Request for Information: Health Coverage That Works For Everyone from Senate Finance Committee Minority Staff

Summary of Information Requests

Submission Instructions

Written comments should be submitted to insurance@finance.senate.gov no later than **October 2, 2026**

Submission Guidance from USofCare

- **USofCare strongly urges consumer advocates to respond to this RFI –** your perspective is important and we know that state consumer advocacy groups have deep experience working at the state level on a number of the policies discussed in this RFI.
- You **do not need to respond to every question in the RFI** in order to submit a response. Organizations should feel free to focus on areas where you have expertise and perspective.
- There are **no formatting requirements for responses**, so format your response in whatever way makes it easiest for you to submit one. If your organization is short on capacity, **you do not need to create new content for a response**. If you have existing materials (policy briefs, state legislative summaries, reports, one-pagers, etc.) that respond to questions included in the RFI, you can attach those and reference the topic, question, and page number that they respond to.

Section 1: Reversing Republican Cuts and Reimagining a Better Path

I. Ensuring that people can easily enroll in and afford coverage that meets their needs

- *Third-Party Assistance.* Proposals and feedback on approaches to ensure that consumers seeking to enroll in high-quality coverage are protected from misleading marketing and substandard coverage (pg. 14-16).
- *Centralized Enrollment Platforms.* Comments on the benefits of establishing a more standardized or centralized enrollment platform across coverage programs, along with detailed feedback on how best to develop and support such a platform, and how such a platform should account for unique markets and approaches across states, including in the employer market; specific challenges or inefficiencies that employers experience and whether access to a more standardized enrollment platform could help reduce burden and costs for employers and people with employer coverage. Additionally, feedback on ways the operations and authorities of State-Based Marketplaces (SBMs) could potentially be expanded to strengthen insurance markets and streamline enrollment processes across private markets and public programs, and invite proposed reforms that would better support the ongoing work of SBMs and encourage broader adoption across states (pg. 16).

- *Essential Health Benefits*. Feedback on approaches to strengthen existing federal and state essential health benefits requirements and flexibilities in order to improve the quality of coverage for consumers across private markets (pg. 17-18).
- *Affordability Determinations*. Feedback on reforms to affordability determinations, including whether they should be inclusive of costs beyond premiums, and other approaches that would expand protections and assistance for people who cannot afford to use their health insurance (pg. 18).
- *High-Value Care without Cost Sharing*. Analysis, data, and evidence-based feedback on the types of outcomes and measures that should inform consideration of policies that eliminate cost sharing for high-value services (pg. 18-19).
- *Rate Review*. Feedback on whether some states' enhanced rate review approaches could strengthen existing federal rate review standards to reduce annual premium increases and improve access to higher value care; feedback on additional criteria that should subject proposed rates to automatic review; and feedback on approaches to establishing an enhanced uniform federal rate review standard or benchmark that would subject unreasonable or outlier rates to stronger automatic review, adjustment, or rejection (pg. 19-21).

II. Reining in the unsustainable spikes in deductibles and out of pocket costs Trump and Republicans have piled onto American families

- *Benefit Design and Cost-Sharing*. Detailed proposals and reforms that strengthen benefit design and cost-sharing requirements within existing coverage options (pg. 22).
- *Deductibles for Non-Shoppable Services*. Feedback on the application of deductibles to non-shoppable services, and solicits proposals that prioritize consumer access and affordability while appropriately taking into account patient safety, care quality, and evidence-based utilization management (pg. 23).
- *Income-Based Deductibles*. Comments on proposals to eliminate, limit, or cap deductibles along with specific feedback on the types of benchmarks that could be considered (pg. 23-24).
- *Coinsurance*. Comments on the use of coinsurance as a utilization management tool, including feedback on reforms and whether the use of this form of cost-sharing in plan designs should be limited, or prohibited altogether (pg. 24).
- *Maximum Out-of-Pocket Caps*. Comments and feedback on approaches to reforming out-of-pocket maximums so they are reachable and reasonable for consumers, and protective across private insurance markets (pg. 25).
- *Managing Out-of-Pocket Costs*. Other proposals that would ensure that all consumers receive true protection from unreachable out-of-pocket costs (pg. 25).

