreme market consolidation, enabling the rise of not only Big Insurance but also Big Medicine—which includes insurance conglomerates, Big Pharma, pharmaceutical middlemen,

[1] AELP is a nonpartisan, nonprofit research and advocacy organization dedicated to understanding and addressing the problem of concentrated economic power in the United States.
[2] The Alliance of Independent Dentists represents independent dentists and believes health care decisions should be made between the doctor and the patient, without corporate or other third-party interference.
[3] Doctors for America is a physician-led, nonpartisan movement uniting doctors, medical trainees, and advocates to fight for equitable health care that is backed by clinical experience and driven by evidence.
[4] Pharmacists United for Truth and Transparency is a nonprofit advocacy organization educating the public about how pharmacy benefit manager business practices drive up prescription drug costs for patients and plan sponsors and create pharmacy deserts by forcing community pharmacies to close.
[5] PSiAN is a national mental health advocacy organization focused on expanding access to care and empowering the clinicians who provide that care.
[6] The Searchlight Investigative Journalism Foundation—founded by Tom Mueller, who wrote *How to Make a Killing: Blood, Death and Dollars in American Medicine*—turns investigative reporting into tangible positive change.
[7] Small Business Majority is a national small business organization that empowers America's entrepreneurs to build a thriving and equitable economy.
[8] Sen. Ron Wyden (D-OR), "Health Coverage That Works For Everyone," Senate Finance Committee, July 30, 2026, https://www.finance.senate.gov/imo/media/doc/073026_sfc_health_coverage_rfi.pdf.

hospital monopolies, and private equity-backed practices—at the expense of American patients, employers, and taxpayers.[9] The passage of Republicans' One Big Beautiful Bill Act has only exacerbated these harms, pushing an already strained system to the brink.

The problems laid out in the RFI—Republican cuts, unnecessary coverage complexity, and corporate greed—require solutions that are commensurate with their scale. However, many of the policy options presented in the RFI are incremental in nature and limited in scope. For these reasons, we urge Senate Democrats to prioritize the following structural reforms, many of which are discussed in our response to your first RFI, "Commonsense Policy Options to Lower Drug Prices for Patients."[10] A growing body of research indicates that these proposals will lower health care costs and expand access.[11] Polling also shows there is strong bipartisan support among U.S. voters for more aggressive intervention.[12]

In addition, we submit the attached AELP reports—"Break Up Big Medicine: An Agenda to Restore Power Over the U.S. Health Care System to Patients and Practitioners While Saving Families More Than $6,000 a Year" and "Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care"—which provide more detailed background information and policy proposals.[13]

Historical Context

Ensuring that health coverage works for everyone requires understanding why it currently works for almost no one.

Beginning in the 1970s, federal policymakers and regulators adopted a new philosophy of deference to private market forces, based on a belief that this would result in efficiency gains and, ultimately, lower costs. A core tenet of this neoliberal approach to health policy was the purported "moral hazard" of coverage. In 1968, economist Mark Pauly published an influential paper that argued insured patients would overuse health care relative to uninsured patients

[9] Emma Freer and Morgan Harper, "Break Up Big Medicine: A Health Care Agenda to Restore Power to Patients and Practitioners and Save Families $6,000 a Year," American Economic Liberties Project, August 2026, https://www.economicliberties.us/wp-content/uploads/2026/08/AELPHealthcareAgenda.pdf.
[10] "Response to Request for Information: Commonsense Policy Options to Lower Drug Prices for Patients," American Economic Liberties Project et al., Aug. 17, 2026, https://www.economicliberties.us/wp-content/uploads/2026/09/AELP-Joint-Comment-Drug-Prices-RFI-August-2026-1.pdf.
[11] See 2.
[12] Results of June 10-12, 2026 YouGov poll commissioned by American Economic Liberties Project, https://www.economicliberties.us/wp-content/uploads/2026/08/AELP_YouGov_HealthcarePoll.pdf.
[13] See 2; Hannah Garden-Monheit and Emma Freer, "Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care," American Economic Liberties Project, August 2026, https://www.economicliberties.us/wp-content/uploads/2026/08/prior-authorization-1.pdf.

because they are not responsible for the full cost.[14] His hypothesis—based on economic theory, not empirical research—implicated physicians, who, as some later argued, would likewise overprescribe care, assuming insurers bore most of the expense.[15]

It also gave rise to the "managed care" revolution, shifting health care financing from a fee-for-service model, in which insurers reimbursed providers a set rate for each service, to a new model, in which insurers took a more active role in cost containment.[16] They disincentivized patients and practitioners from overusing benefits by narrowing provider networks, increasing patient cost-sharing requirements, and deploying "utilization management" techniques like prior authorization.

