



October 2, 2026

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

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

Dear Ranking Member Wyden and fellow Senate Democrats,

[United States of Care](#) (USofCare) is pleased to submit comments in response to the [Request for Information \(RFI\)](#), “Health Coverage That Works for Everyone” from the Senate Finance Committee Minority Staff. We appreciate the interest in pursuing bold reforms to address challenges people face with the health care system.

USofCare is a listening-first, nonpartisan health care advocacy organization that brings people’s experiences to the policy decisions that shape our health care system. Too often, decisions about our health care system are shaped by industry stakeholders and partisan priorities rather than the experiences of the people who rely on it every day. USofCare was founded to fix that. We listen to people, understand how they experience the health care system in their daily lives, and bring those voices into the decisions that shape policy.

Our mission is to ensure that everyone has access to quality, affordable health care, regardless of who they are, where they live, or how much money they make. We advocate for policy solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our [work in the states](#) and [listening to people’s experiences](#) with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the federal level.

Our listening work demonstrates that people’s [top concern](#) with the health care system is affordability. The United States spends [considerably more](#) on health care than peer nations despite [no improvement](#) in outcomes, saddling everyday people and families with the high cost of care. Regardless of partisan affiliation, 71% of people [rate](#) the cost of health care in the U.S. as “unaffordable for people and families.” Moreover, half of Americans [report](#) skipping or delaying care due to cost. Prices are rising in [large part](#) because of a decades-long movement toward [consolidation](#) led by corporate health care actors. **With this in mind, USofCare focuses our comments in response to the RFI around the following areas:**

Section 1: Reversing Republican Cuts and Reimagining a Better Path

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- IV. Getting rid of junk insurance plans and ending the constant cycle of higher premiums, skyrocketing deductibles, shrinking networks and worse coverage
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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 Benefits](#)
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- II. Simplifying the process to get insurance, and protecting people from losing coverage each year due to unexpected costs or red tape
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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
 - [Private Equity](#)
- II. Ending the shell games Big Insurance exploits to raise prices, eliminate competition, and place unaccountable middlemen between patients and affordable care
 - [Vertical Integration](#)
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- 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](#)
- IV. Stopping corporate insurance companies and third parties from making money by acting as unaccountable middlemen that delay care and deny claims
 - [Third-Party Administrators](#)

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

Essential Health Benefits

Senate Democrats invite 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)

Preserving coverage and availability of critical benefits for people seeking to maintain health and wellness is critical in ensuring people stay healthy and access the care they need. A crucial element of health care coverage policy that significantly improves access are the Affordable Care Act's (ACA) essential health benefits (EHBs). Currently, EHBs include [ten categories](#) of coverage without annual or lifetime limits. [Prior](#) to the EHB requirements, 62% of individual market enrollees did not have coverage for maternity services, 34% did not have coverage for substance use disorder services (SUD), 18% did not have coverage for mental health services, and 9% did not have coverage for prescription drugs. Since requirements were implemented, millions of people gained coverage for, and benefited from, these services which previously may not have been covered by their plan.

EHBs are a proven consumer protection, and states have [demonstrated](#), when leveraged strategically, updating EHB benchmark plans can expand and improve access to care and services. Since 2020, [11 states](#) received federal approval to update their EHB benchmark in an effort to add or expand benefits to their populations. **Colorado** used this approach to enhance pediatric services, while a number of states, including **Michigan, North Dakota,** and **Oregon**, sought to align their benefits to address the opioid epidemic. The **District of Columbia** received federal approval to expand coverage of infertility services to include treatment.

Polling [strongly supports](#) maintaining coverage of EHBs, and people have long depended on the comprehensive coverage they provide. In light of public opinion research and proven state actions to improve benefits packages, coverage, and access, **USofCare supports efforts to strengthen federal EHB requirements and promote states' ability to build on federal requirements.**

Strengthening Federal EHB Requirements

Adult Dental and Vision

While the ACA included pediatric dental benefits as one of the ten EHBs, federal regulations outlining the benchmarking process did not allow states to include adult dental benefits as EHBs until [2025](#). However, the 2027 Notice of Benefit and Payment Parameters (NBPP) [final rule](#) subsequently prohibited plans from including adult dental services as an EHB, a policy change USofCare [opposed](#).

We know that the health of someone's teeth [impacts](#) the health of their entire body. The restriction on the inclusion of these benefits results in more limited access to dental care and insurance coverage more generally. Despite the gains that have been made over recent years in increasing the traditional medical [insured rate](#), dental coverage has lagged behind, with [one in four](#) Americans lacking dental coverage. [Disparities](#) in oral health exist across sex, poverty status, race and ethnicity, and education levels – and are exacerbated by a lack of insurance coverage.

“Why is it that you have major medical insurance, but dental and vision isn't covered? Because somehow you don't need teeth?”

- WHITE MAN, NEW YORK

Similar equity concerns apply to vision health. Removing the EHB adult vision restrictions will improve disparities in access for communities of color and additional marginalized populations typically underserved by the health care system. Notably, rates of visual impairment are [higher](#) among communities of color and are [associated](#) with increased injury risk, social isolation, and premature death.

USofCare supports the inclusion of adult dental and vision benefits as EHBs and urges Congress to address these gaps in the EHB package.

Doulas

Despite scientific advances over the past 30 years, the United States' maternal mortality rate has [increased](#) and continues to [disproportionately impact](#) Black, Indigenous, and additional marginalized groups of people – populations that are already more likely to experience adverse health outcomes and barriers to care. Access to doula care was [identified](#) by the American College of Obstetrics and Gynecology as a proven intervention by non-clinical health workers to improve maternity care and outcomes by providing emotional and physical care during the prenatal, labor and delivery, and postnatal periods.

USofCare's [listening](#) research has focused on the difficulty many women, particularly from marginalized communities, face in receiving needed care throughout the maternal journey, particularly in the postpartum phase where doulas can help close gaps in care.

You kind of have to heal up because [childbirth] is a whole experience. You are still bleeding, and you are still very tender and hormonal, emotional...I think that support is 100 percent necessary, so I would love to have a lactation person, a doula, anyone to like be there with me to kind of hold my hand through it.

- HISPANIC WOMAN, NORTHEAST

USofCare supports increased access to doula care through the Maternity and Newborn Care EHB, as this will ensure that pregnant patients' needs are met during this important period.

Virtual Behavioral Health Standards

The use of virtual care, or telehealth, to address gaps in behavioral health access must ensure that barriers to accessing care and disparities are eased, not exacerbated. We believe that a well-designed approach to virtual care — including synchronous video and audio-only telehealth services, asynchronous remote patient monitoring, and other digital forms of communication — has the potential to break down long-standing barriers to health care access. During the pandemic, the [most common](#) use of virtual care services during the pandemic was for behavioral health conditions. Virtual care accounted for [40% of mental health and SUD outpatient visits](#) during the pandemic's peak compared to 1% pre-pandemic, and still comprised 36% of these outpatient visits in March 2022 — a trend that [has continued post-pandemic](#).

A well-designed, people-centered approach to virtual care can [break down long-standing barriers](#) to health care access, especially for mental health and SUD. Some of the barriers people face in accessing behavioral health care, such as long wait times, social stigma, and social factors like transportation insecurity, can be addressed with virtual care. One such provider [shared](#) their perspective on the merits of delivering behavioral health virtually:

The behavioral health team has been so busy, many of the patients having worsening depression, anxiety, and bipolar disorder - they are able to reach out regularly through telehealth.

— SAFETY NET PROVIDER, YAMIKA, WA

While virtual care is not a panacea and there remain barriers to accessing virtual care, especially [among already underserved communities](#), it can be a tool to address inequities and close gaps in accessing behavioral health services. **USofCare supports requiring plans to establish virtual behavioral health care standards so that people have the option to access these services in a setting that is best suited to their needs – whether virtually or in-person.**

Promoting States' Ability to Strengthen EHB

State Benchmarking

CMS developed a state benchmark approach to satisfy the EHB requirement while also allowing states the ability to adapt the requirement to fit people's demonstrated health care needs. As discussed above, USofCare supports CMS's state benchmark approach to EHB allowing states the flexibility to establish their own EHB coverage requirements while ensuring that people's coverage remains comprehensive and comparable to what people typically receive through private insurance.

States across the country have used the flexible benchmarking process to close coverage gaps and respond to advances in medicines and related therapies to improve care for people, including [Alaska](#) to cover hearing aids and massage therapy and [North Dakota](#) to cover hearing aids and weight loss and diabetes drugs. Additionally, [Illinois](#) leveraged the state benchmarking process to prevent insurance companies from imposing utilization management tools, including prior authorization, fail first policies, dispensing limits, or lifetime limit requirements, on medication assisted treatment or opioid use disorder.

States have also utilized the existing framework and flexibilities to ensure coverage is robust and meets the unique needs of their population. It has allowed states to increase access and reduce barriers to important services, like mental health and SUD services, for people. This is particularly important for rural populations where access challenges have been [particularly acute](#). Certain subgroups within rural communities, including farmers, ranchers, and other agricultural workers, are [disproportionately likely](#) to have coverage on the individual market and thus benefit from EHB. **USofCare supports maintaining states' flexibility to add benefits to their benchmark plan and pursue additional coverage policies that help ensure access to comprehensive, affordable health coverage for all people.**

Defrayal

State EHB packages were never meant to be static, although concerns that states would be responsible for defraying the cost of additional coverage outside those considered EHB have limited state efforts to expand coverage options. In 2018, CMS [determined](#) that additional coverage mandates adopted through the standard benchmark process would not be subject to cost defrayal rules, even if they existed outside the original ten benefit categories.