III. Expanding pathways to coverage for low-income people and exploring the benefits of giving all Americans access to Medicare-type choices for health care

- *Universal Coverage Systems*. Detailed analysis, data, and feedback on specific proposals to establish and finance a universal coverage system (pg. 26).
- *International Universal Coverage Systems*. Analysis and feedback on international efforts to design universal coverage systems and reform diverse health care markets (pg. 27).
- *Employer Coverage System*. Detailed feedback and analysis of the benefits and challenges of the current system of employer coverage and opportunities for reform that address existing coverage gaps and affordability challenges in the employer market (pg. 27).

- *Strengthening the Existing ACA Coverage Framework*. Feedback on approaches to expand and strengthen existing ACA programs and authorities that are paired with new market reforms that protect consumers from access and affordability challenges that emerged prior to the expiration of enhanced premium tax credits (pg. 27-28).
- *Expanding Choice and Competition in ACA Markets*. Specific comments and feedback on approaches to address limited competition, including allowing state employee health plans or Federal Employee Health Benefits Program plans to offer coverage on ACA Marketplaces, expanding consumer operated and oriented plans, and aligning plan participation requirements across Medicaid MCOs and Marketplace plans (pg. 28-29).
- *ACA Firewall*. Feedback and analysis on the effects of eliminating the ACA firewall and allowing people with ESI to purchase plans on ACA Marketplaces (pg. 29).
- *Improving Oversight of Existing Private Insurance Markets*. Comments on proposals to establish an independent entity to evaluate behaviors and trends in the commercial market and recommend reforms (pg. 29-30).
- *State Authorities & 1332 Waivers*. Comments on the outcomes and lessons learned from state Section 1332 waiver efforts that could inform the development of similar or related federal options and whether additional flexibilities are needed to spur reforms at the state level (pg. 30-31).
- *State-Based Single Payer Authority*. Comments on state-based approaches that would build on existing waiver authorities and allow states to pursue transitions to state-level single-payer models, including how lessons learned from Section 1332 waiver authority would inform the establishment and administration of this 'super waiver' authority (pg. 31).
- *Establishing a Federal Public Option*. (pg. 32-36)
    - Specific feedback and comments on approaches to establishing a federal public option that would address persistent affordability challenges and achieve universal coverage;
    - Feedback on gaps in existing data and research that would need to be addressed in order to fully evaluate the effects that a federal public option could have on cost and coverage in the current environment of increased affordability challenges;
    - Analysis and feedback on how public option plan design and pricing would, or should impact the existing market;
    - Comments on establishing payment rates in a federal public option, including providing HHS secretary with negotiating authority, establishing references for payment, and requiring CMS to establish payment rates;
    - Feedback on approaches to financing a federal public option;
    - Feedback on topics and concepts related to performing administrative tasks like establishing networks and paying claims .
- *Medicare or Medicaid Buy-In*. Comments on how changes to or expansions of federal financing that individuals currently receive for coverage could impact spending, enrollment, state operations, and provide payments; and specific feedback and detailed analysis on Medicare and Medicaid buy-in proposals focused on the effects on access to coverage and care, and program administration for current and future enrollees, including whether CMS could administer these options using existing resources (pg. 36-37).
- *Single Payer*. Updates to previous analyses of single payer proposals related to mortality rates and health outcomes, administrative savings, health care costs and spending, and wages; and feedback on the establishment of and transition to a single payer system (pg. 37-39).

- *Federal Independence*. Feedback on approaches to ensure that any Medicare-type choice is administered independently, decisions are made based on facts and science, and access to a wide range of essential care is protected and guaranteed (pg. 39).

IV. Getting rid of junk insurance plans and ending the constant cycle of higher premiums, skyrocketing deductibles, shrinking networks and worse coverage

- *Junk Plans*. Feedback on approaches to ensuring that consumers are protected from substandard plans that provide little to no coverage or financial protection, and whether insurance companies that market or sell junk insurance should receive taxpayer support (pg. 40-41).

V. Eliminating surprise tax bills levied on working people who buy their own insurance

- *Income-Based Caps on Premium Tax Credit Recapture*. Feedback on proposals that restore premium recapture caps and expand safe harbors for lower-income people (pg. 41-43).

Section 2: Making Health Care Simpler for Families

I. Simplifying and standardizing plan options and benefits, so people can efficiently select coverage and services that will meet their needs

- *Standardized Plans*. Feedback on approaches to establish minimum requirements for standardized plans (pg. 45-47).
- *Provider Directories*. Feedback on proposals to hold consumers harmless for costs incurred as a result of inaccurate provider directories, stronger penalties and removal of repeat offenders from the market, and additional reforms to ensure that consumers are not being misled by inaccurate provider directories (pg. 47-48).
- *Network Adequacy*. Feedback on proposals to strengthen networks and ensure broad access to high-quality providers (pg. 47-48).