Several laws enacted by Congress facilitated this revolution, including:

- The ***Health Maintenance Organization Act of 1973***, which pressured states to create exceptions to longstanding prohibitions against the corporate practice of medicine for certain managed care organizations, i.e., private insurers.[17] Along with other government actions, the resulting loopholes enabled Big Medicine insurance conglomerates to acquire and control health care providers and then raise their prices, among other harms.

- The ***Medicare and Medicaid Patient and Program Protection Act of 1987***, which weakened protections against financial conflicts of interest and self-dealing by decriminalizing rebates paid by prescription drug manufacturers to middlemen, including pharmacy benefit managers (PBMs), which have since vertically integrated with insurers. Such rebates result in higher list prices, as manufacturers try to recoup the cost of rebates, and higher patient cost-sharing requirements, which are based on list price.

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[14] Mark Pauly, "The Economics of Moral Hazard: Comment," *The American Economic Review*, June 1968, https://www.jstor.org/stable/1813785.
[15] Atul Gawande, "The Cost Conundrum," *The New Yorker*, May 25, 2009, https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum.
[16] Adam Gaffney, "The Neoliberal Turn in American Health Care," *Jacobin*, April 15, 2014, https://jacobin.com/%202014/04/the-neoliberal-turn-in-american-health-care/; Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.
[17] State corporate practice of medicine laws emerged from ethical standards promulgated by the American Medical Association (AMA) in the late 19th century. In 1975, the Federal Trade Commission successfully challenged the AMA's prohibition against the corporate practice of medicine, arguing that it prevented physicians from adopting "more economically efficient business formats" and therefore "inevitably had an adverse effect on competition." Eric Fuse Brown and Mark Hall, "Private Equity and the Corporatization of Health Care," *Stanford Law Review*, March 2024, https://review.law.stanford.edu/wp-content/uploads/sites/3/2024/03/Fuse-Brown-Hall-76-Stan.-L.-Rev.-527.pdf; Stephen Johnson, "The Corporate Practice of Medicine: An Old Conflict Continues in New Forms," *Maryland Medicine*, July 2015, https://www.medchi.org/Portals/18/files/MM-July2015-final.pdf.

- The ***Medicare Modernization Act of 2003***, which accelerated the privatization of the federal health care program under the managed care model by establishing Medicare Advantage and Medicare Part D as alternatives to traditional, fee-for-service Medicare.[18] It led to a windfall for private insurers, which gained both additional market power and new revenue streams, including federal subsidies that could be driven higher via regulatory gaming, such as upcoding and spread pricing.[19]

- The ***Affordable Care Act (ACA) of 2010***, which significantly expanded coverage but also included provisions that advanced managed care—since rebranded as "value-based care"—and promoted vertical integration between insurers and providers.[20] In particular, the law's medical loss ratio (MLR) provision requires large insurers to spend at least 85% of premiums on medical care in an effort to cap overhead costs.[21] However, due to a regulatory loophole, insurers are incentivized to engage in transfer pricing among their corporate affiliates—i.e., overpaying their provider subsidiaries and then booking the cost as spending on medical care to circumvent the cap while shifting costs to consumers in the form of higher premiums.[22] The MLR and some of the ACA's other provisions created new opportunities for Big Medicine conglomerates to divert public subsidies away from patient care toward their own bottom lines—an outcome that the law's architects did not intend but which its structure made inevitable.[23]

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[18] The Balanced Budget Act of 1997 created Medicare Part C—the managed care alternative to traditional, fee-for-service Medicare (Parts A and B)—under the name Medicare+Choice. The Medicare Modernization Act of 2003 renamed this program Medicare Advantage and expanded it. Thomas McGuire et al., "An Economic History of Medicare Part C," *The Milbank Quarterly*, June 2011, https://pmc.ncbi.nlm.nih.gov/articles/PMC3117270/.

[19] Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care," American Economic Liberties Project, April 2024, https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.