This defrayal policy allowed states to expand access to critical benefits, such as SUD and mental health treatment, fertility treatment, and others, without fear of incurring additional costs through defrayal. By ensuring these additional benefits are considered EHBs, they are also subject to EHB non-discrimination rules and consumer protections like restrictions on annual or lifetime dollar limits, further benefiting the people who have come to depend on these services. States made these changes to their benchmark plans on the basis of CMS policy on defrayal clearly stated in an October 2018 [CMS FAQ](#), and, in a number of cases, with direct [approval](#) from CMS. For example, in 2020, CMS [approved](#) changes to EHB benchmark plans for Michigan, New Mexico, and Oregon to improve access to services for people with opioid use disorder.

However, the 2027 NBPP [final rule](#) reversed this defrayal policy, a policy change USofCare [opposed](#). This policy change may result in states incurring unexpected costs, particularly given the 2027 implementation date, which likely does not allow enough time for many state legislatures to revisit previously enacted benefit mandates. It may also result in states rolling back these important benefit expansions, which will negatively impact people getting the care they need to improve their health. **USofCare supports reverting back to the 2018 defrayal policy for states when they require coverage of additional benefits in their EHB benchmark plan.**

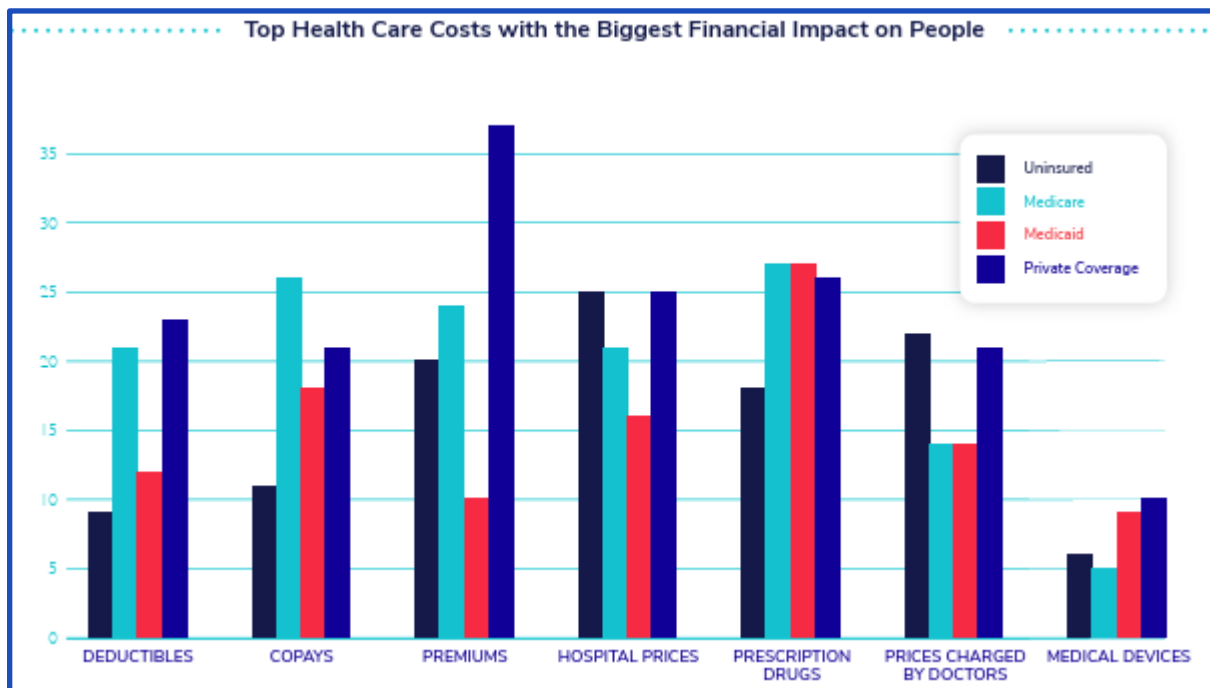
Affordability Determinations

Senate Democrats request feedback on [reforms to evaluate plan “affordability” beyond premiums] and other approaches that would expand protections and assistance for people who cannot afford to use their health insurance.

Through USofCare’s extensive work listening to people about the health care system and their experiences with it, [cost](#) is consistently the first – and most prominent – issue people raise. It is important to note that while people with private insurance coverage [struggle](#) with the cost of their premiums, they also find other health care costs, including deductibles and copays, difficult to manage as well. Given this, it is critical that any measure of whether a person’s health coverage is “affordable” that this determination be inclusive of deductibles and out-of-pocket costs in addition to premiums.

“When I told [the receptionist] I’d have to pay my bill using four cards, but I would be there, she said, ‘Oh, well, just go and run your hands through the couch, and find change in your couch.’ I said, ‘Ma’am, I don’t even own a couch.’ She said, ‘Well, look in your car, in the cup holders, and get change.’ I said, ‘Ma’am, I just paid \$1,200 that I didn’t have to have my car fixed. There’s no change in the car.’”

- BLACK WOMAN, WAYNE COUNTY, NC



Note: Percentages do not add to 100% due to the survey question, which asked respondents to select the top two costs they experience as most difficult.

Source: [USofCare/ Morning Consult, Public opinion poll \(April 2026\)](#)

In order to help reduce the burden of non-premium out-of-pocket costs, USofCare supports Congress [capping](#) annual deductibles in the commercial market, as well as [lowering](#) the annual out-of-pocket maximum and indexing these caps to wage growth, rather than medical inflation. For further discussion of our perspective on these policies, see “[Employer Coverage System](#)” section on pg. 17.

We also encourage Congress to explore additional mechanisms that can help measure consumers' health care costs, including both premium growth and out-of-pocket costs, and their impact on overall health care affordability.

"Well I think that if they established some affordability standard, it would make it where you know, they wouldn't be able to raise the prices so high, you wouldn't be able to charge an arm and a leg for somebody to pay for something that they really need, you know, or to be able to get care for something that could be life-threatening."

- JAMES, GEORGIA

Affordability standards have [long been used by a number of states](#), all taking varying approaches to the development and implementation. For example:

- In **Connecticut**, the state Comptroller's office worked with the Office of Health Strategy to develop the [Connecticut Healthcare Affordability Index \(CHAI\)](#), which builds upon the state's [self-sufficiency standard index](#) to measure the impact of health care costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs, like housing, transportation, childcare, and groceries. The CHAI is used to establish and adjust Connecticut's [household health care spending target](#), inform their health care benchmarking initiative, and set primary care spending targets.
- **Rhode Island** adopted a [health care affordability standard](#) in 2010, based on the Consumer Price Index for Urban Consumers and other market factors. This metric, set annually by the Office of the Health Insurance Commissioner, informs their review and approval of contracted rates between providers and insurers. The state [has also leveraged](#) this affordability standard to incentivize value-based payment reforms, such as primary care investments and risk sharing agreements between providers and commercial payers.

If leveraged effectively, these standards can help policymakers and regulators understand how people are experiencing health care affordability challenges and how different policy solutions translate to improved affordability for people. Addressing the underlying cost of care is inextricably linked to making sure that care is affordable. Even with low uninsured rates and fairly adjusted premiums and cost sharing, ever-rising costs will erode wages and crowd out consumers' spending on other important goods and services. Affordability standards can help inform health insurance [rate review](#) and provider payment policy. For further discussion of our perspectives on driving improved affordability by strengthening the health insurance rate review process, see “[Rate Review](#)” section on pg. 10.

High-Value Care without Cost Sharing

Senate Democrats invite analysis, data and evidence-based feedback on the types of outcomes and measures that should inform consideration of [eliminating or reducing cost sharing for high-value services]. (pg. 18-19)

Our health care system should provide people with access to proven, cost-effective services that maintain and improve overall health, although it often falls short in achieving this balance. More can and should be done to ensure that people have access to such “high-value” services and care. Reducing or eliminating out-of-pocket costs for patients and pursuing other policies to incentivize access to high-value services – including primary and preventive services and some specialty care – can [increase access](#) and [improve health outcomes](#) for patients.

"I went to a doctor one time, and he refused to see me because I hadn't paid my copay. So, because I didn't have my copayment, he said he couldn't see me. I told the staff I was broke. I was poor. I didn't have the copay. So, I didn't see the doctor, but they still charged me for that visit."

- RESIDENT, VANCE COUNTY, SC

Advancing these policies is part of the broader movement towards “[patient-first care](#)” (also known as value-based care) that aims to shift incentives within the health care system to better align with patient needs. This includes moving away from unnecessary or “low-value” care – such as an overreliance on imaging services or diagnostic tests – that [does little](#) to improve people’s health outcomes and collectively costs patients [billions of dollars annually](#).

USofCare supports Congress taking steps to advance the implementation of value-based insurance design principles and other policy levers to leverage cost sharing arrangements that shift the system toward greater patient uptake of high-value, cost-effective services. To promote access to these services, Congress should require plans to provide certain high-quality, cost-effective benefits with limited or no cost sharing as part of a mandated standardized plan option or by adding to other benefit design requirements. Congress should prioritize services that reduce health disparities and, if allowing cost sharing, emphasize predictable cost structures like copays over coinsurance to better help patients budget for care.