II. Ensuring that patients do not face hurdles or delays in accessing the care they need

- *Prior Authorization*. Comments and analysis on approaches and concepts to reform prior authorizations and reduce associated barriers to care, such as gold carding, limitations or bans on prior authorization, neutral third-party evaluators, reviewer requirements, shared risk, shifting burden to insurers, standardization, and time restrictions, including feedback on how they could be applied across private markets and how they would meaningfully change the consumer experience (pg. 49-54).
- *Voluntary Commitments on Prior Authorization*. Specific feedback about the real-world effectiveness and impact of voluntary prior authorization reforms (pg. 53-54).
- *Claims Denials Data Collection*. Feedback on approaches to expanding existing authorities to ensure that data collection and reporting takes place across private insurance markets, and that data collection is sufficiently detailed to be useful for researchers and policymakers (pg. 54-55).
- *Communication and Transparency on Claims Denials*. Feedback on specific types of information that insurance companies should be required to send to providers and patients when a claim is denied, and how to establish a standardized plain language format for communications (pg. 55).
- *Independent Claims Review Process*. Feedback on how an independent claims review process could be designed to ensure the application of uniform, clinically appropriate, objective

standards that incorporate appropriate utilization management safeguards across private insurance markets (pg. 55-56).

- *Mid-Year Plan Changes.* Detailed comments on approaches that would hold plans accountable for costs and delays imposed by mid-year changes to networks and coverage, and eliminate their use as a tool to generate profit and deny care (pg. 56-57).
- *Consumer Appeals for Claims Denials.* Detailed comments and feedback on approaches, such as appeals oversight, automatic external review, consumer communications, reforms to existing consumer protection frameworks, and unified appeals frameworks, as well as additional reforms (pg. 57-59).
- *Consumer Communications on Appeals.* Comments and feedback on the role of insurance companies in ensuring that consumers have access to their billing records, correspondence, and information about claims denials and appeals in a centralized, accessible, electronic location (pg. 58-59).

III. Holding Big Insurance accountable to patients and providers for practices that generate profits by stepping between patients and their doctors to delay or deny access to care

- *Administrative Waste and Profits.* Analysis and research that provides additional detail on the revenue and profits generated by for-profit insurance companies when they impose delays and denials that are ultimately overturned, and feedback on whether and how the excessive revenue generated through these administrative abuses could be returned to providers, hospitals, and consumers (pg. 59-60).
- *Delayed Payments.* Proposals to streamline the responsibilities that doctors and hospitals are required to take on (pg. 60-61).
- *Consumer Payment Collection from Insurers.* Specific feedback on requiring large health plans to make prompt payments to providers and collect applicable copays and cost-sharing directly from patients and its impact on costs and premiums, as well as other proposals to address administrative hurdles and payment burdens for providers, including proposed reforms to level the playing field for smaller providers in highly concentrated markets (pg. 60-61).
- *Direct Contracting.* Comments and analysis of the administrative savings being realized from direct contracting approaches, as well as specific feedback on the benefits of these approaches relative to contracting for the same services through a health plan or third-party administrator (pg. 61).
- *Independent Clearinghouse.* Comments and feedback on establishing an independent clearinghouse to standardize coding and billing processes, as well as specific proposals on the type of entity that should own and operate such a clearinghouse (pg. 61).
- *Consistency Across Markets.* Comments and feedback on approaches to bolstering federal oversight and enforcement authorities in order to address concerns about third-party administrator practices that impose administrative hurdles and other problems in the employer market (pg. 62-63).
- *State Authority on Self-Insured Markets.* Comments and feedback on proposals to allow states to obtain waivers to regulate their self-insured markets in certain circumstances (pg. 63).
- *Explanations of Benefits.* Feedback on ways to increase consumer transparency on benefits and ensure that consumers receive plain language information about their costs from their insurance plan (pg. 64).

- *Clear and Timely Billing*. Comments on the benefits and challenges associated with proposals on timely billing requirements and feedback on additional proposals to simplify billing for patients (pg. 64).
- *Accountability for Plans - Interests of Employers*. Feedback on how to protect the interests of employers engaging in good faith to design coverage and benefits while also ensuring that health plans and third-party administrators are held accountable for improper utilization management decisions that harm patients (pg. 64-66).
- *Accountability for Plans - Interests of Consumers*. Proposals and feedback to improve consumer protections and plan accountability across private insurance markets, along with proposals that would ensure accountability when plans or third-party administrators improperly delay or deny care (pg. 64-66).

