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The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

October 2, 2026

Subject: Request for Information: Health Coverage That Works for Everyone

Dear Senate Finance Committee Ranking Member Ron Wyden and Senate Finance Committee Minority Staff,

On behalf of the California Public Employees' Retirement System (CalPERS), we are writing in response to the Senate Finance Committee Minority Staff's Request for Information on Health Coverage That Works for Everyone. We share the Minority Staff's view that all Americans should have access to comprehensive and affordable coverage, regardless of where they live or work or what they can afford.

With more than 1.5 million members, CalPERS is the largest purchaser of public employee health benefits in California and the second largest public purchaser in the nation after the federal government. In 2025, we spent over $13.9 billion to purchase health benefits for active and retired members and their families on behalf of the State of California (including the California State University) and nearly 1,200 public agencies and schools.

CalPERS is providing the following comments to help the Committee address tactics that drive up costs and impose undue barriers to care for employers and patients. We offer four key recommendations:

- Ensure any reform of the Affordable Care Act's (ACA) firewall includes protections against adverse selection to preserve the stability of risk pools for employers and purchasers offering comprehensive coverage.
- Strengthen provider directory accuracy by establishing shared accountability between health plans and providers.

- Address vertical integration by increasing oversight, including through joint federal-state antitrust investigations, and prohibiting anticompetitive practices, such as anti-tiering and anti-steering clauses. Support the Break Up Big Medicine Act (S. 3822), Patients Over Profit Act (S. 2836), and the Competition and Antitrust Law Enforcement Reform Act (S.130).
- Increase oversight, accountability, and financial alignment between third-party administrators (TPAs) and plan sponsors.

SECTION I: Reversing Republican Cuts and Reimagining a Better Path

ACA Firewall

We share the minority staff's goal of improving affordability and addressing coverage gaps and acknowledge that unaffordable employer coverage with substantial cost-sharing burdens creates genuine hardship for employees. Eliminating or modifying the ACA firewall is one approach to providing relief in these cases. Should policymakers adopt this policy change, caution should be exercised to ensure that it does not destabilize the risk pools of employers and purchasers like CalPERS who offer comprehensive coverage.

Currently, the ACA prevents employees from receiving federal marketplace subsidies if their employer offers them affordable coverage. Allowing employees to redirect that value to instead purchase ACA marketplace coverage could encourage adverse selection within employer health plans. Healthier lives could migrate to the ACA marketplace where plans with lower actuarial value are available, leaving a higher concentration of older and sicker individuals in employer-sponsored coverage, ultimately increasing costs for employees and employers.

Any policy lowering or eliminating the ACA firewall should have protections to ensure affordability goals are achieved without unintentionally destabilizing the risk pools for employers offering generous coverage.

SECTION II: Making Health Care Simpler for Families

Network Adequacy

Inaccurate directories obstruct access to care, increase out-of-network utilization, lead to misinformation, and impair purchasers and regulators' ability to assess network adequacy. CalPERS and our members have experienced challenges related to the accuracy and reliability of provider directory information. Our health plans face difficulties maintaining accurate and up-to-date directories in part because providers may not respond to requests to verify or update their information. As a result, we believe ensuring directory accuracy should be a shared responsibility between health plans and providers. Further, we believe a central utility for updating provider information would reduce duplication, administrative burden, and improve the timeliness and consistency of directory data.

California recently enacted Assembly Bill 280 (Aguiar-Curry, Chapter 499, Statutes of 2026), which is consistent with this approach. It requires health plans and providers to use a central utility designated by the Department of Managed Health Care (DMHC) to collect, manage, and

verify provider directory information. Federal policy should support and build on such state efforts rather than duplicate or conflict with them.

Prior Authorization

We support appropriate prior authorization when it protects patients from unnecessary, unsafe, or low-value care and helps ensure that health care resources are used effectively. Prior authorization should not become a routine administrative barrier to clinically appropriate care. Our collective goal should be to move toward a targeted, evidence based and accountable prior authorization system.

Process reforms, such as streamlining coverage decisions, standardizing requirements, and improving transparency about coverage limitations and approval criteria, can reduce the administrative burden of prior authorization on patients and providers.[1,2] These reforms can make the process more predictable and easier to navigate by ensuring that patients and providers have clear information about when prior authorization is required, what documentation is needed, and how coverage decisions are made.