The [Colorado Option](#) is a successful model for effectively driving the use of high-value services through insurance design. In 2021 Colorado passed [legislation](#) that established a standardized health plan option that required plans to cover certain high-value services pre-deductible with no cost sharing. The law required the State Department of Insurance to establish the benefit design through an [extensive stakeholder engagement process](#). The Colorado Option requires primary care and non-preventive visits; mental, behavioral health, SUD visits; prenatal and postnatal visits; and diabetic supplies, including continuous glucose monitors, to be covered without a copay, pre-deductible. Additionally, diabetes self-management education services must be covered pre-deductible with a \$5 copay.

A subsequent [analysis](#) of the impact of the Colorado Option on consumers' out-of-pocket spending found that in 2024, out-of-pocket spending declined more for consumers enrolled in Colorado Option plans than for non-Colorado Option enrollees. The introduction of the Colorado Option resulted in a 15 percent decline in out-of-pocket spending per year relative to 2022 and it is estimated that people enrolled in Colorado Option plans spent about \$222 less per year on out-of-pocket costs in 2023 and 2024 compared to similar non-Colorado Option enrollees. It is also important to note that Colorado Option plan premiums were generally lower than those of non-Colorado Option plans over that same time period, meaning that Colorado Option consumers were not generally seeing higher premiums in exchange for lower out-of-pocket spending plan design.

This [analysis](#) also looked at utilization of no-cost services under the Colorado Option and found that Colorado Option enrollees were more likely to use most of these high-value services, but the extent of those differences in utilization varied depending on the service. Additionally, most Coloradans enrolled in Colorado Option plans were aware of which services were available at no-cost and expressed more confidence in accessing these services when their out-of-pocket responsibility was clearly defined – particularly for \$0 copay services. Conversely, enrollees remained cautious about using services not included under the first-dollar, pre-deductible coverage.

Rate Review

State Authorities. Senate Democrats invite feedback on whether these or other state approaches could strengthen existing federal rate review standards that would reduce annual premium increases and improve access to higher value care. (pg. 19-20)

Capped Rates. Senate Democrats invite 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. 21)

Acknowledging that consumers are being hit with affordability pressures [across every interaction](#) they have with the health care system (e.g., deductibles, copays, etc.), premiums deserve additional focus as the first hurdle that consumers face in accessing and maintaining their coverage. While policymakers on both the state and federal levels have taken steps to strengthen insurer oversight, these policies often fail to prioritize patient affordability.

"[Expensive] costs keep a lot of people from seeking care, even if they have insurance. Most people won't go in until it gets more serious than they have to go in."

- BLACK MAN, RURAL GEORGIA

State Departments of Insurance (DOI) have long overseen traditional insurance rate review, a process that allows regulators in [most states](#) to review and approve proposed rates for certain plans, including those offered in the individual and small-group markets. Instead of using this process to secure cost savings for people, however, many states restrict their rate approval criteria to whether rates are actuarially adequate, excessive, or discriminatory. Additionally, in most states, insurers are typically only required to submit projections of “medical trend” to support their rate change requests and DOIs generally review only aggregated data about projected increases in costs for broad service categories – which provides more limited visibility into insurer spending on various services.

However, there are a number of states that have established enhanced rate review programs that help ensure that rates filed by insurers are truly reflective of costs and adequately take into account consumer affordability. The RFI specifically makes note of **Oregon’s, Rhode Island’s, and Maine’s** rate review approaches, which we believe are valuable models for state rate review programs – as well as for potential updates to federal “Effective Rate Review” standards (more on this below).

- [Oregon](#) makes public all rate filings, as well as all correspondence between insurance companies and regulators. The DOI holds public conference calls and hearings where insurers are required to present their rate requests. Additionally, the DOI [scrutinizes](#) insurer assumptions about increasing medical claims costs and administrative costs to ensure they are reasonable and not overinflated.
- [Rhode Island](#) passed legislation establishing state authority to employ the use of a “public interest” affordability standard to guide its enhanced rate review process that explicitly prioritizes impacts on affordability. Their rate review process also requires plans to meet certain [criteria](#), such as making [investments in primary care](#), to deliver cost savings for people.
- We also highlight [Vermont’s](#) rate review program model, which requires the DOI to determine whether a rate is “affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to [state law].”

Updating Federal “Effective Rate Review” Standards

USofCare strongly supports updating the “Effective Rate Review” standards established by the ACA; and we believe that enhanced rate review programs in states include elements that should be incorporated into an updated federal standard. When initially established, these federal standards [prompted many states](#) to update and expand their DOIs’ rate review authority. Strengthening the federal standard has the potential to not only increase minimum standards across state rate review programs but also allows state-tested approaches to enhanced rate review to be more broadly adopted.

[Enhanced rate review](#) expands the role of rate review from a sole focus on actuarial soundness into a process by which states can incorporate additional considerations when approving rates, such as consumer [affordability standards](#), primary care investment thresholds, and other criteria. This allows regulators to take steps to make sure that insurance rates reflect the actual cost of care and ensure any cost savings are passed along to consumers. Leveraging the ACA’s

“Effective Rate Review” standard, **USofCare recommends that Congress update this standard to require state rate review programs to include the following components.**

Place limits on states’ use of “file and use”

Under the current “Effective Rate Review” standards, states are only required to conduct a review of rates, they are not required to act on them. A number of states [limit](#) the authority of their DOI entirely or for certain markets to “file and use,” meaning that the DOI can require insurers to submit their rates, but they have no authority to force insurers to actually change or stop those rates from being implemented. Placing limits on “file and use” would create incentives for states to empower DOIs to act on unreasonable or excessive rate increases, but it is important that be paired with support for states to enable them to shift their approach to rate review (more on this below). **Congress should require that states have authority set forth in state statute or regulation to approve, reject, or modify proposed rates before they take effect.**

Establish a Consumer Affordability Standard

States have [different authorities](#) related to reviewing proposed rates and making determinations on whether those rates are permissible on the basis of different standards in accordance with that authority. However, with appropriate authority, states can – and should – review rates from the perspective of whether they are affordable for consumers (inclusive of premium and out-of-pocket spending). For example, [Rhode Island](#) requires the state DOI to “view the health care system as a comprehensive entity and encourage and direct insurers toward policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.” This has led to targeted state efforts to reduce costs and increase quality through the establishment of the state’s [affordability standards](#) to work in tandem with robust rate review.

Minimum Public Disclosure Requirements

State rate review processes should include sufficient public disclosure of information related to proposed rates. This includes publicly posting proposed rate filings (including those not subject to review), states’ approval, denial, or modification of the proposed rates, and the final rates. To help ensure that all stakeholders – especially consumers – can understand the rate filings and meaningfully engage in the rate review process, USofCare supports requiring states to post plain language information about the proposed rating filings. Congress can look to states like [Washington](#) for models that provide robust public disclosure of information contained in rate filings and decisions in a consumer-friendly manner that is easily accessible on the DOI’s website. **USofCare also urges Congress to establish a minimum federal standard related to health insurance issuer redactions of their rate filings, or portions of their rate filings, on the basis that they contain proprietary information or trade secrets.** Some states, including **New York** and **California**, have [strong rules](#) limiting insurers’ ability to redact information from their rate filings.

Minimum Stakeholder Engagement Requirements

As noted above, states have established a number of strategies to engage consumer stakeholders in their rate review processes. **USofCare recommends that Congress incorporate minimum stakeholder engagement requirements into federal “Effective Rate Review” standards.** This could include requiring a public comment period on proposed rate filings, including those not subject to review, prior to rate approval. This comment period should include a reasonable amount of time for stakeholders to review proposed rates and respond.

We also recommend Congress include a requirement for states to hold at least one public hearing prior to rate approval for all rate filings subject to review, during which health insurance issuers are required to justify their proposed rate increases. Requiring insurers to engage with the public during the rate review process, such as through public hearings or stakeholder roundtables, can improve transparency and [lower costs](#) generally. For example, the insurance commissioner in [Iowa](#) is required to hold a public hearing for proposed rate increases prior to approval or disapproval, while a consumer advocacy officer solicits public comment on rate increases that are posted on the insurance division’s website and presented at the public hearing. States can also require insurers to publicly justify premium increases and share how cost savings or other financial benefits are being passed along to consumers.

Grants to States to Support Implementation of Updated Standards & Technical Assistance

In recognition of [limited state resources](#) available for state rate review programs, the ACA included federal grant funding for states to enhance rate review and strengthen oversight of rate increases. **If Congress establishes updated standards or requirements for state rate review programs, USofCare urges the inclusion of federal grant funding to help enable states to make these improvements.** Additionally, state DOIs have [varying levels](#) of experience with rate review, which is an inherently technical and complex process that requires significant expertise among staff in order to do effectively. Congress providing technical assistance grant funding and opportunities for cross-state collaboration and learnings to build DOI expertise and share best practices and strategies could help improve the effectiveness of rate review programs nationwide.

