



October 2, 2026

The Honorable Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Request for Information: Health Coverage that Works for Everyone

Dear Ranking Member Wyden and Senate Democrats,

As the longtime national, nonpartisan health care consumer advocacy organization, Families USA appreciates the opportunity to provide input to Senate Democrats in response to the request for information (RFI) on health coverage that works for everyone. For 45 years, Families USA has worked to advance the goal of quality, equitable, affordable health care and coverage for all Americans. To that goal, we support a broad range of policy reforms to make our health care system more affordable and accessible; to guarantee important consumer rights and protections; to provide a better, simpler, respectful, and equitable experience for patients and families; to ensure that the system provides efficient and effective care at the right time and place; and to advance health and economic security and justice for all.

Research reveals broad agreement that the health care system costs too much, is too complex, and the quality of care is mediocre.¹ Families and consumers across the country still lack affordable access to the health care services they need, even if they are insured,² and the U.S. population has some of the worst health outcomes among comparable countries, including high rates of maternal and infant death, low life expectancy, and a high prevalence of chronic disease.³ These data are evidence of how broken the U.S. health care system has become — a system where the unchecked market power of hospitals, health plans, and drug companies has led to such high prices that families and consumers are forced to choose between their health and basic needs like buying groceries or gas;⁴ a system designed with so much complexity and fragmentation it can be nearly impossible to navigate;⁵ a system with little accountability for how much care costs, for the patient experience or for health outcomes;⁶ a system that denies medically necessary care because of the business interests and opaque administrative processes designed by corporate health plans and hospital systems.⁷

Put simply, our health care system was not designed to deliver health. Instead, it has been structured over decades to treat sickness in silos, to shift financial risk instead of effectively managing population health, to control utilization as a cost management strategy while allowing corporate health plans and health systems to flourish, and to manage payment with no real accountability for costs, health outcomes, equity, or patient affordability.⁸ Families need reforms that both relieve the daily harms of a broken health system *and* fix the root causes of unaffordable, low-quality care: closing coverage gaps and strengthening premium subsidies, while also redesigning how we pay for and deliver care.

Now is the time for bold vision and action. Our nation's families have reached a breaking point, becoming deeply frustrated with the entrenched business interests of the health care sector and the desire by many in power to maintain the status quo financial interests of drug companies, corporate hospitals and health plans at their expense. Public opinion surveys show that the American public now

gives the U.S. health care system a grade of “C” on costs, access, and quality.⁹ With now near universal agreement that the U.S. health care system is deeply entrenched in a health care affordability and quality crisis, health care affordability now ranks as the top issue for voters across the political spectrum with more than 94% of voters wanting lawmakers to lower their health care costs and fix the broken system.¹⁰

This crisis has been compounded by the historic attacks on U.S. health coverage, particularly on Medicaid and the Affordable Care Act (ACA) marketplaces.¹¹ We are now faced with a critical opportunity — and responsibility — not only to repeal cuts and rebuild what was lost, but also to reclaim and reimagine a better health system for everyone. That vision starts with restoring key public programs and extends to a broader framework of health and economic security: one that guarantees access and affordability across public and private coverage alike.

More than 185 million Americans — 55% of the population — rely on employer-sponsored coverage or the ACA marketplaces for their health insurance,¹² making private health insurance reform foundational to any vision and policy agenda to meet the health and health care needs of patients and consumers. Any reforms to the private market must fundamentally shift the paradigm for offering health insurance coverage to the American people by making new guarantees in what people can access and afford.

Families USA envisions a future health system built on a set of core guarantees for every consumer, no matter how they get their coverage:

- 1. The Affordability Guarantee:** Families have their health care costs capped on a sliding income-based scale (premiums up to 8% of income across all payers including employer coverage), with real-time cost protection at the point of care, limits on co-insurance and deductibles, and a ban on predatory medical debt practices. People know in advance that they can get the care they need without undue financial burden.
- 2. The Access Guarantee:** Every person has access to a standardized benefit package and an attributed primary care provider responsible for coordinating their care. Health plans must meet federal network adequacy benchmarks, national prior authorization standards with independent peer review, and mandatory reporting on denials and utilization.
- 3. The Consumer Protection and Experience Guarantee:** Patients are protected against unfair bills and unsafe and predatory business practices, and they retain the ability to appeal bad decisions by plans or providers. Patients are empowered in their engagement with the health system and can reasonably expect timely customer service. Every patient owns their health data with real-time portable access. Nationwide interoperability standards eliminate fragmentation. Administrative processes, including prior authorization, eligibility, and enrollment are standardized in real time. AI and algorithmic tools in clinical and coverage decisions are disclosed, audited for equity, and subject to human clinical oversight.
- 4. The Accountability Guarantee:** The system only profits when families are healthy. Payment shifts to population-based models and global budgets tied to outcomes, equity, and total cost of care. Hospital prices are capped, drug negotiation expands to the commercial market, and performance on health outcomes and disparity reduction is measured, reported, and enforced.

We appreciate the opportunity to comment on this RFI. The following comment letter emphasizes key policy recommendations focused on marketplace and insurance regulation that drive towards achieving the promise of these guarantees across the U.S. health care system.