More substantive reforms can go further by aligning prior authorization criteria with clinical standards of care and evidence and closing the gap between plan coverage policies and access to clinically appropriate treatment.[3] This means ensuring that coverage requirements are evidence based and standardized across health insurers. It also means making these requirements readily available to the public and purchasers, so that prior authorization is a transparent process that does not stand as a barrier to medically appropriate care.

To address inappropriate use, we suggest holding health insurers accountable to the prior authorization pledge they made in June 2025 at the invitation of the Health and Human Services Secretary Kennedy and Centers for Medicare and Medicaid Administrator Dr. Oz. Insurers committed to reduce the volume of medical services subject to prior authorization, enhance transparency and communication around authorization decisions and appeals, expand real-time responses with real-time approvals for most requests, and ensure that medical professionals review all clinical denials.[4]

SECTION III: Taking on Corporate Greed

Vertical Integration

In California, various state agencies attempt to combat anticompetitive behavior across the health care industry. However, a gap exists in state authority to oversee mergers involving for-

[1] *See* Health Affairs. Prior Authorization Reform Heats Up, November 2025, *available at* https://www.healthaffairs.org/content/forefront/prior-authorization-reform-heats-up.
[2] *See* KFF. Are the Tradeoffs from Prior Authorization Worth It? March 2026, *available at* https://www.kff.org/from-drew-altman/are-the-tradeoffs-from-prior-authorization-worth-it/.
[3] *See* Health Affairs. Continuous Glucose Monitor Coverage Criteria And The Need For Prior Authorization Reform, May 2026, *available at* https://www.healthaffairs.org/content/forefront/continuous-glucose-monitor-coverage-criteria-and-need-prior-authorization-reform.
[4] *See* Department of Health and Human Services, HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System, June 2025, *available at* https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html.

profit hospitals and other providers. Because of this, California depends on federal antitrust law and federal agencies to address these mergers.[5]

State oversight of for-profit entities is fragmented. The California Attorney General has the legal authority to oversee mergers and acquisitions involving nonprofit entities. The California Department of Insurance is authorized to approve any mergers involving insurers, while DMHC is authorized to approve any mergers involving health plans. Pharmacy benefit managers (PBMs) are required to register with DMHC; however, DMHC's authority to regulate PBMs is limited. Given that large PBMs are vertically integrated with nationwide health insurers, additional federal oversight would help close this gap.

That said, California is expanding its oversight of health care industry mergers. The Office of Health Care Affordability (OHCA) performs cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health plans, insurers, hospitals, physician organizations, PBMs, and other health care entities. OHCA first reviews the transaction, and if warranted, conducts a full cost and market impact review. Based on its findings, OHCA may coordinate with other state agencies to address the consolidation, including referring proposed transactions to the AG, who can pursue legal action to block or restrict a transaction.

CalPERS encourages the Committee to pass legislation requiring oversight of these practices and prohibit anti-tiering and anti-steering clauses in contracts between health plans and health care providers, including vertically integrated health systems. These policies should also include meaningful enforcement mechanisms to promote compliance. Increasing competition in health care and limiting anticompetitive practices can help drive down the cost of care for employers and members.

While preventing further consolidation in healthcare is critical, the current state of consolidation is already deeply problematic. For this reason, we support the Break Up Big Medicine Act (S.3822), which prohibits insurance companies from owning provider groups and PBMs; and the Patients Over Profit Act (S.2836), which prohibits ownership between health insurers and physician groups or outpatient provider entities that bill under Medicare Part B or participate in Part C networks.[6,7] We also support the Competition and Antitrust Law Enforcement Reform Act (S. 130), which prohibits mergers that create an appreciable risk of materially lessening competition. Notably, S. 130 directly addresses restrictive anti-steering clauses in health plan contract language, while the former two bills do not.

Medical Loss Ratio (MLR) Oversight and Reporting

CalPERS supports strengthening transparency, verification, accountability in MLR oversight and reporting. As a large purchaser, CalPERS relies on accurate pricing data to negotiate effectively and reduce unnecessary costs. Effective MLR oversight similarly requires that plans and

[5] *See* OAG, Attorney General Bonta Combats Anticompetitive Hospital Consolidations, Fights for Affordable and Accessible Healthcare, *available at* https://oag.ca.gov/news/press-releases/attorney-general-bonta-combats-anticompetitive-hospital-consolidations-fights.

[6] *See* S. 3822, Break Up Big Medicine Act, 119th Congress (2025-2026), *available at* https://www.congress.gov/bill/119th-congress/senate-bill/3822.