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

As mentioned, USofCare’s listening research reveals that [cost](#) is the biggest pain point that people experience in the health care system – including out-of-pocket costs. It’s why people often describe a feeling of being preyed upon by the system, rather than cared for. One person [shared](#) the following:

“I think that the out-of-pocket costs are a big thing, because we pay – we have that insurance and then you pay your copays, and you pay this, and then you get a bill from the hospital for a procedure, or for an x-ray or something, and that amount is astronomical. Then right behind that, I don’t know if it’s a certain hospital thing or what, but right behind that, you get a collections bill...almost immediately, and that’s frustrating to me.”

- NORTH CAROLINA WOMAN, EMPLOYER INSURANCE

The RFI references several types of out-of-pocket costs that hit consumers and patients as they seek to use their insurance and receive care. USofCare conducted [survey](#) research to understand which costs pose the biggest financial impact on people, disaggregating the findings by source of coverage. Among people with private insurance coverage, we found that after premiums, deductibles, copays, hospital prices, prices charged by doctors, and prescription drugs all straddle a very similar level of impact on people.



Source: [The Health Care Affordability Crisis: People's Lived Experience](#), USofCare

With these insights, USofCare responds to the out-of-pocket cost prompts in the RFI anchored to two key goals our research shows that people tend to agree on when describing what they want from the health care system: that people have certainty they can **afford** their health care, and that people can **depend** on their health coverage even as life changes or emergencies happen.

Benefit Design and Cost Sharing

Senate Democrats invite detailed proposals and reforms that strengthen benefit design and cost sharing requirements within existing coverage options. (pg. 22)

USofCare believes that Congress should pursue insurance design concepts across insurance markets that eliminate and reduce out-of-pocket costs for consumers and move away from unpredictable out-of-pocket cost structures like coinsurance.

See “[High-Value Care without Cost Sharing](#)” section on pg. 9 and the “[Employer Coverage System](#)” section on pg. 17 for additional perspective on these issues.

Deductibles

Senate Democrats invite 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)

As USofCare’s listening [research](#) confirms, people experience affordability challenges at every turn within the health care system, including through out-of-pocket cost structures like [deductibles](#) which adds a layer of worry and anxiety for many people seeking to use their insurance coverage but finding care financially burdensome or simply out of reach.

“Money comes to mind...because a lot of times, to get good [coverage], you’ve got to pay the money for it. Then, even after you pay the money, it is the copays and deductibles and all these other things that go along with it.”

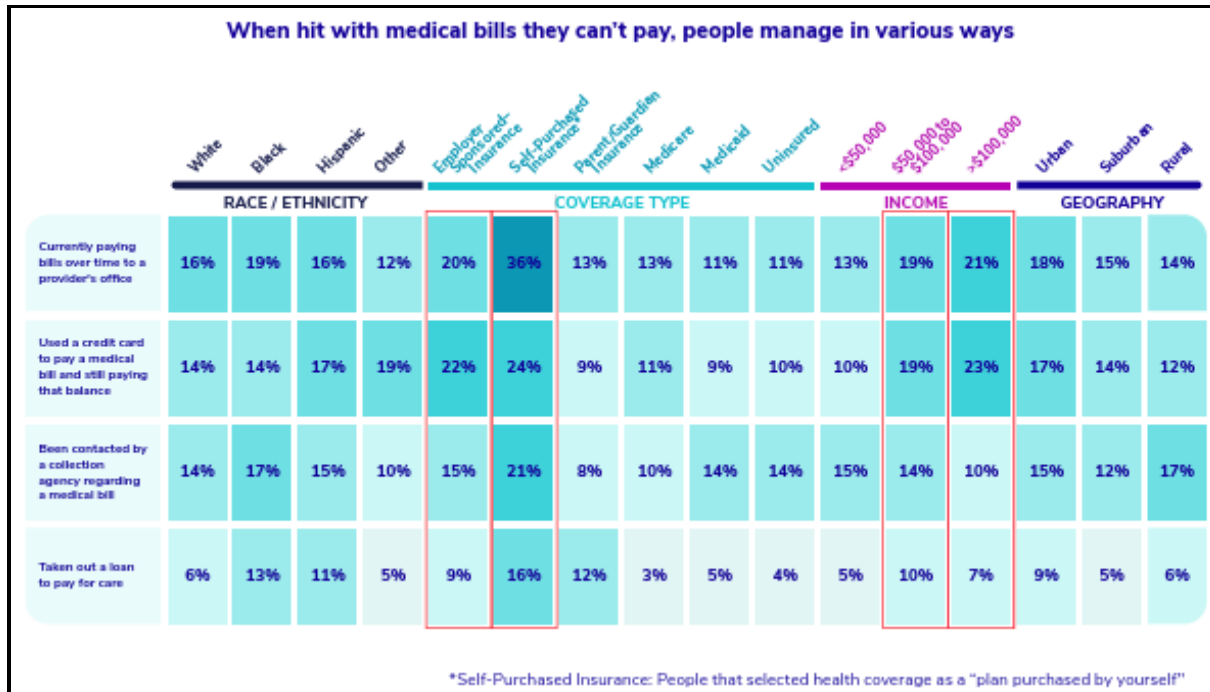
- BLACK WOMAN, NORTHEAST

USofCare believes that Congress should consider [capping](#) annual deductibles in the commercial market and indexing this cap to wage growth, rather than medical inflation, across insurance markets. For additional perspective on this issue, see “[Employer Coverage System](#)” section on pg. 17.

Coinsurance

Senate Democrats request 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)

Years-long [public opinion research](#) by USofCare demonstrates consistent and overwhelming struggles that everyday people have affording the care they need. Too often these affordability struggles result in the devastating reality of [medical debt](#). In one [recent USofCare poll](#), nearly half of adults (49%) reported experiencing at least one financial pressure related to a medical bill (i.e. contacted by a credit agency, took out a loan, etc.) in the past two years – and 21% of people with insurance reported having medical debt.



Source: USofCare Action/Morning Consult [Poll](#) (April 2026)

Unpredictable cost structures like coinsurance make it very difficult for people to plan for and manage their out-of-pocket costs – and coinsurance is a common element of commercial insurance design. According to the [2025 KFF Employer Health Benefits Annual Survey](#), 65% of covered workers have coinsurance requirements on inpatient hospital services; and the average coinsurance rate for a hospital admission is 20%. The average coinsurance rate is 19% for both primary care and specialist visits. Benefit designs that require consumers to pay a percentage of their insurer's allowed amount for a service that can sometimes total in the tens of thousands of dollars can be financially devastating, especially considering the fact that the current [annual maximum out-of-pocket limits](#) of \$12,000 for an individual and \$24,000 for a family offer little protection for many people.

"I mean, when you think about some things like surgeries and stuff, they can be well up in the six-digit range, I mean, we're all living check to check in some cases, even if you tell a person to come up with \$400 or \$500, which should be a very fraction of a major surgery, it's going to be a lot of money to that person. So you know, 80/20%, 90/10%, 95/5% would probably be too much for a lot of people."

- CALEB, IOWA

USofCare supports Congress implementing policies that eliminate coinsurance cost sharing structures and emphasize predictable cost structures like copays to better help patients budget for care.

Maximum Out-of-Pocket Caps

Senate Democrats invite 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)

Senate Democrats request comments on these proposals and others that would ensure that all consumers receive true protection from unreachable out-of-pocket costs. (pg. 25)

USofCare believes that Congress should consider [lowering](#) the annual out-of-pocket maximum and indexing this cap to wage growth, rather than medical inflation, across insurance markets. For additional perspective on this issue, see [“Employer Coverage System”](#) section on pg. 17.

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

Employer Coverage System

Senate Democrats invite 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)