Affordability: Make Commercial Coverage Affordable and Control the Costs that Drive it

Patients should have the peace of mind that they can afford needed health care, regardless of their income. To achieve this, Congress must advance policy reforms that guarantee affordability to consumers when they purchase comprehensive insurance and when they access care, while also addressing the root drivers of unaffordable care such as hospital and drug prices. As such, we recommend policy solutions for both direct consumer relief and structural cost-side controls including:

Consumer-Side Relief

- **Cap total household health care cost exposure**, premiums plus out-of-pocket costs, on a sliding income-based scale so coverage does not consume an unmanageable share of family budgets.
 - **Provide a guarantee that no one should pay more than 8% of their household income on premiums.** In the individual market, permanently extend and expand premium tax credit (PTC) enhancements so that no one is priced out of marketplace coverage, and allow all those with unaffordable employer coverage to shift to subsidized ACA coverage, adjusting the “ACA firewall”. For example, the now expired PTC enhancements guaranteed marketplace enrollees would not pay more than 8.5% of their annual household income on premiums no matter their income.¹³ These protections allowed millions more people — primarily people with low or moderate incomes and people who would otherwise have very high premiums — to afford high-quality coverage between 2021 and 2025.¹⁴ With the PTC enhancements now expired and many consumers re-exposed to the full cost of coverage in the marketplace, ACA marketplace enrollment has dropped significantly, with 2.6 million fewer people enrolled in February 2026 compared to February 2025.¹⁵ New Mexico was the only state that used their own resources to maintain the full PTC enhancements after federal funding expired, and the state not only avoided enrollment loss in 2026, but also experienced the highest enrollment growth (an 18% increase) in the nation in 2026.¹⁶ Other states have funded more limited state subsidy programs to assist consumers losing PTC enhancements, but these efforts strain state budgets and are unlikely to be sustainable in the long term.¹⁷
 - **Limit or eliminate coinsurance as a cost-sharing structure.** In contrast to copayments, which provide a fixed dollar amount the consumer is responsible for paying for specific categories of services, coinsurance obligates a consumer to cover a share of the of the covered amount — an amount that is often unknown and usually significant. A percentage of a very big number is often still a big number, one that exposes consumers to significant medical debt. In the absence of stronger price transparency and price regulation requirements, consumers faced with coinsurance obligations have no way to make accurate out-of-pocket cost comparisons when choosing a plan or to budget appropriately for known health care needs. Even in current standardized plans, federal rules still allow coinsurance for some service categories and metal tiers.
 - **Limit or eliminate deductibles in ACA-compliant plans and strengthen annual out-of-pocket caps** so cost-sharing does not become a functional barrier to using coverage. High deductibles are a major barrier for consumers’ ability to access timely health care with an estimated 26% of adults in high-deductible health plans reporting cost burdens or delays in accessing needed care due to the cost.¹⁸ Reducing or eliminating deductibles would significantly increase access to needed health care for patients and consumers.¹⁹ For many plans, deductibles are a way to shift costs from broad premiums onto those

who access health care, but there are ways to limit or eliminate the use of deductibles. For example, in 2023, California allocated \$82.5 million to eliminate deductibles and reduce cost sharing for low-income enrollees up to 250% of the federal poverty level (FPL) in cost-sharing reduction silver ACA plans.²⁰ In January 2024, over 850,000 Covered California enrollees qualified for the cost-sharing reduction resulting in over 400,000 Californians receiving Enhanced Silver plan coverage for only \$10 or less per month.²¹

- **Cap out-of-pocket drug costs** for essential medications including insulin, inhalers, and treatments for chronic conditions, across all private market plans. The Inflation Reduction Act's Part D redesign which capped Medicare beneficiaries' annual out-of-pocket drug costs is projected to generate an average of \$759 a year per enrollee for more than 8 million enrollees.²² Twenty-nine states and D.C. have enacted laws to cap out-of-pocket drug costs for insulin, including North Dakota, Texas and Connecticut.²³ New York eliminated cost-sharing for insulin entirely for new, renewed, modified or amended health plans starting in January 2025.²⁴ Enacting a more comprehensive cap on out-of-pocket drug costs for all private market plans would significantly lower drug costs for families.
- **Eliminate junk plans, short-term, limited benefit, and association health plans** that offer an illusion of coverage without access to comprehensive benefits. These junk insurance plans skirt ACA consumer protections, exclude essential health benefits like preventive screenings, and expose consumers to higher financial liability, often resulting in people being forced to delay care or skip it altogether. Five states, including California, Illinois, Massachusetts, New Jersey, and New York, have laws that prohibit the sale of short-term, limited duration plans,²⁵ but consumers in every state should be protected from these inadequate plans. While federal regulations have at times provided some consumer protections, both Trump administrations have taken regulatory action to reverse or weaken these protections.²⁶ They should be enshrined in law to end the regulatory back-and-forth and provide consistent consumer protections. Additionally, although no state has limited the sale of fixed-indemnity or other excepted-benefits products, many have increased related consumer protections and restricted the ways these products can be marketed and sold. For example, California requires fixed indemnity plans to be marketed as "supplemental" and only sold to consumers with major medical insurance.²⁷ Similarly, Arkansas requires fixed indemnity plans sold to Medicare beneficiaries to provide notice that the plan is not Medicare supplemental insurance and that Medicare pays for "most or all" of the services the indemnity plan would pay for.²⁸

Cost-Side Controls

- **Establish federal rate review authority and approval requirements** to stop excessive premium increases. The ACA established Rate Review Programs, and currently 47 states plus Washington, D.C. conduct their own rate review for individual and small group markets.²⁹ However, major gaps exist, including that many states lack the needed authority to deny rates; that the 15% review threshold allows most increases to go unscrutinized; and that the requirement does not apply to the self-insured employer market, to Medicare Advantage, or to Medicaid managed care.³⁰ A national rate review process would create stronger accountability for rising health insurance premiums and directly lower health care costs for consumers.
- **Bring hospital prices under control by cracking down on the anti-competitive behavior** that has given hospital corporations unchecked pricing power in communities across the country. Policy reforms include:

- **Enacting site-neutral payments** to reduce the financial incentive for big hospital systems to buy-up doctors' offices and rebrand them as outpatient departments that push care delivery to higher-cost settings. The Medicare Payment Advisory Commission (MedPAC) recommends site-neutral payments for 66 distinct Ambulatory Payment Classifications that can be paid at the physician fee schedule rate while maintaining the safety and quality of care.³¹
- **Prohibiting anticompetitive contracting practices** that enable major hospital systems to further suppress market competition. Contract provisions such as all-or-nothing clauses, anti-tiering and anti-steering clauses, gag clauses, and non-compete agreements ratchet up the cost of health care, often by restricting insurers' ability to drive patients to lower-cost, higher quality providers.³² For example, both Texas and Connecticut have banned anti-tiering clauses.³³ While Congress has already taken some steps in this direction by banning anti-competitive gag clause provisions from hospital contracts,³⁴ lawmakers should build on this effort to further ban all-or-nothing and anti-steering/anti-tiering clauses as is currently proposed in the bipartisan Healthy Competition for Better Care Act (S.4207/H.R. 6248).³⁵
- **Enacting limits on hospital prices or the growth of hospital prices each year.** Congress must directly intervene on the issue of high and variable hospital prices driven by hospital consolidation that has led to high and rising premiums and out-of-pocket costs.³⁶ States like Indiana and Vermont have adopted legislation to establish direct limits on hospital prices across commercial prices through reference-based pricing models.³⁷ Oklahoma, Oregon, and South Carolina have also leveraged reference-based pricing methods to set payment rates or limits in their state employee health plans.³⁸ Meanwhile, several states, including Washington, Rhode Island and Delaware, have implemented hospital price growth limits using Medicare and the Consumer Price Index as the benchmark.
- **Establishing a national health care cost commission or affordability board.** Currently 17 states, including South Carolina, New Jersey, California, and Massachusetts, have enacted versions of health care cost commissions to analyze market trends and cost drivers. These commissions inform targeted solutions to lower health care costs and are particularly effective when given the authority to establish health care cost growth targets.³⁹ Cost commissions can also be leveraged to create specific spending targets for each health care sector including hospitals, health plans and drug companies. Establishing a national cost commission would be a major step towards controlling health care spending and unveiling the complex financial web of the health care sector that drives up costs for everyone. In the interim, the federal government can support the development and enforcement of state-based cost-containment commissions and goals.
- **Expand prescription drug price negotiation beyond Medicare and into the commercial market** so that consumers and patients who rely on commercial insurance can also benefit from negotiated prices and limits on price growth. Many states are taking steps to lower drug costs, including seven states that operate a Prescription Drug Affordability Board (PDAB) or similar entity: Colorado, Maine, Maryland, Minnesota, New Jersey, Oregon, and Washington.⁴⁰ Particularly noteworthy are the four states that have established the authority to create upper payment limits (UPLs) for drug prices: Colorado, Maryland, Minnesota, and Washington.⁴¹

Maryland and Colorado have now both implemented a UPL based on Medicare's Maximum Fair Price.⁴²

- **Crack down on patent abuses such as product hopping, patent thickets, and pay for delay agreements** which abuse intellectual property law and entrench anticompetitive behaviors in the pharmaceutical supply chain.⁴³ Legislation currently introduced in the 119th Congress could help to address this problem, including the ETHIC Act (S.2276/H.R. 3269),⁴⁴ the Drug Competition Enhancement Act (S. 1040),⁴⁵ and the Preserve Access to Affordable Generics and Biosimilars Act (S. 1096).⁴⁶

Access: Ensure Coverage Is Comprehensive and Prevents Underinsurance

Patients should have equitable access to high-quality, affordable care regardless of the type of insurance they have. All insurers should be required to cover the same standardized benefits floor, and the use of prior authorization and other utilization management tools should never result in patients being denied medically necessary care. To achieve this, Congress should advance policy reforms that guarantee access to health care and remove any unnecessary barriers that make it difficult for consumers and patients to get the care they need. Policy solutions should include:

Standardized Benefits

- **Establish a national standardized benefit floor across all public and private coverage, including ACA marketplace and employer-sponsored insurance plans, that includes comprehensive dental, vision, and behavioral health coverage in addition to medical care.** Such a standard benefit and cost sharing package should be created through a public process with stakeholder input. Without a standard benefit floor, inequities in access to care will persist, even among insured patients, creating unnecessary complexity in the system and leaving many patients underinsured without the care and coverage they need. Previous federal action highlights the impact of standardization on access to care: following the 2023 requirement for insurers operating on HealthCare.gov to offer standardized plans, the percentage of silver plans covering primary care before the deductible increased across states — as much as 36% in Wisconsin.⁴⁷

More than one-third of employer-sponsored insurance and marketplace enrollees report difficulty understanding what they have to pay out-of-pocket under their plan and struggle to compare cost-sharing responsibilities across different insurance options.⁴⁸ Standardized plans set fixed cost-sharing structures across plans, allowing consumers to make comparisons based primarily on premiums and provider network, reducing complexity for enrollees. For example, California has required standardized benefits and cost-sharing across all health plans within its state marketplace since 2013, allowing consumers to easily compare plans across Bronze, Silver, Gold, and Platinum tiers.⁴⁹ These standardized benefits foster clearer price competition and allow consumers to make apples-to-apples comparisons, minimizing confusion about which plan might not cover a benefit or might require higher cost-sharing in key situations. Similarly, Washington began requiring insurers that offer plans on its state-based marketplace to offer standardized plans in 2021. Although non-standardized plans remain available, standardized plans are popular because they offer affordable premiums, predictable cost sharing and access to services before the deductible kicks in. In fact, by 2026, 90% of marketplace enrollees in Washington opted for a standardized plan.⁵⁰

- **Further standardize other coverage processes including explanations of benefits, formularies, and prior authorization standards** to reduce administrative complexity, create more

predictability and transparency, and close loopholes that allow for care denials, discussed in more detail later.

