April 16, 2026

The Honorable Bill Cassidy
Chairman
Senate Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

The Honorable Bernie Sanders
Ranking Member
Senate Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Re: Insurance Practices that Increase Prescription Drug Costs

Dear Chairman Cassidy, Ranking Member Sanders, and Members of the Committee:

We commend the Committee for its continued focus on reducing prescription drug costs for American patients. This is a critical issue. But the current policy debate remains incomplete—and risks missing a central driver of rising costs: the role of health insurance companies in determining what patients actually pay.

In recent years, policymakers – including President Donald Trump – have demonstrated that Washington can take meaningful action to reduce drug costs for American patients. The "Trump Rx" approach is a notable example of this. Nonetheless, insurance barriers continue to pose the greatest threat to affordability. Rising premiums, tight formularies, and high out-of-pocket costs reduce access to medicines, regardless of their list prices.

These challenges can only be addressed by serious health insurance reforms. National polling conducted in January 2026 by OnMessage on behalf of the Insurance Watchdog Coalition shows that, by a 63% margin, voters believe policymakers should focus on health insurance companies – not other parts of the system – to fix healthcare problems. The same survey found overwhelming, bipartisan agreement on core reforms:

- 97% support greater transparency in how insurers determine coverage and pricing;
- 95% support requiring insurers to report claim denials;
- 94% support requiring more healthcare dollars to be spent on patient care rather than administrative costs and profit;

- 92% support limits on premium increases;
- More than 90% oppose insurer practices that increase drug costs through hidden markups and opaque financial arrangements.

More recent polling conducted in March 2026 in states such as Maine and Ohio reinforces these findings. Roughly three in four voters (72–73%) identify insurance-related costs—premiums, deductibles, and claim denials – as their primary healthcare burden. When asked where policymakers should focus, voters favor cracking down on insurer practices by wide margins over additional pharmaceutical price controls.

Most insured patients don't know that their costs at the pharmacy counter—co-pays, coinsurance, and deductibles – are set by insurers. These amounts often bear little or no relation to the list price of drugs.

Insurance design, ownership structures, and payment practices are now a dominant—and often overlooked – force driving total costs. The nation's largest insurers are vertically integrated enterprises that own or control pharmacy benefit managers (PBMs), specialty pharmacies, provider groups, and data platforms.

Insurer consolidation has created significant conflicts of interest across the prescription drug supply chain. The same corporate entity can design formularies, negotiate rebates, manage benefits, dispense drugs, and set reimbursement levels – creating powerful incentives to maximize internal profit rather than minimize patient costs.

An increasingly important – and underexamined – component of this system is the use of offshore or foreign-domiciled group purchasing organizations (GPOs) affiliated with PBMs.

By routing financial flows through affiliated GPOs, PBMs and their parent insurers can retain a larger share of manufacturer concessions while reducing transparency into how those funds are used or whether they are passed on to patients.

Recent enforcement activity underscores these risks. The Federal Trade Commission has reached a settlement with Express Scripts, a subsidiary of Cigna, related to aspects of its GPO and rebate arrangements. While that action represents an important step toward greater oversight, similar structures remain in place across other major PBMs, including those affiliated with UnitedHealth Group and CVS Health.

These challenges are not isolated – they reflect a broader pattern of insurance practices that distort costs and restrict access to care. Patients face increasing barriers through prior authorization delays, coverage denials, and benefit designs that shift more costs onto individuals. At the same time, opaque pricing structures and complex financial arrangements – often routed through affiliated PBMs and offshore entities – make it difficult to understand where healthcare dollars go or whether savings ever reach patients.

Conflicts of interest embedded in vertically integrated insurance models further compound the problem. When insurers control multiple points in the supply chain – from benefit design to drug

dispensing – they have the ability and incentive to prioritize internal revenue over patient affordability and access. These dynamics can override clinical judgment, limit provider participation, and leave patients paying more – even when underlying drug costs are stable or declining.

There is a direct connection between wasteful spending in federal health programs and what patients pay at the pharmacy counter.

Reforms such as the No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act would help correct these distortions. By eliminating an estimated $124 billion in excess payments, policymakers could help ensure those savings are directed toward lowering out-of-pocket drug costs for Medicare enrollees.

We appreciate the Committee's leadership and stand ready to provide additional data and analysis to support these efforts.

Sincerely,

Mark Merritt
Executive Director
Insurance Watchdog Coalition