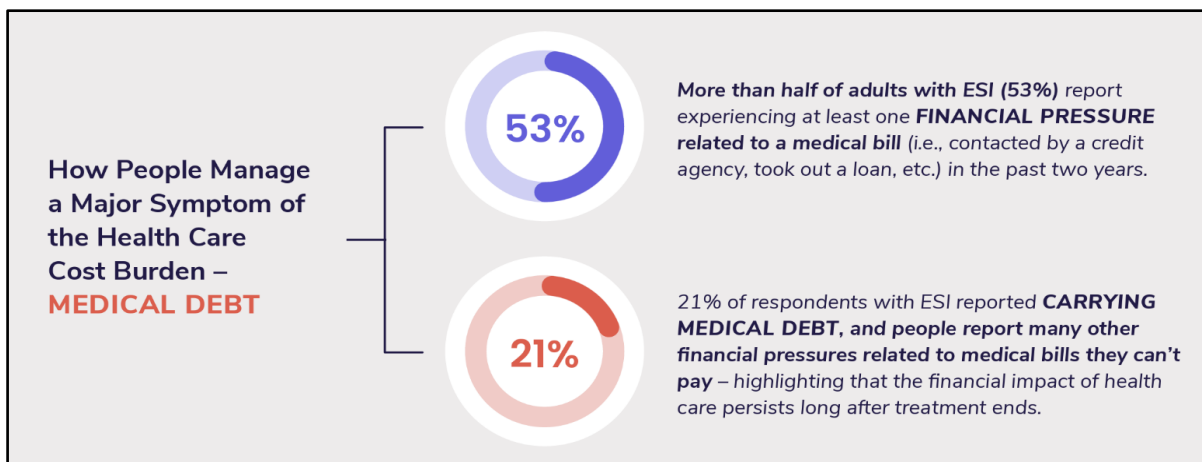
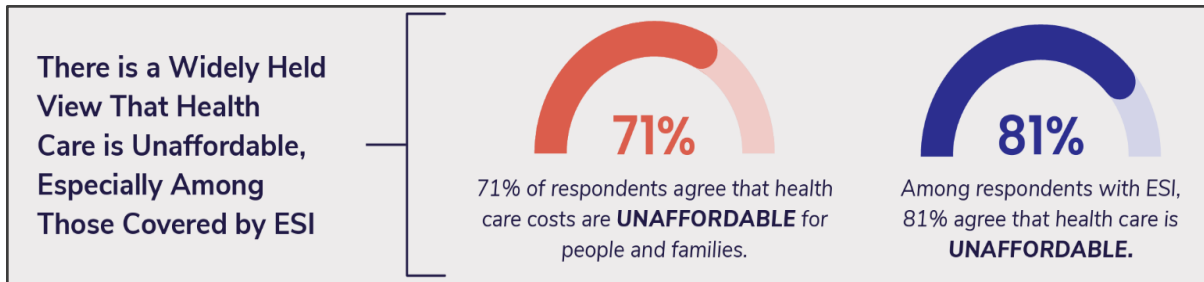
Year after year, people are straining to access care as costs and prices continue to skyrocket. In that time, more and more people are assuming greater costs, especially among those covered by employer-sponsored insurance (ESI). [Recent data](#) show that among people with ESI, premiums reached almost \$27,000 for family coverage in 2025, showing a 6% increase from 2024. For an individual, the annual premium in 2025 totaled \$9,325, a 5% increase from the previous year. Meanwhile, as premiums increased, wages trailed behind – increasing by only 4% while inflation reached 2.7%. Beyond premiums, deductibles mirror the cost burden that workers are increasingly facing in affording health care. Annual deductibles for covered workers increased over recent years, amounting to 17% over the last five years, and 43% over the last decade.

USofCare’s [years-long research](#) shows cost as the top concern for people in health care, which breeds further [mistrust](#) of the health care industry. With ESI [covering](#) 165.6 million people, the largest source of coverage in the country, understanding the experiences of workers and working families is of critical importance if policymakers want to address the overall health care affordability crisis.

“I just feel like I can’t retire. I’ll have to keep working so I can run my health into the ground just so I could have [health care coverage] for longer.”

- NORTH CAROLINA WOMAN, EMPLOYER INSURANCE

People perceive a health care system that is unaffordable and those perceptions are rooted in the realities of their experiences with high health care costs at nearly every interaction they have with the health care system. Across most aspects of the health care experience, [recent polling from USofCare](#) found that people covered under ESI encounter the affordability crisis with more intensity than overall respondents.



America's health care debate historically has revolved around the future of government programs, their contraction, expansion, and cost. **But the ESI market covers the most people and accounts for the greatest portion of health spending in the nation, so we applaud the Committee for their interest in pursuing reforms in this market.**

Capping Deductibles and Lowering Out-of-Pocket Costs

It is important to note that while people with ESI [struggle](#) with the cost of their premiums, they also find other health care costs, including deductibles and copays difficult to manage as well.

"We do have Blue Cross Blue Shield with a \$40 primary care copay, so I can go to the doctor. But I waited a long time to have knee surgery — too long — because I didn't want to pay \$8,500 out of pocket. And in the end, that's exactly what I had to pay."

- BLACK WOMAN, NORTH CAROLINA, EMPLOYER INSURANCE

The ACA [included](#) important protections across most of the commercial market through a maximum annual out-of-pocket limit that encompasses deductibles, copays, and coinsurance. However, for 2027, that limit is set at \$12,000 for an individual or \$24,000 for a family – amounts that are completely unaffordable for most people and families. This means that out-of-pocket costs are real barriers to actually using their coverage when they need it and can drive people into medical debt when they do. In fact, [recent polling](#) from USofCare found a negligible difference between the percentage of people with medical debt who are insured (21%) versus uninsured (23%), debunking the myth that people with insurance are insulated from feeling the financial pressure of out-of-pocket health care costs.

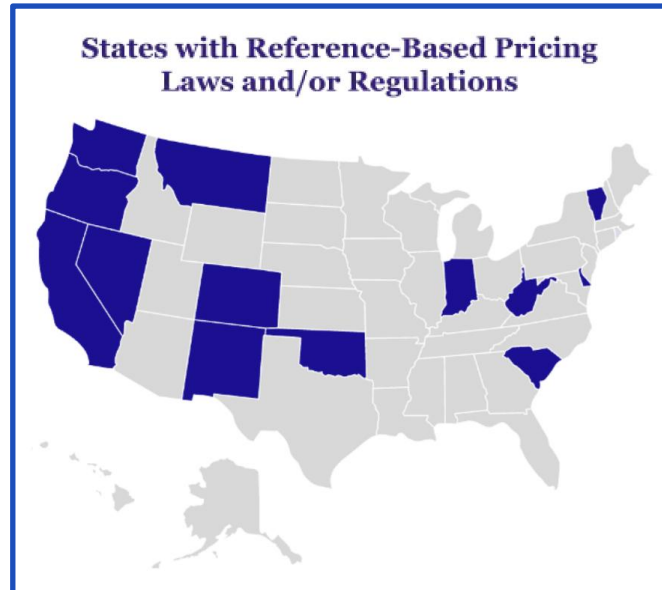
USofCare supports Congress [capping](#) annual deductibles in the commercial market, as well as [lowering](#) the annual out-of-pocket maximum and indexing these caps to wage growth, rather than medical inflation.

Ensuring Reasonable Prices in Anticompetitive Markets

Policies that insulate consumers from high deductibles and out-of-pocket costs must be paired with policies that address the underlying cost of health care items and services in order to prevent those costs from being shifted to consumers in other ways (i.e. higher premiums). [A main driver](#) of those high costs are the [prices charged by certain hospitals](#), which only continue to increase as a consequence of [consolidation](#) – and commercial insurers have been unable to negotiate better rates. On average, prices paid by commercial insurance to hospitals in 2022 were [267%](#) of what Medicare paid. These [higher prices](#) paid by health insurers result in health plans increasing premiums and out-of-pocket costs as they attempt to recoup revenue. This impacts patients, employers, and state and federal governments in significant ways – [costs](#) go up, health care [value](#) stagnates, and [quality](#) does not improve.

Recognizing the [impact](#) of these trends on state budgets and people alike, state policymakers are increasingly pursuing [solutions](#) to lower hospital prices. One emerging solution USofCare has advocated for in states is to directly limit the prices hospitals charge by implementing [reference-based pricing](#) within programs or markets states run or regulate, such as the commercial market or within state employee health plans (SEHPs). This policy directly targets what hospitals can charge by benchmarking prices to a “[reference price](#)” – most often a percent of Medicare payment rates. This would bring the prices charged for hospital services more in line with the [actual cost](#) to provide services, rather than relying on negotiated rates set by hospitals, as Medicare rates are [regularly](#) reviewed and updated to reflect local market conditions. Importantly, reference-based pricing can also be designed to bolster certain rural or financially strained hospitals and providers and improve access to [high-value care](#) by creating payment floors for specific services or types of providers, such as behavioral health services or for primary care providers. [Recent polling](#) from USofCare found that 60% of respondents support Congress setting limits on hospital prices.

As of March 2026, [13 states](#) (see map) have implemented reference-based pricing in a segment of their health insurance markets through the legislative or regulatory process. Bold action from states reflecting broad philosophical diversity within their electorate proves that these policy solutions are politically durable. With this momentum, federal uptake would be the natural next progression for Congressional consideration.



Contrary to claims from industry executives that these cost-containment policy reforms will lead to hospital closures and harm patients, a recent [report](#) from Brown University found that capping hospital payments at 200% of Medicare rates would have saved SEHPs an average of \$150.2 million per state in 2022, totaling \$7.1 billion nationwide, all while minimally impacting hospital operating margin. When used in the commercial market, reference-based pricing benefits other purchasers by helping to [lower](#) premiums and out-of-pocket costs. Moreover, a recent USofCare/Brown CAHPR [analysis](#) found that capping hospital payments in the commercial market in three states alone (**Indiana, Massachusetts, and North Carolina**) could generate almost \$26 billion for consumers in premium and out-of-pocket cost savings. This policy can also provide more predictability for people by establishing more uniformity and fairness with prices that don't rely on how well their plan is able to negotiate with an individual hospital or health system.

This policy provides the opportunity to constrain cost growth, lowering costs for the state and other purchasers, such as people and employers. **Congress should follow the lead of red, blue, and purple states that have worked to tackle hospital costs inflated by rampant consolidation and anticompetitive health care markets to place reasonable limits on hospital costs in the commercial market.**

Facility Fee Limitations

A growing body of research [shows](#) that provider consolidation is raising out of pocket health care costs for consumers. As more sites of care fall under hospital ownership, consumers have more exposure to facility fees for even routine services. In some cases, patients are being charged facility fees for telehealth visits with their doctors, without ever stepping foot in a facility. In one instance, a [Colorado family](#) was billed for an \$847.35 facility fee for one speech therapy session that was conducted via telehealth.