- **Protect, restore, and expand access to reproductive health services and gender-affirming care across all forms of coverage**, and ensure that employers cannot deny people coverage for these and other evidence-based treatments on religious grounds. Congress should also establish a coverage program similar to the Biden administration's 2023 proposal to expand access to contraception.⁵¹
- **Establish categories of high-value services beyond preventive care that are exempt from cost-sharing**, building on state innovations that have shown this approach works. For example, cost sharing and deductibles can be waived for targeted services for those with select chronic conditions.⁵²

Primary Care and Prevention

- **Require a minimum investment in primary care and prevention across all private payers** — 15 to 20% of total medical spending — to shift the paradigm of health care payment and delivery toward keeping people healthy rather than primarily treating them when they are sick. There are a variety of approaches and metrics that can be used to implement and track an increased investment in primary care and prevention. For example, the average primary care and prevention investment across other Organization for Economic Development and Cooperation (OECD) countries was 14% in 2025.⁵³ By comparison, the U.S. spends approximately 4% of total health care spending on primary care. Increasing this minimum investment to be on par with other OECD countries is an important starting point.⁵⁴ Within the U.S., several states are implementing different approaches to increase state spending on primary care or to set a minimum benchmark for that investment. In 2010, Rhode Island became the first state to establish a commercial market primary care target of 10%,⁵⁵ and much larger and more rural states have since also established primary care targets for other payers. For example, California has set a goal of 15% for all payers by 2034, and Oklahoma has established a goal of 11% for Medicaid.⁵⁶ Virginia is in the process of refining its definition of primary care and establishing a benchmark.⁵⁷

Behavioral Health and Mental Health Parity

- **Require behavioral health services to be available on equal terms with physical health including for benefits, cost-sharing, and network composition.** Advance meaningful behavioral health network requirements that enforce parity in network composition, not just in coverage policy on paper. Several states have taken steps to advance such efforts. For example, Georgia has enacted a state Mental Health Parity Act, and enforcement of this state law has resulted in \$25 million in fines across 22 insurers, underscoring the need for this heightened level of accountability.⁵⁸ California has also enacted a comprehensive network adequacy standard for behavioral health which requires plans to submit annual compliance reports and gives the Department of Managed Health Care and the Insurance Commission authority to fine health plans not in compliance.⁵⁹ The state recently announced penalties against 10 behavioral health plans for failure to comply with state law.⁶⁰
- **Ensure patients and their representatives have clear information and accessible pathways to pursue mental health parity appeals.** Some states have worked with providers, who are often more aware of consumer protections related to behavioral health care, to identify patients who are encountering barriers and educate them about their rights. For example, Colorado has a

dedicated portal for behavioral health providers to file complaints with the state's Division of Insurance.⁶¹

Prevent Unneeded Delays and Denials

- **Provide a right to appeal benefits denial decisions.** Establish robust, independent external appeals with clear timelines and deemed approval if plans fail to respond within established deadlines. Independent reviews help to rein in the conflict of interest inherent to insurers overseeing their own denials and appeals processes, including through subsidiary or affiliate companies.⁶²
- **Require prior authorization decisions to be made in a timely manner.** Require responses to prior authorization requests for medical coverage and prescription drugs within 72 hours for expedited cases and 7 days for standard requests. Deem both medical and prescription drug requests as approved if plans fail to respond within these timeframes. Beyond these standards, use technology, including Artificial Intelligence (AI), to approve most prior authorizations in real time while ensuring human clinical review processes to override any wrongful prior authorization determinations. Alaska, Indiana, and Maryland have all passed laws requiring insurers to make a prior authorization determination within 24 hours for urgent requests and 72 hours for non-urgent requests,⁶³ and at least 5 other states have passed laws setting timeframes since January 2025.⁶⁴ Indiana's law includes meaningful enforcement language, automatically approving requests that do not meet the deadline.⁶⁵
- **Establish uniform, evidence-based utilization review criteria developed by independent, nonprofit, professional societies, rather than using insurer financial considerations or proprietary algorithms, and require peer-to-peer review conducted by a clinician in the same specialty and geographic area as the requesting provider.** Prior authorization should be used to promote valuable care for patients, not to improve insurers' bottom lines. Something that is medically necessary in one health plan should be medically necessary within another plan, and insurers should not seek competitive advantage by how aggressively or not they deny claims. More than one-third of physicians surveyed in 2025 reported that prior authorization criteria are rarely or never evidence-based.⁶⁶ Seven states have passed laws requiring health care providers to be involved in the prior authorization review process in some way.⁶⁷ Congress should also prohibit incentives for internal reviewers that reward denials over approvals. Standardizing prior authorization could be achieved through a public process or utility that all insurers must use, with standard review criteria, appeals processes, and the ability to review data and set precedents.⁶⁸
- **Ensure that prior authorization processes are transparent.** Require plans to specify up front exactly what clinical information they need from a provider before making a decision, with the goal of ending repeated piecemeal information requests designed to delay approval. In concert with requiring provider review of prior authorization, require the name of the reviewing clinician to appear on all prior authorization determinations. Additionally, expand reporting requirements for insurers' use of prior authorization to apply consistently to all payers, and require reporting of data disaggregated by race, ethnicity, language, sexual orientation, and gender identity, as well as by service line.
- **Prohibit repeated prior authorization requirements and retroactive denials of approval.** In particular, prior authorization requirements for patients with chronic conditions should be limited to no more than once a plan year, and mid-year formulary changes that would disrupt

care for patients should be banned. Require insurers to forward prior authorization approvals and step therapy history for patients who change coverage mid-year, and require insurers to honor PA approvals from a patient's previous insurer. Nine states require minimum approval lengths and limit retroactive denials,⁶⁹ and five states have passed requirements that insurers honor PA approvals from a consumer's previous insurer, typically for 60 days.⁷⁰