[20] Jennifer Tolbert et al., "The Uninsured Population and Health Coverage," KFF, Oct. 8, 2025, https://www.kff.org/uninsured/health-policy-101-the-uninsured-population-and-health-coverage/; Hayden Rooke-Ley, "The Same Script: Value-Based Payment, Managed Care, and Neoliberalism," The Law and Political Economic Project, July 15, 2025, https://lpeproject.org/blog/the-same-script-value-basedpayment-managed-care-and-neoliberalism/.

[21] "Medical Loss Ratio," Centers for Medicare & Medicaid Services, updated March 13, 2026, https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio.

[22] Indeed, research shows that UnitedHealth Group's insurer arm pays affiliated providers up to 61% more than unaffiliated competitors. A recent Tennessee state audit likewise found that CVS Health's PBM pays affiliated pharmacies up to 16,510% more than unaffiliated competitors. See 12; Daniel Arnold and Brent Fulton, "UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers," *Health Affairs*, Nov. 3, 2025, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00155; "Report on Audit of Caremark, L.L.C., Caremark PHC, L.L.C., and CaremarkPCS Health, L.L.C. ('Caremark')," Tennessee Department of Commerce and Insurance, Feb. 12, 2026, https://tnpharm.org/wp-content/uploads/CaremarkReportAuditPackage_20260212.pdf.

[23] Robert Kocher et al., "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges," *Annals of Internal Medicine*, Oct. 19, 2010, https://www.acpjournals.org/doi/10.7326/0003-4819-153-8-201010190-00274.

Against this backdrop, private insurers consolidated to gain leverage in price negotiations with providers and win managed care contracts with employers, state Medicaid programs, and, later, the federal Medicare Advantage program.[24] Providers began to consolidate for the same reason.[25] Eventually, the two camps began to integrate vertically, a process that has accelerated over the last decade and grown to include many other entities along the health care supply chain, including banks, PBMs, and claims processors, among others.[26] Despite engendering such extreme market consolidation, the managed care revolution failed on its own terms: health care is neither more affordable nor more accessible than it was at its outset, 50 years ago. In fact, as the RFI lays out, both problems have gotten much worse.

Policy recommendations

The RFI treats taking on corporate greed as a separate, tertiary track from making coverage more affordable, accessible, and simple. But the order should be reversed if Congress wants to lower costs: Big Medicine insurance conglomerates' market power and vertically-integrated business models are the reasons coverage doesn't work, so any reforms that leave them intact will be futile.

For example, in Section I.III of the RFI, Senate Democrats request feedback on public option proposals.[27] However, as Medicare Advantage has proven, the federal government's increasing reliance on private insurers to administer public benefits has only extended the harms of "America's broken for profit private health insurance system" while undermining confidence in the feasibility of a true public option.[28] In other words, Senate Democrats must first take on corporate greed by enacting the following policies to undo the managed care revolution—or else risk advancing it further.

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[24] Christopher Whaley et al., "Addressing Healthcare Consolidation in the U.S. Potential Policy Options for a Competitive and Transparent Future," Brown University Center for Advancing Health Policy through Research, Aug. 30, 2024, https://cahpr.sph.brown.edu/sites/default/files/documents/CAHPR_Health%20Care%20Consolidation_Policy%20Brief.pdf.

[25] See above.

[26] Emma Freer, "UnitedHealth Group Is a Bank: How Policymakers Can Protect Independent Physician Practices from Becoming Loan Shark Bait," American Economic Liberties Project, December 2025, https://www.economicliberties.us/wp-content/uploads/2025/12/UnitedHealth-Group-Is-a-Bank-FINAL-12-12-2025-1.pdf.

[27] See 1.

[28] Medicare Advantage costs taxpayers more than 14% more per patient—a projected $76 billion this year alone—than traditional, fee-for-service Medicare, despite similar patient populations and coverage criteria across the two coverage programs, according to the independent Medicare Payment Advisory Commission (MedPAC). See 1; "The Medicare Advantage program: Status report," MedPAC, March 2026, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

1. **Break up Big Medicine**

Senate Democrats should break up Big Medicine companies, including but not limited to insurance conglomerates, whose vertically-integrated business model hinges on financial conflicts of interest that drive coverage costs up, among other harms. Research conservatively estimates that divestiture of vertically integrated pharmacies, for instance, would reduce drug costs by more than 7%.[29]

Specifically, Senate Democrats should support the following legislation:

- The bipartisan ***Break Up Big Medicine Act (S. 3822)*** by Sens. Elizabeth Warren (D-MA) and Josh Hawley (R-MO), which would prohibit insurers, PBMs, and wholesale drug distributors from owning or controlling health care providers.[30]

- The ***Patients Over Profits Act (S. 2836, H.R. 5433)*** by Sen. Jeff Merkley (D-OR) and Val Hoyle (D-OR-4), which would force insurers to divest certain Medicare providers, achieving a component of the broader Break Up Big Medicine Act.[31]

- The ***Stop Corporate Takeovers of Physicians Act*** (H.R. 10444) by Sen. Warren, Ron Wyden (D-OR), and Merkley and Reps. Hoyle, Alexandria Ocasio-Cortez (D-NY-14), and Suhas Subramanyam (D-VA-10), which would establish a federal ban on the corporate practice of medicine, making it illegal for insurance conglomerates and other corporate entities to interfere with a medical practice's business or clinical functions.[32]

- The ***Take Back Our Hospitals Act*** (S. 4085, H.R. 7920) by Sen. Chris Murphy (D-CT) and Rep. Mary Gay Scanlon (D-PA-5), which would effectively prohibit private-equity

[29] Mark Cuban—the billionaire founder of Cost Plus Drugs, which bypasses PBMs—estimates that the legislation would lower costs 30% to 40% by eliminating "all the money that's going to health insurance companies that isn't going to care itself." Eric Yde, "Vertical Integration and Regulated Profits in Pharmacy Benefits Markets," University of Virginia Department of Economics, Oct. 14, 2025, https://www.dropbox.com/scl/fi/bgwfw0axy7sw9pozed60q/Yde_JMP.pdf?; Caitlin Owens, "The growing thirst for health insurance trustbusting," *Axios*, April 3, 2026, https://www.axios.com/2026/04/03/health-insurancetrustbusting-congress.
[30] "S. 3822—Break Up Big Medicine Act," Library of Congress, accessed Sept. 25, 2026, https://www.congress.gov/bill/119th-congress/senate-bill/3822/text.
[31] "S. 2836—POP Act," Library of Congress, accessed Sept. 25, 2026, https://www.congress.gov/bill/119th-congress/senate-bill/2836/text; "H.R. 5433—POP Act," Library of Congress, accessed Sept. 25, 2026, https://www.congress.gov/bill/119th-congress/house-bill/5433.
[32] A Senate companion bill is forthcoming. "H.R. 10444—Stop Corporate Takeovers of Physicians Act of 2026," Library of Congress, accessed Sept. 25, 2026, https://www.congress.gov/bill/119th-congress/house-bill/10444?; "Warren, Hoyle, Wyden, Merkley, Ocasio-Cortez, Subramanyam Introduce Bill to Ban the Corporate Practice of Medicine," Sen. Elizabeth Warren (D-MA), Sept. 16, 2026, https://www.warren.senate.gov/newsroom/press-releases/warren-hoyle-wyden-merkley-ocasio-cortez-subramanyam-introduce-bill-to-ban-the-corporate-practice-of-medicine/.

ownership of hospitals and skilled nursing facilities by prohibiting them from receiving Medicare reimbursements.[33]

Pending structural legislative reform, Senate Democrats should close the MLR loophole by raising the percentage of premium dollars that insurers must spend on medical care and by directing the Centers for Medicare and Medicaid Services to use its existing authority under the ACA to prohibit transfer pricing.[34]

In addition, Senate Democrats should end insurers' utilization management techniques, which deter, delay, or deny coverage in order to boost their own profits—with predictably tragic results.[35] Specifically, Senate Democrats should advance legislation to ban prior authorization and patient cost-sharing requirements in the private insurance market. Under the attached proposal, "Ban Prior Authorization," the former practice would be allowed only in rare, narrow circumstances where no conflict is present and where strict safeguards are in place, including a prohibition against AI-based denials.[36] Doing so would simplify payment processes and broaden coverage.[37] The resulting administrative savings would also help offset any increase in spending on medically necessary care.