In addition, as hospital prices rise, consumers face increased out-of-pocket costs through deductibles and coinsurance, which are tied to the underlying cost of the service. One [study](#) found that between 2011 and 2017, outpatient surgeries saw a 53% increase in facility fee

charges and consumer out-of-pocket expenses grew by 50 percent. These additional charges and higher prices are expected to only [increase](#) as provider consolidation intensifies. And finally, as overall hospital prices increase, commercial payers are [more likely](#) to pass those costs onto consumers in the form of higher premiums.

“I don't know how the federal government lets [facility fees] happen and doesn't stop them happening by law. What's the good of something like this, other than giving people such high medical costs? There are so many people out there that don't have insurance at all.”

- US OF CARE FOCUS GROUP PARTICIPANT

Hospitals have argued they need to charge facility fees to account for key features that are unique to hospital care like 24/7-hour operations and staffing for high-acuity services like emergency and trauma care. But physician offices owned by hospitals that have none of these key features are charging facility fees – something that these very same offices didn't do before they were bought by the hospital. Policies that put reasonable limits on facility fees for services like routine doctors' office visits and telehealth appointments have been successfully implemented in [states](#) such as **Indiana, Connecticut, and Colorado**, part of growing momentum that over 40% of states are pursuing. As of August 2026, [21 states](#) (see map) have successfully passed legislation aimed at protecting people from unnecessary, costly, and unfair facility fees.



Tellingly, despite hospital arguments that these policies will devastate hospitals financially, a [recent study](#) found that Connecticut's 2017 facility fee law had *no overall impact on hospital profits in the state*, while it also protected consumers from facing additional exorbitant fees. [Recent polling](#) from USofCare found that 62% of respondents support Congress prohibiting facility fees in non-hospital settings. Eliminating or limiting facility fees is a proven policy solution that transcends political division. If implemented at the federal level, these policies would make a meaningful difference to making health care more affordable for people and patients. **As such, USofCare urges Congress to take steps to prohibit facility fees for routine, preventive, and telehealth services in the commercial market.**

Site Neutral Payments

[Payment differentials](#) between care settings is a significant contributor to increased spending across the health care system – and drives [vertical integration](#) through hospital acquisition of physician practices. When this occurs, health systems are able to reclassify these formerly independent facilities as hospital-based outpatient departments (HOPDs) eligible for a higher payment rate, despite providing the same service they provided before with [no corresponding increase](#) in quality. Health systems have [increasingly shifted](#) care delivery away from physicians' offices toward more profitable HOPDs, with average prices for services delivered in an HOPD setting [increasing faster](#) than those delivered in a physician's office.

"I went to a clinic and they informed me that it's basically part of the hospital, so they'll charge me hospital prices. The hospital sent me an email and informed me, like, 'hey, by the way, this is part of the hospital, so the cost of things will be a little bit different since it's not really a clinic,' even though it's literally a clinic."

- USofCARE FOCUS GROUP PARTICIPANT

Vertical integration and these shifts in site of service have highlighted the need to implement site neutral payments in the [commercial market](#). In too many instances consumers are charged more for a service on the sole basis of where it's performed, increasing costs for them personally as well as to the system overall. States are increasingly exploring site neutral payment policy within markets they regulate. For example:

- **New York's** [Fair Pricing Act](#) would cap prices in the commercial market for a list of common outpatient procedures at 150% of what Medicare pays and save people more than \$213 million in out-of-pocket costs.
- Site-neutral [legislation](#) was also introduced in **Illinois** for both the commercial market and State Employee Health Plan.
- For the [commercial market](#) in **Pennsylvania**, site neutral legislation was introduced in 2026.
- **Virginia's** [law](#), while narrow in scope, calls on using data from the state's all-payer claims database to analyze potential cost containment measures, including site-neutral payment policy.

Additionally, [recent polling](#) from USofCare found that 62% of respondents support Congress establishing site neutral payment policies federally. **USofCare urges Congress to apply site neutral payment rates in the commercial market to services that can be safely performed in outpatient settings with a particular consideration of the [66 services](#) identified by the Medicare Payment Advisory Committee.**

Strengthening the Existing Coverage Framework

We invite feedback on efforts to strengthen existing ACA protections 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)

Lowering Costs for ACA Marketplace Enrollees

Health care affordability has been [a challenge](#) for people across coverage markets, but these challenges have been particularly acute in different segments of the commercial market, including the ACA Marketplaces. [Enhanced premium tax credits](#) (ePTCs) were established as part of the [American Rescue Plan Act of 2021](#). This policy temporarily expanded access to the ACA's advanced premium tax credit to people in additional income brackets and increased the amount of these subsidies available to help people off-set the cost of ACA Marketplace plan premiums. The [Inflation Reduction Act of 2022](#) extended ePTCs through 2025, but ePTCs expired at the end of 2025.

An [analysis](#) of 2026 ACA Marketplace enrollment data indicates that the expiration of ePTCs has had a negative impact on people with Marketplace coverage. In 2025, 22.3 million people were enrolled in Marketplace coverage and enrollment could fall to between 17.5 and 16.5 million in 2026. A disproportionately large share of the drop in sign-ups (27%) is among people with incomes just above the ePTC “cliff” (i.e. people with incomes between 400%-500% of the federal poverty level (FPL) who lost access to premium tax credits with the expiration of ePTCs), despite this group making up just 3% of plan selections in 2025. People who were able to retain their Marketplace coverage faced higher premiums and many migrated from higher-metal tier coverage (i.e. gold or silver plans) to lower-metal tier plans (i.e. bronze and catastrophic plans) and now face higher deductibles and out-of-pocket cost liability.

Although they were exacerbated by the expiration of ePTCs, it is important to acknowledge that people were facing very real affordability challenges previously. Given this, USofCare believes that additional policy action needs to be taken to reduce the cost of ACA Marketplace coverage. **USofCare supports Congress expanding access to premium tax credits that help people afford coverage on the ACA Marketplace, however, tax credits in isolation will not address the true affordability problems everyday people face in the Marketplace and must be paired with other solutions. In addition to ePTC expansion, USofCare supports [capping](#) annual deductibles in the ACA market, and [lowering](#) the annual out-of-pocket maximum and indexing these caps to wage growth, rather than medical inflation. We believe that policies that insulate consumers from high premiums, deductibles, and out-of-pocket costs must be paired with policies that address the underlying cost of health care items and services in order to prevent those costs from being shifted to consumers in other ways or become unsustainable for the federal government.** For further discussion of our perspective on these policies, see “[Employer Coverage System](#)” section on pg. 17.

Public Option

There is also some [evidence](#) that the introduction of a [public option](#) into the ACA Marketplaces can help improve affordability of non-public option plans. See “[Establishing a Federal Public Option](#)” section on pg. 27 for additional perspective on this issue.

State Authorities and 1332 Waivers

Senate Democrats invite comments on the outcomes and lessons learned from these and other state efforts that could inform the development of similar or related federal options, and whether additional federal flexibilities are needed to spur reforms at the state level. (pg. 30-31)

[Section 1332](#) of the ACA allows states the flexibility to pursue innovative approaches to high-quality health care coverage by waiving certain requirements of the ACA. These waivers, referred to as State Innovation waivers, allow states more flexibility in adapting coverage options to meet the needs of their states while still retaining the ACA’s basic consumer protections.

These waivers allow states to receive "pass-through" funding equal to the amount of money people would have received to fund premium tax credits and cost sharing reduction amounts without the waiver. States have the flexibility to reinvest this funding into additional affordability or coverage measures, such as state premium wraps or benefits to address social determinants of health.

Currently, [20 states](#) have 1332 waivers in effect, most of which have established state-based reinsurance programs to lower premiums for residents, waiving Section 1312(c)(1) of the ACA to do so (which falls under Part II of Subtitle D of Title I).

In recent years, states have been exploring other uses for 1332 waivers in an effort to provide more choice, competition, and affordability to their consumers. It is important to note that 1332 waivers have been an effective tool for some states to pursue truly innovative approaches that have expanded affordable coverage options that have generated savings states can use towards other health care affordability and coverage programs that they would otherwise be unable to fund.

As the RFI notes, states that have established public options have successfully leveraged 1332 waivers as part of this process.

- **Colorado** was the first state to use a 1332 waiver to implement a public health insurance option known as the “[Colorado Option](#).” This was a new waiver amendment that builds upon the state’s previously established [reinsurance program](#). The Colorado Option is implemented as outlined in [HB21-1232](#), offering standardized health plans on the state-based exchange that are available to all residents, regardless of immigration status. Compared to similar plans, the Colorado Option is less expensive than other Marketplace plans due to premium reduction targets of 15% over three years. The revenue generated from the Colorado Option and the reinsurance program [have](#)

[generated significant savings](#) to further improve health coverage affordability in the state.

- **Nevada’s** 1332 waiver enables the state to lower costs and capture savings from the State’s [public health insurance option program](#), Battle Born State Plans, and reinvest those savings in the new [Market Stabilization Program](#). The Market Stabilization Program establishes:
 - A reinsurance program;
 - A quality incentive program for issuers and providers to increase utilization of value-based payment models; and
 - The “Practice in Nevada” program, a workforce development program that allows Nevada to dedicate resources to attract and retain providers through a new loan repayment program.

Other states have leveraged 1332 waivers to advance additional reforms that improve affordability and stability in their insurance markets. For example, [Maine](#) received approval in [2022](#) to merge their individual and small group markets to help stabilize the risk pool and premiums for small businesses and people in the individual market. Through this waiver, the State was also able to extend reinsurance to small businesses purchasing coverage through the pooled market.