- **Consider gold carding, exempting providers with strong approval track records from prior authorization requirements for specified services, and preclude prior authorization for categories of care with near-universal historical approval rates, as well as emergency services, services ordered by a primary care provider, and commonly bundled services routinely approved together.**⁷¹ Several states have exempted categories of services from prior authorization. For example, Nebraska prohibited prior authorization for emergency and preventive services, and Rhode Island is operating a pilot program to exempt routine primary care ordered by a primary care physician.⁷² In 2021, Texas became the first state to implement legislation establishing a gold carding exemption for health care providers with 90% or more of their prior authorization requests approved for a service within a six-month period.⁷³ Alternatively, or in addition, policymakers could require insurers to exempt services from prior authorization when the issuer has routinely approved past prior authorization requests for the service at high rates. A law set to take effect in California in 2028 adopts this approach, requiring issuers to cease prior authorization for services where such requests are approved 90% of the time or more.⁷⁴
- **Mandate disclosure of the use of algorithms and AI tools in prior authorization and coverage decisions, prohibit AI tools that produce discriminatory outcomes, and require mandatory equity audits and human clinical oversight for all determinations.** As the use of AI in prior authorization and clinical and coverage decision making continues to grow, it is critical to ensure these tools are not preventing access to medically necessary care and coverage or exacerbating health inequities, and that a human remains in the loop before final decisions are issued. More recommendations related to the use of AI in health care decision-making are included below.

Consumer Protection and Experience: Ensure Patients Can Easily Navigate the Health System

People need timely and streamlined access to health care services that meet a full range of health and health care needs in a way that preserves their dignity and centers their experience. Unnecessary complexity, corporate profiteering, and administrative red tape too often hinder this goal. This leads to inequitable access to coverage and care, and ultimately, inequitable health outcomes that exacerbate existing health disparities.⁷⁵ Many groups, including people with chronic or severe health conditions, language barriers, health literacy barriers, and lower incomes, are put at an unfair disadvantage, often to the financial benefit of the corporate entities involved.

Reform efforts should be aimed at streamlining and simplifying the health care system, bolstering consumer protections, modernizing patient and provider access to data and claims processing, ensuring provider network information is up to date and accessible, and preventing the discriminatory use of AI in health insurance and clinical decisions. Taken together, these reforms would significantly advance efforts to improve the exchange of patient health care data and to equip providers with the data they need to better coordinate patient care and manage patient health outcomes. Policies include:

Navigators and Consumers Assistance Programs

- **Establish long-term and sustainable funding for enrollment and consumer assistance programs** that provide unbiased, consumer-centered support, including the Navigator program in states

with Federally Facilitated Marketplaces and state Consumer Assistance Programs. These programs provide untold value both to consumers who face significant barriers to unassisted enrollment, and to people facing challenges with their commercial coverage.⁷⁶ In a 2020 KFF survey, nearly one in five consumers (18%) who looked for or actively enrolled in coverage received some form of consumer assistance — most of whom said their assistance made a difference in their enrollment.⁷⁷ Unfortunately, federal funding for these programs has been significantly eroded since the ACA's enactment, including an 85% cut in funding during the first Trump administration and a 90% cut last year,⁷⁸ and the current availability of assistance varies tremendously from state to state. In the same KFF survey, 12% of respondents tried to get help but were unable to, suggesting insufficient capacity or consumer awareness.⁷⁹

While Congress should enact simplifications to enrolling in coverage, there will always be a need for robust, free, individualized assistance, particularly to assist people who face barriers to enrollment including people with Limited English Proficiency, people with complex health needs, and people who are immigrants. These programs can also serve as a backstop to formal oversight and enforcement efforts, making sure that that people are benefiting from the consumer protections enshrined in law and regulation and identifying places where more oversight is needed.

Streamlined Enrollment

- **Beyond reversing H.R. 1 and the Trump administration's marketplace rules that erect new barriers to enrollment, a new Congress should go further: removing bureaucratic hurdles, streamlining eligibility and enrollment for public programs and premium tax credits (PTCs), and moving toward easy, if not automatic, enrollment in coverage.** In addition to outright eligibility cuts, H.R. 1 included multiple new administrative barriers that make it more challenging for eligible people to get and keep coverage, and must be reversed, including: the Medicaid work reporting requirement; the requirement that certain Medicaid enrollees recertify their eligibility at least every six months; the elimination of provisional PTC eligibility; the elimination of automatic reenrollment in PTCs; the requirement that all marketplaces verify individuals' PTC eligibility in advance of the open enrollment period every year; and the requirement that individuals who have not reconciled past advance premium tax credits are barred from receiving credits in the future until they do so. The Trump administration also included multiple new administrative requirements in its marketplace regulations issued in 2025 and 2026 which must be reversed (to the extent they are not overturned in court), including additional verification requirements for individuals whose information is not available in federal tax databases, individuals who attest to a very low income, and individuals seeking to enroll through certain Special Enrollment Periods; and requiring a shorter annual open enrollment period.
 - In the place of these punitive policies that seek to keep eligible individuals from getting and keeping affordable coverage, any future proposal should **build on the ACA's original vision for "no wrong door" eligibility and enrollment.** Federal and state agencies should be required to leverage all existing data at their disposal to make timely eligibility decisions that are paperless and frictionless for consumers. All health eligibility systems should be calibrated to deliver consistent results to all consumers in a given state, ensuring individuals get the same determination and timely access to benefits no matter their point of entry. Transitions between programs when income, household size, or other eligibility factors change should be seamless and ensure that no one loses

coverage simply due to a change in circumstance. For example, Maryland has been operating Easy Enrollment, which allows tax filers to share their state income tax data with the marketplace and expedite and automate enrollment with the individual's consent.⁸⁰ The program helped 19,000 individuals connect to coverage in 2026.⁸¹ Many other states have adopted similar tax-based programs or other data-sharing arrangements across public agencies to expedite, and in some cases automate, enrollment.⁸² Federal policymakers should explore opportunities to ensure these simplifications are available to consumers in every state, for example through legislation like the Easy Enrollment in Health Care Act (S. 2057/H.R. 3947).⁸³