Presumably, Congress has shied away from such a ban due to fears that it would cause health care costs to rise. However, that fear is not grounded in robust evidence, as analysis of the effects of eliminating prior authorization have been quite limited—and often compromised by industry interests.[38] In addition, the Congressional Budget Office's (CBO's) panel of health advisers includes several Big Medicine insurance conglomerate executives, who have an obvious conflict of interest when it comes to scoring coverage reforms.[39] For these reasons, Senate Democrats

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[33] "S. 4085—Take Back Our Hospitals Act of 2026," Library of Congress, accessed Oct. 2, 2026, https://www.congress.gov/bill/119th-congress/senate-bill/4085; "H.R. 7920—Take Back Our Hospitals Act of 2026," Library of Congress, accessed Oct. 2, 2025, https://www.congress.gov/bill/119th-congress/house-bill/7920.

[34] "Medicare Program; Request for Information on Medicare," Centers for Medicare & Medicaid Services, Aug. 1, 2022, https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-forinformation-on-medicare.

[35] See "Ban Prior Authorization" at 6; Hannah Garden-Monheit, "Big Medicine profits by denying care your doctor ordered. My father paid the price." MS NOW, Aug. 6, 2026, https://www.ms.now/opinion/health-care-prior-authorization-medicare-medicaid.

[36] See "Ban Prior Authorization" at 6.

[37] Nicole Fusco et al., "Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systemic literature review, " *Journal of Managed Care & Specialty Pharmacy*, January 2023, https://pmc.ncbi.nlm.nih.gov/articles/PMC10394195/.

[38] See "Ban Prior Authorization" at 6.

[39] "Panels of Advisers," Congressional Budget Office, accessed Sept. 25, 2026, https://www.cbo.gov/about/panels-advisers; Matt Stoller, "The Secret Society of Nerds Who Control Congress and Ruin Our Health Care," *Big*, Aug. 12, 2026, https://www.thebignewsletter.com/p/the-secret-society-of-nerds-who-control.

should require CBO to account for the administrative costs of prior authorization when scoring any such bans and to replace its conflicted advisers.

2. Lower prices

Senate Democrats should lower coverage costs through direct health care price controls, new public options, and stricter prohibitions against anticompetitive business practices, all of which would force private insurers to compete on quality rather than market dominance and thus undo financial incentives to consolidate further.

Specifically, Senate Democrats should pursue legislation that standardizes and caps health care prices across public and private payers using traditional Medicare reimbursement rates for inpatient and outpatient services and negotiated drug prices as benchmarks. Doing so would streamline payment processes by eliminating administrative bloat and undo incentives to consolidate among insurers, health care providers, and drug manufacturers alike. Additional benefits include ensuring independent providers can compete on a level playing field by guaranteeing fair payment and obviating the need for indirect funding mechanisms, like the beleaguered federal 340B Drug Pricing Program.[40]

Senate Democrats should also pursue legislation that creates public options for insurance—by expanding traditional, fee-for-service Medicare—and for PBM services, starting with a fee-for-service alternative to private Medicare Part D prescription drug plans. Several state Medicaid programs have carved out pharmacy benefits, either administering them directly under their Medicaid fee-for-service program or replacing private insurers' affiliated PBMs with independent PBMs.[41] In 2017, West Virginia became the first state to do the former, saving $54 million in its first year.[42] In 2019, Ohio chose the latter option, saving $333 million over a two-year period, much of which the state reinvested in increasing the dispensing fees paid to pharmacies.[43]

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[40] Karen Mulligan, "The 340B Drug Pricing Program: Background, Ongoing Challenges, and Recent Developments," Leonard D. Schaeffer Center for Health Policy & Economics, October 2021, https://schaeffer.usc.edu/wp-content/uploads/2024/10/USC_Schaeffer_340BDrugPricingProgram_WhitePaper.pdf.

[41] Hannah Garden-Monheit and Tyler Haydell, "Cutting out the Middleman: How States Can Save Medicaid Dollars by Firing Pharmacy Benefit Managers," Institute for Responsive Government, Nov. 14, 2025, https://responsivegov.org/research/cutting-out-the-middleman-how-states-can-save-medicaid-dollars-by-firingpharmacy-benefit-managers/.

[42] "West Virginia Medicaid saves $54.5 million with prescription drug carve-out," National Community Pharmacists Association, March 12, 2019, https://ncpa.org/newsroom/news-releases/2019/03/13/west-virginiamedicaid-saves-%2454.4-million-with-prescription-drug-carve-out.