For additional discussion of state public option efforts and how those efforts can inform a federal public option, see “[Establishing a Federal Public Option](#)” section on pg. 27.

Statutory Guardrails

In order for CMS to approve a 1332 waiver, it must meet the following four statutory guardrails:

- The coverage provided under the waiver must be as comprehensive and affordable as coverage would be for people without the waiver;
- Provide coverage to a comparable number of residents as would be covered without the waiver;
- Protect against excessive out-of-pocket costs through protections of affordable coverage and cost sharing; and
- It must be budget neutral and not add to the federal deficit.

It is important that statutory guardrails protecting access to affordability and quality coverage remain in place, as there have been regulatory attempts to [dilute](#) prior more stringent interpretations of these guardrails. It is equally important to ensure that 1332 waivers cannot be leveraged to impose policies or programs that would [threaten access](#) to affordable coverage.

Federal “Pass-Through” Funding

Federal “pass-through” funding from 1332 waivers provides critical funding for state coverage expansion and affordability efforts. States’ “pass-through” amounts are calculated by CMS and the Treasury Department on an annual basis. CMS and the Treasury Department [have discretion](#) on the formula used to calculate “pass-through” amounts annually and these

determinations have resulted in states receiving “pass-through” amounts that were [less than expected](#).

Importantly, states would likely not be able to fund reforms without federal “pass-through” funding. **New York**, for example, received a [1332 waiver](#) to allow their Essential Plan to be expanded to individuals between 200-250% of FPL. The Essential Health Plan provided comprehensive health insurance to [1.7 million New Yorkers](#) with zero monthly premiums, no deductibles, and minimal cost sharing. The expansion saved participants an average of over [\\$6,000 per year](#) compared to Qualified Health Plan coverage. However, New York subsequently [terminated](#) this waiver due to funding losses stemming from H.R. 1 premium tax credit eligibility changes that the State determined it could not absorb in the absence of the previously provided “pass-through” funding. Additionally, because “pass-through” funding is calculated on the basis of advanced premium tax credit savings, the expiration of ePTCs [reduced federal funding](#) available to fund states’ 1332 reinsurance programs, creating instability and uncertainty in this funding stream.

Uncertainty in the Federal Approval and Reapproval Process

As noted above, generally speaking, states cannot independently fund the policies and programs established in 1332 waivers without being able to leverage federal “pass-through” funding. While the ACA requires that all approved 1332 waiver applications meet the four “guardrails” outlined in the statute, CMS has considerable flexibility in approving or denying 1332 waiver applications and in their interpretation of the statute. [Shifting interpretations](#) and regulations across different administrations creates uncertainty for states.

Federally, different administrations prioritize different policies and overall goals, and approval of a waiver application during one administration does not necessarily guarantee renewal during a subsequent administration. For example, addressing inequities in health care and the role of 1332 waivers in advancing that goal has been prioritized differently from administration to administration, which can impact states’ approaches in waiver design. Under one administration, the 1332 statutory “guardrail” requiring that coverage be provided to “a comparable number of people” could require that the demographics of who may lose coverage be a factor, while another administration could be agnostic on this point. These shifts in priorities can impact how states need to design their waiver programs.

Although **New York’s** Essential Health Plan waiver termination was not the result of a CMS decision on renewal, it demonstrates how states can be forced to make [major programmatic transitions and policy changes](#) to mitigate negative impacts associated with federal changes that are outside of their control.

Establishing a Federal Public Option

Senate Democrats request specific feedback and comments on approaches to establishing a federal public option that would address persistent affordability challenges and achieve universal coverage. (pg. 33)

A well-designed federal public option can build on previous health care reform efforts to address some of the key challenges in our health care system and make it work better for everyday people. Some states have established public options at the state level and these policy designs and experiences provide valuable [lessons learned](#) for federal policymakers should they choose to pursue this policy at the federal level. USofCare and our partners are proud to have been deeply involved in such efforts, including in [states](#) that have successfully done so – **Nevada** and **Colorado**.

Many of the problems states sought to solve by pursuing public options are issues federal policymakers are also grappling with, and these different state approaches provide important insights and possible frameworks from which to draw. In our response to this RFI, we lift up key state public option experiences for the Committee’s consideration.

Premiums and Impact on the Existing Market

Senate Democrats request analysis and feedback on how public option plan design and pricing would, or should, impact the existing market. (pg. 34)

Premiums

Improving premium affordability was top-of-mind for some states when establishing and implementing their public health insurance options (referred to as “public option”).

- **Colorado** had some of the [highest premiums](#) in the country in the years preceding the consideration of the public option. Relatedly, Colorado also had some of the [highest hospital prices](#) in the country, which contributed to high premiums. The state implemented the Colorado Option, having passed legislation in 2021 and enrolling people for 2023. In [2026](#), the average monthly premium savings for Colorado Option plans are \$14-\$33 per month, depending on plan type. Additionally, Colorado’s efforts to standardize Colorado Option plans have made out-of-pocket costs more predictable for consumers and out-of-pocket costs are 15% lower in these plans than non-public option plans in [2026](#).
- [Washingtonians](#) who purchased Marketplace plans faced an average premium increase of 36% in 2018, which was followed by an average increase of 13.8% in 2019. These year-over-year premium increases [resulted](#) in a subsequent drop in enrollment in **Washington**. [Between 2021 \(when the state began enrollment in its public option\) and 2023](#), Cascade Select premium costs in **Washington** trended down 6%, while non-public option Marketplace plans increased 15%.
- Additionally, in [plan year 2026](#) (the first plan year in which **Nevada’s** public option was available), the average total (gross) premium for Battle Born State Plans was approximately 4.7% lower and the average out-of-pocket (net) premium for these plans was about 4% lower. Evidence from Nevada [also indicates](#) that Battle Born State Plans have created competitive downward pressure on non-public option Marketplace plan

premiums – which are about 4.6% lower in 2026 than they would have been without the public option.

Impact on the Existing Market

A federal public option can positively interact with other public programs through the so-called “welcome mat effect,” driving increased enrollment in other benefit programs and the potential for lower costs stemming from increased competition.

Following the implementation of the ACA and the institution of the Marketplaces in 2014, Medicaid and the Children’s Health Insurance Program (CHIP) saw [surges of new enrollees](#). From 2013 to 2016, the percentage of children covered by these programs in families with incomes below 100% FPL increased by 1.9 percentage points; it increased an additional 5.5 percentage points for children in families earning up to 199% of the FPL. These gains are attributed to the “welcome mat” effect,” which refers to the surge in families enrolling in subsidized private plans – after the launch of the ACA Marketplaces – only to learn that they and/or their children were already eligible for existing public health insurance programs. The “welcome mat effect” was particularly discernible in Medicaid expansion states and families where the adults became newly eligible for Medicaid coverage. Assuming it’s implemented smoothly and advertised effectively, a federal public option would likely come with a “welcome mat” of its own. We could reasonably expect an increased child and adult enrollment in Medicaid and CHIP, marketplace coverage, and dual [eligible](#) enrollment in both Medicare and Medicaid.

Evidence suggests that introducing a public option would increase competition among insurers and lead to lower overall rates for consumers, including those with private coverage. This has been the case in [Massachusetts](#), which requires all health insurance carriers with over 5,000 beneficiaries to make plans available through the Health Connector or the state’s Marketplace. That requirement has maximized competition and led to an array of plans with reasonable premiums for consumers to choose from; a similar dynamic is likely to play out at the national level. In fact, the [Urban Institute](#) calculates that if the public option were introduced in both the employer and nongroup markets, it would cause median premiums for employers to decline by 18 to 25% percent and allow upwards of one million currently uninsured Americans to enroll in affordable health care coverage.

Payment

Senate Democrats welcome comments on establishing payment rates in a federal public option... (pg. 34-35)

Determining provider payment rates has been one of the most contentious debates surrounding public options – *but it is the most important policy to get right if a public option is going to be leveraged to [lower premiums](#) and meaningfully address affordability challenges for people.*

Provider payment rates need to be based on the cost of providing care in order to contain costs in the public option – which is key to reducing high premiums and out-of-pocket costs for people, as well as constraining costs in state and federal budgets. Establishing provider payment

rates in a federal public option not only provides an opportunity to constrain payments to providers that have ballooned far beyond the actual cost of providing care but also provides an important opportunity to bolster payments for certain high-value services or certain hospital or provider-types that have lagged.

Under the current system, hospital and provider market power is more determinative of payment rates than factors that actually impact consumers in a positive way. And the [data](#) clearly show that consolidation – and the resulting market power – drives up prices. There is also significant variation in the financial position of different providers and provider-types. For example, according to an [analysis](#) from the Medicare Payment Advisory Committee (MedPAC), in fiscal year 2024, one-quarter of hospitals in the U.S. had an all-payer operating margin below -2%, while another quarter had a margin above 12%. Additionally, federally qualified health centers (FQHCs) – a critical source of care in many communities – had, on average, [net margins](#) of -2.1% in 2024. Establishing appropriate payment rates for providers in a federal public option that rein in excessive payments for certain providers and include thoughtfully crafted policies that strategically target higher payments to other providers is an effective way to ensure provider financial stability, while simultaneously preserving access and bringing down costs for people.