Universal Digital Health Records and National Provider Directory

- **Establish a federal framework for universal digital health records that ensures every American owns and controls their own complete health information with real-time, portable access across all providers and plans.** Such a reform would help close the gap created by fragmented, non-interoperable systems and would help to increase the ability of providers to exchange patient data and strengthen care coordination while reducing diagnostic errors and duplicate testing.⁸⁴
- **Establish strong patient privacy protections governing who can access, use, and share digital health records,** with meaningful penalties for misuse and explicit patient consent requirements for non-clinical uses of health data.
- **Create a national provider directory and data exchange infrastructure** so that network directories are accurate, real-time, and accessible, ending the ghost network problem at its administrative root. Utah has a novel requirement that insurers publish health care provider directories and maintain them with the most up-to-date information. When there is no in-network option, insurers are required to establish a procedure to assist patients to access behavioral health services from an out-of-network mental health provider.⁸⁵

Mandatory Interoperability and Data Sharing Standards

- **Expand and strengthen nationwide interoperability standards for all providers, plans, and health information systems** to ensure they can securely access, exchange, integrate and use health care data. Every clinician must be able to access a patient's complete health information at the point of care without delay or friction.
- **Require real-time data exchange across all health plans, providers, and health information systems** for care transitions, referrals, prior authorization, and post-acute care placements so that no patient falls through the cracks at a handoff between providers or settings.
- **Prohibit information blocking** in which health systems, plans, and technology vendors restrict access to patient data to protect competitive advantage and strengthen enforcement of existing information blocking rules with meaningful financial penalties.

AI and Algorithm Governance

- **We need federal policies in place to both promote the promise and protect against the peril of AI in health care.** AI can help address many of health care's challenges, from limited access and heavy administrative burdens to poor interoperability. But its rapid deployment with little oversight or regulation raises serious concerns.⁸⁶ Without guardrails, AI tools can lead to inappropriate denials of care or financial assistance, drive upcoding that inflates costs,

contribute to medical errors, create new barriers to treatment, and deepen health inequities.⁸⁷

Policymakers must develop and deploy national standards for patient-centered use of AI in health care that allow for transparency into AI-driven decision-making, identify and correct algorithmic bias, protect individuals' privacy, and require human accountability for AI-driven decisions. Key steps include:

- Establishing a federal framework governing the use of AI and algorithms in clinical and coverage decisions, including mandatory disclosure of when and how AI tools are used in prior authorization, utilization management, and care recommendations.
- Require mandatory equity audits of all AI tools used in clinical or coverage decisions to identify and remediate discriminatory patterns before they harm patients.
- Require human clinical oversight for all determinations that involve algorithmic input and prohibit the use of AI tools that produce discriminatory outcomes based on race, ethnicity, language, gender identity, age, or disability.
- Establish patient rights to explanation when an AI tool has contributed to a coverage denial or care recommendation, and ensure those decisions are fully appealable on the same terms as human-generated determinations.

In addition, we encourage policymakers to pass a Patient's Bill of Rights regarding Health AI and consider the following principles when regulating the use of AI:

- I. People should remain in control of health care. This means people must be the ultimate decision-makers, particularly when it comes to informed consent, access to care, and delivery of patient care.⁸⁸
- II. AI in health care must prioritize and ensure the well-being and safety of people. This means government regulators need to put appropriate safeguards in place, including rigorous testing and evaluation.⁸⁹
- III. AI in health care should advance and improve access to care, health outcomes, quality of care, sustainability of financing, and affordability. This means that every AI tool should serve at least one of these purposes and that sufficient feedback loops should be built into oversight and accountability processes to ensure continuous improvement.
- IV. Transparency in AI must be sufficient to empower people to remain in control of health care and prioritize well-being and safety.⁹⁰
- V. Organizations and providers developing and deploying AI in health care must be responsible and accountable for the impact of AI on people.⁹¹
- VI. The application of AI must be inclusive and equitable.⁹² AI development and use policy in health care should prioritize interests of all patients, regardless of identity or geography. This can be achieved in part by ensuring AI development and use reduces or prevents bias and discrimination. This also means that benefits and risks of AI are equitably distributed, allowing patients to share in the substantial savings that could accrue from AI.⁹³

Virtually every state has passed laws regulating AI in recent years, and momentum around regulating AI in health care specifically has grown. Since 2024, California, Colorado, Indiana, Maryland, Texas, and Washington have all passed laws addressing insurers' use of AI in utilization

review and prior authorization, with requirements around transparency, ensuring determinations are applied fairly and equitably, maintaining human accountability, and enforcing monitoring and oversight.⁹⁴ These state laws may provide a helpful starting point for efforts to develop a national policy.