IV. Simplifying the process to get insurance, and protecting people from losing coverage each year due to unexpected costs or red tape

- *Addressing Fraud*. Feedback on policies that would address fraud in the private insurance market where it may actually exist, without harming access to coverage and care (pg. 66-67).
- *Streamlining Eligibility*. Feedback on proposals to streamline eligibility and predictable enrollment for all Americans and guarantee access to coverage throughout the plan year and feedback on ways to align enrollment and eligibility rules so consumers are not subject to barriers that keep them from purchasing coverage in certain markets (pg. 67-68).
- *Leveraging State-Based Marketplaces*. Comments on policies and comments that would bolster and expand the work of SBMs as part of a comprehensive strategy to improve and streamline eligibility and enrollment processes (pg. 68-69).
- *Leveraging Technology*. Feedback on ways to leverage and promote advances and best practices to expand efficient enrollment platforms across private markets and protect consumers against false accusations of fraud (pg. 69).

Section 3: Taking on Corporate Greed

I. Putting patients over profits by making sure federal dollars are being used to drive enrollee satisfaction, not corporate profits, executive compensation and stock price

- *Stock Buybacks and Executive Compensation*. Feedback on proposals to restrict ways that health insurance companies can use or invest taxpayer dollars, including taxing or restricting stock buybacks, limiting executive compensation, and limits on certain types of investments (pg. 72).
- *Private Equity*. Feedback on proposals to address concerns around private equity's presence in health care, including restricting investments, limiting private equity entry, and ownership and investment transparency (pg. 72-73).

II. Ending the shell games Big Insurance exploits to raise prices, eliminate competition, and place unaccountable middlemen between patients and affordable care

- *Vertical Integration*. Feedback on proposals and reforms that would strengthen oversight of vertically integrated insurance companies (pg. 73-75).
- *Intercompany Transfers and Eliminations*. Feedback on proposals that could address gaming through the use of intercompany transfers and eliminations that aim to raise costs and increase profits (pg. 75-76).

- *Transparency around Ownership Structures and Financial Relationships*. Specific feedback on the types of transparency and reporting requirements that would provide researchers and policymakers with the relevant and actionable information needed to fully understand the ownership, structure and financial relationships that exist within vertically-integrated insurance conglomerates (pg. 75-76).

III. Eliminating Big Insurance gaming that hides profits, and ensure that those dollars are spent on providing care and lowering costs for consumers

- *Medical Loss Ratio Reporting*. Feedback on proposals that would strengthen Medical Loss Ratio reporting (pg. 76-77).
- *Quality Improvement Activities*. Feedback and comments on reforms and improvements to Quality Improvement Activity data collection and reporting requirements (pg. 78).
- *Medical Loss Ratio Modernization*. Comments on approaches to modernize and strengthen MLR rules to address loopholes in existing requirements and account for the existing corporate structures of insurance companies (pg. 79).
- *Reformulating or Increasing Existing MLR Thresholds*. Feedback on reformulating or increasing existing MLR thresholds, along with detailed proposals for specific adjustments that appropriately limit insurance company profiteering and gaming (pg. 79).

IV. Stopping corporate insurance companies and third parties from making money by acting as unaccountable middlemen that delay care and deny claims

- *TPA and Administrative Services Only Contract Reforms in the Self-Insured Market*. Comments and analysis on TPA oversight and regulation, transparency for plan sponsors, payment rates, profits, unbiased administrative services, and benefit to plan sponsors (pg. 80-83).
- *Reforms to Other Health Insurance Middlemen*. Detailed proposals and feedback on concepts to reform payment structures, transparency and reporting requirements, and other policies to address abuses and profiteering by middlemen affiliated with large insurance companies (pg. 83-84).
- *System-Wide Transparency and Reporting*. Feedback on concepts and proposals to improve federal oversight across private insurance markets. Feedback on system-wide transparency should take into account questions posed throughout this RFI related to achieving a stronger understanding of for-profit health care ownership and corporate structure, and practices across markets such as MLR gaming, TPA abuses, and intercompany transfers and eliminations within vertically-integrated insurance conglomerates (pg. 85-86).