[43] Memo to Ohio Rep. Adam Holmes and Ohio Department of Medicaid Executive Director Jada Brady Re: SPBM Program Review/Experience Analysis, Ohio Department of Medicaid, April 9, 2025, https://acrobat. adobe.com/id/urn:aaid:sc:us:9e7a9930-022d-42a0-b3c5-73a702cc00c5.

In addition, Senate Democrats should support repealing the safe harbor for PBMs and group purchasing organizations, which exempts them from federal anti-kickback law and allows them to accept post-sale rebates from drug manufacturers that would otherwise constitute a felony offense.[44] Extensive research finds rebates drive drug list prices, on which patient cost-sharing requirements are based.[45]
However, CBO continues to rely on unfounded assumptions and false premises when scoring PBM reforms, thwarting or delaying their passage.[46] For this reason, Senate Democrats must account for CBO's shortcomings when advancing any of the above policies.

Finally, Congress should pass legislation both prohibiting private Medicare Advantage and Part D insurers from using brokers and other agents and capping broker compensation across all markets.[47]

Crucially, we urge Senate Democrats to prioritize these recommendations over efforts to expand transparency and reporting requirements in private markets, as detailed in Section III of the RFI.[48] Federal hospital price transparency regulations have proven ineffective at lowering costs, with the majority of hospitals still failing to comply more than five years after the regulations took effect.[49] Furthermore, such requirements do nothing to address the underlying drivers of health care costs—most notably, corporate greed—for consumers. In other words, increased transparency, at best, will inform consumers to what extent they are being gouged without lowering their costs.

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[44] Philip Zweig, "White Paper: A Cost Analysis of the 1987 Medicare Anti-Kickback Safe Harbor for Group Purchasing Organizations and Pharmacy Benefit Managers," Physicians Against Drug Shortages, revised April 2, 2024, https://nebula.wsimg.com/6d8b8a93bb8e7651d4300550dfbebffc?AccessKeyId=62BC662C928C06F7384C&disposition=0&alloworigin=1.
[45] Neeraj Sood et al., "The Association Between Drug Rebates and List Prices," USC Leonard D. Schaeffer Institute for Public Policy & Government Service, Feb. 11, 2020, https://schaeffer.usc.edu/research/the-association-between-drug-rebates-and-list-prices/.
[46] The first Trump administration finalized a rule that would have repealed the safe harbor for PBMs in January 2023, but flawed CBO scoring—which assumed, without any clear reasoning, that banning rebates would *increase* Medicare Part D premiums, despite extensive state-level evidence to the contrary—has since delayed its implementation until 2032. Specifically, Congress pushed it back to pay for other unrelated legislation. Erik Sherman, "Gun Safety Bill Extends Drug Middlemen Protection From Anti-Kickback Measure," *Forbes*, June 30, 2022, https://www.forbes.com/sites/eriksherman/2022/06/30/gun-safety-bill-extends-drug-middlemen-protection-from-anti-kickback-measure/?sh=56256771ac30; Joyce Frieden, "Gun Violence Bill Contains an Unlikely Provision on PBMs," *Medpage Today*, Aug. 30, 2022, https://www.medpagetoday.com/pharmacy/pharmacy/100474; Sara Sirota, "Why We Should Ban PBM Rebates," American Economic Liberties Project, February 2024, https://www.economicliberties.us/wp-content/uploads/2024/02/20240103-AELP-Rebates-Brief_Final.pdf.
[47] "Health Insurance Brokers," American Economic Liberties Project, June 2025, https://www.economicliberties.us/wp-content/uploads/2025/06/Brokers-One-Pager-June-2025.docx.pdf.
[48] See 1.
[49] "Eighth Hospital Price Transparency Compliance Report," Patient Rights Advocate, September 2026, http://patientrightsadvocate.org/blog/new-report-majority-of-hospitals-still-noncompliant-with-hospital-price-transparency-rule.

Conclusion

The U.S. health care coverage crisis is the result of decades of deliberate policy choices that enabled the rise of Big Medicine at the expense of patients and health care professionals. Fortunately, Senate Democrats can end this crisis by enacting the popular structural policy reforms outlined here, all of which break with the managed care paradigm and instead tackle the corporate greed of Big Insurers and other bad actors directly. However, any incremental reforms that leave this paradigm intact, in some or all markets, will prevent Senate Democrats' from achieving their stated goals. We appreciate the opportunity to submit these comments and welcome the chance to provide additional information as the Committee continues its work on this critical issue.