Accountability: Hold the System Responsible for Cost and Outcomes

The health care sector must be held accountable for health care costs and the health care quality, outcomes and experiences of the patients they serve. Payment should be tied to the total cost of care, patient outcomes, and equity. Providers and plans must share accountability for managing a patient's full set of health needs and reducing disparities. To achieve this guarantee, Congress should:

Price and Coverage Transparency

- **Strengthen and codify federal health care price transparency rules requiring hospitals and health plans to publicly disclose the underlying price of health care in dollars and cents** (i.e. negotiated rates).⁹⁵ Despite federal regulations that require hospitals and health plans to disclose health care prices, the majority of hospitals continue to skirt these federal requirements and the hospital price and health plan data remains inaccessible and unusable for most consumers.⁹⁶ Disclosing health care prices is an important step to not only informing consumer choice but to better equipping employers with the data needed to negotiate lower costs for their members and to inform policy reforms to lower health care costs for everyone.⁹⁷ In response to persistently low hospital compliance with federal price transparency rules, more than 20 states have moved to codify those requirements in state law and strengthen enforcement.⁹⁸ Ultimately, Congress should enact comprehensive price transparency legislation such as the Patients Deserve Price Tags Act (S.2355/H.R. 5582)⁹⁹ or the Lower Costs, More Transparency Act (H.R. 5378 in the 118th Congress).¹⁰⁰
- **Establish a national all-payer claims database (APCD)** that aggregates price and utilization data across public and private payers to identify pricing abuses and track cost trends in real time. While 24 states now operate state-level APCDs, more progress is needed to increase transparency into meaningful health care cost and utilization data.¹⁰¹ APCDs serve as one of the only tools that aggregate claims data across commercial insurers, Medicaid and Medicare into a longitudinal dataset that can be used to inform policy reforms to strengthen health care payment and delivery.¹⁰² Establishing a national APCD would be a transformational step to collect, study and analyze the health care data needed to better understand trends in health care costs and outcomes across the country.¹⁰³
- **Require health plans to disclose claims denial rates including denials due to prior authorization**, at the individual claims level and at the aggregate level, to better understand insurers use and misuse of prior authorization.

Insurer Accountability, Medical Loss Ratio, Vertical Integration

- **Congress must enact policy reforms to rein in anticompetitive insurance practices and increase insurer accountability, including for Medicare Advantage plans.** Health plans have built a business model that prioritizes profits at the expense of patients. Through systematic upcoding, deceptive marketing of supplemental benefits, wrongful care denials, and subverting Medical Loss Ratio (MLR) requirements, corporate health plans exploit flaws in the system to inflate their payments without corresponding improvements in the quality of care. To end these practices, reforms must:

- **Strengthen the Medicare Advantage (MA) risk adjustment system against industry gaming** to prevent MA insurers from upcoding and wrongfully billing diagnoses in order to inflate their Medicare payments without providing additional care or coverage. Coding reforms drafted in the bipartisan No Unreasonable Payments, Coding, Or Diagnoses for the Elderly (No UPCODE) Act (S. 1105) would rein in abuses such as sham health risk assessments and chart reviews.¹⁰⁴
- **Improve the MA benchmark and bidding system** to ensure MA insurers are only financially rewarded for bidding at or below their true costs, thereby promoting healthy competition between MA plans and traditional Medicare. Potential benchmark reforms could include calculating benchmarks using a blend of national and county-level spending in traditional Medicare, as well as initiating long-term reforms that test setting MA benchmarks using an administrative benchmark approach (taking a base payment rate and increasing it year over year using a fixed administrative factor or through competitive bidding).¹⁰⁵
- **Hold MA insurers accountable for delivering high-quality care and coverage by strengthening the quality bonus program (QBP).** Reforms include making quality bonus payments budget neutral, incorporating financial penalties where appropriate, and setting higher performance targets not based on average plan performance.¹⁰⁶
- **Promote meaningful transparency in Medicare Advantage (MA) by requiring insurers to submit complete, high-quality encounter data to CMS.** Lawmakers and the public need to know whether MA is delivering on its obligation to provide affordable, quality care. Better encounter data is also critical to understanding how plans use prior authorization and market supplemental benefits. This information is the foundation of effective oversight, and it would support targeted policies to remove unnecessary barriers to key services, reform prior authorization, and eliminate it for services with strong evidence of high value to patients.
- **Mitigate harms related to vertically integrated plans and ensure health care dollars are spent on the health and health care of our nation's families.** Congress should strengthen medical loss ratio (MLR) reporting by requiring vertically integrated plans to report a combined MLR, covering both the insurer and its affiliated provider groups, at the parent-company level for their Medicare business. Plans should also be required to report transfer prices, meaning what they pay their affiliated and employed providers, and be held to pricing benchmarks that keep those payments in line with what they pay unaffiliated providers.¹⁰⁷
- **Prohibit common ownership across vertically integrated chains** so that major health care corporations are unable to own or control multiple sectors of the supply chain (e.g. insurers, providers, pharmacy benefit managers, pharmacies, and medical device wholesalers), and ensure the Federal Trade Commission (FTC), Department of Justice (DOJ), and Department of Health and Human Services (HHS) have the resources and authority to ensure strong enforcement oversight as is established in the Break Up Big Medicine Act (S. 3822).¹⁰⁸

Value-Based Care and Care Coordination

- **Accelerate the adoption of payment models that hold providers accountable for the total cost of care and population health outcomes.** Commercial insurance remains significantly behind public payors in the shift away from fee-for-service payment with only 7.8% of commercial dollars flowing through population based, two-sided risk Alternative Payment Models (APMs) compared to 14.2% for traditional Medicare and 33.4% for Medicare Advantage as of 2025.¹⁰⁹ Despite the private sector setting a goal of achieving 50% of commercial payments and 100% of traditional Medicare through two-sided risk models by 2030, the vast majority of payments are still flowing through fee-for-service architecture with minimal links to quality and the sector now self-measuring progress towards their voluntary goals.¹¹⁰ Policy solutions include:
 - **Requiring health plans to adopt accountable care arrangements and alternative payment models** with two-sided risk and accountability for the total cost of care, care coordination and population health outcomes.
 - **Requiring plans to demonstrate that their minimum primary care investment is producing measurable improvements** in care coordination, chronic disease management, and population health, not just meeting a spending floor on paper.¹¹¹