[7] *See* S. 2836, POP Act, 119th Congress (2025-2026), *available at* https://www.congress.gov/bill/119th-congress/senate-bill/2836.

regulators have verifiable information on how premiums are allocated across medical care, quality improvement, administrative expenses, and other costs.

Current oversight would be strengthened by routine audit authority, standardized reporting, and greater visibility into the underlying data used to calculate MLR results and rebate obligations. CalPERS has invested significantly in the infrastructure needed to support this transparency. Our Health Care Decision Support System, a centralized data warehouse, supports rate setting, clinical program evaluation, performance monitoring, and analytical reporting. It allows us to directly develop, reconcile, and validate premiums, identify cost drivers and market inefficiencies, and optimize provider networks, offering a more complete view of plan performance than aggregated or self-reported data alone.

Many purchasers lack the infrastructure to achieve the level of transparency and oversight needed to verify self-reported MLR data from plans. Improved MLR oversight should give purchasers and regulators greater access to underlying claims, pharmacy, capitation, administrative, and quality-improvement data, support reconciliation of reported expenditures against actual payments, and strengthen accountability across the market.

Third-Party Administrators

As a large health care purchaser, CalPERS agrees that greater oversight and transparency requirements for TPAs are needed to enable plan sponsors to act in the best interests of their members. CalPERS addresses concerns about TPA costs, transparency, profits, and oversight through total cost of care guarantees and financial incentives for meeting quality measures.[8,9]

In 2025, CalPERS implemented new five-year health plan contracts for its self-funded preferred provider organization (PPO) plans, with Blue Shield of California (BSC) as the TPA and Included Health (IH) to provide population health management. Both BSC and IH agreed to total cost of care guarantees, with $464 million at risk over the life of the agreements if annual medical cost growth targets are not met. The contracts set an initial medical trend target of 5.5% in 2025, declining each year to 3% by 2029. Under the agreements, the TPAs share both the risk of costs exceeding the benchmark and the savings when costs remain below it, creating a strong incentive to control costs.

In addition, the PPO contracts are structured similarly to the CalPERS' Health Maintenance Organization (HMO) contracts, in that they both tie significant financial consequences to quality measures, reinforcing the incentive for improved care. By aligning the PPO and HMO contracts, CalPERS' health plans will put more than $1.3 billion at risk over the five-year agreements if cost and quality targets are not met.

Similarly, as part of CalPERS' commitment to prescription drug affordability, CalPERS recently entered a new PBM contract with CVS Caremark (CVS) designed to better align incentives for

[8] *See* CalPERS Announces New Health Plan Contracts to Lower Costs While Improving Quality and Accountability, June 2024, *available at* https://www.calpers.ca.gov/newsroom/calpers-news/2024/calpers-announces-new-health-plan-contracts-to-lower-costs-and-improve-quality-and-accountability.
[9] *See* CalPERS Announces New Pharmacy Benefits Contract With CVS Caremark to Foster Affordability and Improve Quality, July 2025, *available at* https://www.calpers.ca.gov/newsroom/calpers-news/2025/calpers-announces-new-pharmacy-benefits-contract-with-cvs-caremark-to-foster-affordability-and-improve-quality.

cost control and member health outcomes. Under the five-year agreement, CVS has agreed to put $250 million at risk if it does not meet cost and quality goals.

CalPERS' approach incentivizes accountability and affordability, reduces opportunities for hidden profits, and gives plan sponsors greater insight into whether the TPAs are delivering value. Unfortunately, most employers, especially small and mid-sized purchasers, do not have CalPERS' market leverage and cannot compel PBMs to accept total cost of care guarantees or meaningful downside risk. We recommend that the federal government explore ways of making it easier for smaller employers with less leverage to achieve performance-based contracting arrangements with TPAs and PBMs. We also recommend developing model contract language and standardized reporting requirements for cost and quality metrics and help employers make meaningful comparisons across vendors.

We thank you for your consideration, and we welcome the opportunity to work with you on our shared goal to promote competition and improve health care affordability for everyone. Please do not hesitate to contact Donald Moulds, CalPERS Chief Health Director, at (916) 795-0404, or Danny Brown, Chief of the CalPERS Legislative Affairs Division, at (916) 795-2565, if we can be of any assistance.

Sincerely,

Doug Hoffner
Chief Operating Officer