ERISA and Employer Plan Oversight

- **Amend the Employee Retirement Income Security Act (ERISA) to set clearer federal standards with respect to self-funded employer plans, and grant states more authority to enact standards that exceed a federal floor by allowing them to directly regulate these plans and the entities that administer them.** Self-funded employer plans are currently largely beyond the reach of state consumer protection laws including enforcement of mental health parity, external review standards, and transparency obligations. More than half of people enrolled in employer coverage are enrolled in a self-insured plan; revisiting and amending ERISA is a critical step in any efforts to meaningfully contain health care costs.¹¹²
- **Explore a federal ERISA waiver framework giving states authority to impose meaningful consumer protections on self-funded plans, building on the Section 1332 waiver model.** Such a framework should also include safeguards against states seeking to undermine federal consumer protections, similar to Section 1332's requirements that coverage under a waiver is comparable to coverage without the waiver in terms of affordability, comprehensiveness of benefits, and scope.¹¹³
- **Crack down on unregulated association health plans that exploit ERISA preemption** to offer bare-bones coverage without consumer protections.

Additional Policy Ideas for Consideration: Broader Coverage Reforms including Public Options

Over its 45-year history, Families USA has worked toward universal coverage for everyone living in the United States through a range of approaches, including the State Children's Health Insurance Program (CHIP), the Affordable Care Act, and the Inflation Reduction Act. We support the goals of efforts to expand coverage, such as raising Medicaid income eligibility limits, extending Medicaid to all children, allowing Medicare buy-ins, establishing a new Public Option plan, lowering the Medicare eligibility age, and enacting Medicare for All, while recognizing that the details matter.

As advocates for patients, we are ready to engage on key design features of these proposals, including financing, provider payment and participation, benefit design and standardization, network adequacy,

consumer protections such as cost-sharing design, market participation, and transition issues. Families USA looks forward to working with you on these and other issues as proposals develop.

Below are additional details and considerations for broader public coverage development.

Support for a public option can take several forms: supporting state efforts to establish one, allowing people to buy into existing public programs such as Medicare or Medicaid or otherwise expand eligibility, or creating an entirely new coverage option in the ACA marketplaces. A buy-in approach could be administratively simpler and could help lower health spending as Medicare and Medicaid payment rates are set through a federal administrative process that, while imperfect, tends to hold down costs. Commercial rates, by contrast, largely reflect the relative market power of plans and providers and tend to drive costs up.¹¹⁴ Some proposals aim to fill geographic gaps, especially in "bare counties" with no marketplace insurer, to serve populations that have been excluded, or to add a low-cost competitor to the marketplace. Several would also open the public option to workers whose employer coverage is unaffordable and let enrollees use premium tax credits to pay their premiums.

Three states – Washington, Colorado, and Nevada – have innovated around a state public option by creating tightly regulated marketplace plans that are administered by a private insurer. This public-private partnership was ideal for these states for a few reasons. First, it avoided the need to raise funds to balance the risk of a new insurance program and the claims expenses associated with it. Second, it built on the states' existing marketplace structures, rather than spending significant time and money developing a new infrastructure and regulatory scheme for the plans. For the federal government, however, these hurdles would be smaller. Unlike state governments, the federal government does not need to balance its budget each fiscal year, and the payoff for creating a new federal program is far greater than for creating a single-state program.

Yet, these state public options provide several lessons for a future federal public option. All three programs incorporate efforts to reduce hospital prices,¹¹⁵ advancing affordability directly through lower premiums for enrollees, but also for patients who are not enrolled in them by lowering overall system spending. These cost-containment mechanisms have taken slightly different approaches in each state:

- Washington's "Cascade Select" plans must limit their aggregate reimbursement for all covered, non-pharmacy services to no more than 160% of Medicare rates.¹¹⁶
- "Colorado Option" plans have a statutory requirement to lower premiums by 15% from 2021 to 2025 and increase no faster than inflation afterward, with the state's insurance commissioner able to require provider participation.¹¹⁷
- Nevada's "Battle Born State Plans" are also required to reduce premiums by 15% from 2025 to 2030.¹¹⁸

These plans are improving overall health care affordability as well. Average gross premiums for Cascade Select plans were \$200 less expensive in 2026 than for non-standardized plans.¹¹⁹ Colorado's Division of Insurance announced in September that premiums for Colorado Option plans will be 6.7% lower than for non-Option plans, and estimates that if Colorado Option plans did not exist, premium increases for all marketplace plans would be about 3% higher than they are today.¹²⁰

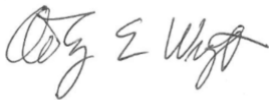
In addition to improving affordability, public options have also been used to improve the value of health coverage for consumers. Both the Washington and Colorado programs include standardized benefits and cost-sharing, allowing consumers to perform "apples to apples" comparisons, evaluating plans on premiums and networks, rather than which services are covered or what their cost-sharing will be.

And now that these public options have operated for several years, the benefit and popularity of these additional coverage options is clear: Nearly 40% of marketplace enrollees in Washington and half of all marketplace enrollees in Colorado enrolled in a public option plan in 2026.^{121,122}

Conclusion

Thank you for the opportunity to respond to this RFI, your ongoing efforts to build consensus around meaningful reforms to America's private insurance system, and your commitment to health coverage that works for everyone. Families USA is in enthusiastic support of these efforts. We look forward to working with you, and to elevating the voices of health advocates from around the country, to advance the next generation of health reform in America. Please contact Sophia Tripoli, Managing Director of Health Policy at stripoli@familiesusa.org with any questions.

Sincerely,



Anthony Wright

Executive Director

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