With these issues in mind, a federal public option can incorporate state experiences and lessons learned when establishing provider payment rates. In **Washington**, [Cascade Select](#) plans are required to pay providers and facilities at or less than 160% of Medicare rates (i.e. a “ceiling”) for all covered benefits, except pharmaceuticals. Any rural hospitals CMS has designated “critical care” or “sole community” hospitals must be paid at or beyond 101% of allowable rates (i.e. a “floor”). Physicians specializing in family medicine, general internal medicine, or pediatric medicine must be paid at or beyond 135% of Medicare rates for providing primary care services.

In [Nevada's](#) public option, Battle Born State Plans are required to pay providers at or beyond Medicare rates, including when paying for services at FQHCs and rural health clinics (RHCs). This payment level is meant to be a starting point and a “floor” for payment rates, not a ceiling. Establishing a “floor” for payment rates for certain providers can help preserve access in high-need areas (i.e. rural or provider-shortage areas), and, importantly, support financially strained providers and others who currently lack the market power to negotiate higher payment rates.

An early draft of **Colorado's** public option legislation mirrored the provider payment “ceiling” and “floor” approach taken up in Washington and Nevada; however subsequent negotiations shifted the approach ultimately taken in the final bill. [Colorado's law](#) authorizes the Division of Insurance (DOI) to set payment rates for Colorado Option plans if the premium rate reduction targets established in statute are unmet.

The law also includes a framework for Colorado's DOI to use in setting these rates, should that happen. Under this [framework](#), hospitals will not receive less than 165% of Medicare, with a base rate of 155% of Medicare. There are additional increases for certain types of hospitals and/or if certain conditions are met (i.e. a 25% increase for critical access and small rural hospitals that are not part of a larger health system; a 30% increase for high Medicare and/or

Medicaid case mix; a 40% increase for hospitals efficient at managing the underlying cost of care). Additionally, under the framework, physicians will receive rates of *at least* 135% of Medicare, guaranteeing them at least that payment rate.

In landing on this policy approach, Colorado policymakers in 2020 first used self-reported data from its state hospital association to identify each hospital's "break-even point," a percentage of Medicare representing the payment necessary to cover the costs of care. On average in Colorado, this was the equivalent of [143%](#) of Medicare. This was factored into the development of the proposed formula incorporated into the 2020 legislation, with each hospital receiving a specific payment rate. This formula provided the additional payment enhancements mentioned above, including critical access and rural hospitals, carried over to 2021 and ultimately included in the final legislation. To date, the Colorado DOI has never publicly stepped in to establish payment rates in their public option and, in [2026](#), two-thirds of Colorado hospitals are receiving payment levels for patients with Colorado Option plans that are at the floor set by the program.

Constraining certain provider rates is critical to establishing a federal public option that actually improves affordability for people and generates savings to the federal government. Federal policymakers should structure the public option in a manner that enables the federal government to set payment rates that are reflective of the costs of delivering care across different types of providers. Highly consolidated provider markets, which are [omnipresent](#) across the country, [don't allow](#) for negotiation of provider rates on a level playing field and often result in higher payments going to the hospitals and providers that need them least.

Establishing a federal public option – whether it's in the individual market, in the employer market or some segment of it, or more broadly across markets – without effective cost containment will only serve the purpose of creating another coverage option without providing one that's substantively more affordable.

While tying payment rates in a federal public option to Medicare rates or some percentage of Medicare rates has some drawbacks, components of the process by which Medicare sets payment rates can provide an important model for a federal public option. Similar to Medicare, the federal government should have the ability to set payment rates in a federal public option and the process by which those rates are established should take into account differences between different types of hospitals and providers, geographic differences, and labor cost variations.

Additionally, the approach of not establishing payment rates in a federal public option or directing insurance companies to drive the required premium reductions and cost savings is not the most effective way to address true cost-drivers in the health care system – and has the potential to drive payment reductions to financially unstable providers, which is not beneficial to patients or the system overall. **A federal public option can – and should – drive cost savings for people and the system as a whole – including through targeting providers that are high-cost outliers. Federal policymakers should not be agnostic about how those cost-savings are achieved.**

Networks

We request feedback on [establishing and administering networks in a federal public option]. (pg. 35-36)

In designing a federal public option, ensuring people have adequate access to providers is critical. While cost is most consumers' top priority when it comes to their health care, the provider network (both hospitals and clinicians) of a plan is also top of mind, particularly for patients with ongoing or complex medical needs. A robust provider network that reflects the community it serves is also an important policy lever in building health equity within the care delivery system.

Congress should develop a federal public option that ties provider participation to participation in other federal health programs like Medicare and Medicaid to better guarantee access to health care services, as states have in their approaches to public options. For example, [Nevada's](#) public option law requires providers and facilities that want to continue to participate in the State's Public Employee's Benefits Program or Nevada's Medicaid program to be included in at least one network of the public option beginning in the 2027 plan year. Further, providers are required to accept new patients enrolled in Battle Born State Plans at the same rate as those not enrolled in Battle Born State Plans.

Similarly, in learning from their [original public option bill](#), **Washington** made adjustments in [their 2021 bill](#) to encourage hospital participation. Beginning in 2022, hospitals that provide services and receive reimbursement from Washington public employee benefits or Medicaid must also provide in-network services for at least one Cascade Select plan. Nevada and Washington's approaches are good examples for federal policymakers to consider due to the large number of providers participating in public programs.

Congress should also take steps to ensure *equitable* access to providers, creating a robust and diverse provider network that reflects the population's needs. Congress can look to a [2021 Colorado law](#) creating new network adequacy requirements for its Colorado Option plans as one example of how to do this in practice. Colorado requires that standardized plans in the individual and small group markets "have a provider network that is culturally responsive and reflects the diversity of its enrollees." [Culturally responsive networks](#) are one tool in helping to close gaps and improve access to high-quality care and health outcomes for people with varied cultural origins and identities, regardless of their culture, race, ethnicity, language, geography, or ability. It provides an inclusive atmosphere where patients' cultural beliefs are respected and taken into account when providing care.

State approaches to provider networks can help bolster patient access under a federal public option. **The federal government has key tools it can leverage to optimize provider access and participation. Tying provider participation to other federal programs like Medicare and Medicaid is one solution for federal consideration.** Moreover, a federal public option could weave in elements of Colorado's [culturally responsive networks](#) to address disparities in care and ensure patients can receive care by providers who reflect the communities in which they live.

Medicare or Medicaid Buy-In

Senate Democrats invite comments on how changes to or expansions of federal financing that individuals currently receive for coverage could impact spending, enrollment, state operations, and provider payments. (pg. 36-37)

We request 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)

All of the state public options in place now are administered by private insurance companies. When states were designing their approaches to establishing a public option, some states [explored](#) the possibility of a government-run public option; however, key barriers prevented this approach from being a viable option at the state level. In [Colorado](#), the state ultimately decided to structure their public option as a public-private partnership and have these plans administered by private insurance carriers. While state officials gave meaningful consideration to a state-run public option structure, they were [ultimately concerned](#) that in addition to funding the start-up expenses, the State would also need to fund initial and growing reserves associated with a health plan, as well as bear the financial risk associated with the plan. This proves to be especially challenging in annual or biennial state budget cycles.

Federal policymakers should keep this in mind for a few reasons:

- First, if Congress opts for a policy approach that envisions states taking the lead on establishing public options, consideration should be given to addressing these barriers for states.
- Second, the involvement of private insurance companies in administering a public option inherently [reduces](#) the amount of savings (and premium reductions) that can be generated compared to a government-administered plan. When considering premium savings that have been associated with state public option plans to date, it is important to factor in the use of private insurance carriers in administering these plans, as well as the limited (or non-existent) cost containment tools that state regulators have available in some of these state laws.
- Third, it is also important to acknowledge the “buying power” that a true government-run federal public option would have and how that could be leveraged to reduce costs for people and the government, as well as embed other valuable reform policies into a federal public option. [Nevada](#) established its public option by leveraging its Medicaid managed care program infrastructure, requiring insurers that offer managed care plans in Medicaid to also submit competitive bids to offer Battle Born State Plans. Given how lucrative Medicaid managed care is for insurers, this provided a valuable hook for the state to bolster Battle Born State Plan offerings and align health care coverage strategies across these two markets, including by requiring more value-based payment arrangements and aligning financial incentives for providers and health plans to achieve more efficiencies in the system and to address state priorities – such as increasing affordability and quality of care.

While states gave due consideration to the notion of a government-run public option, the prevailing policy choice was to pursue administration of public options through private insurers.

Importantly, many of the major limitations states faced in establishing a true government-run public option do not constrain the federal government in the same way, which should assure federal policymakers that such a pursuit is not only possible, but an improvement from state public options to date.

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

Ending Junk Coverage Across Markets

Senate Democrats request feedback on approaches to ensuring that consumers are protected from substandard plans that provide little to no coverage or financial protection, and invite comments on whether insurance companies that market or sell junk insurance should receive taxpayer support. (pg. 40-41)

From our listening research, we know from people that they not only want coverage that is [affordable](#), but also coverage that is [dependable](#) and will be there for them when they need it. Short-term limited-duration insurance (STLDI) is intended to provide temporary coverage for short-term coverage gaps. While STLDI can be less expensive, it provides less comprehensive coverage and has fewer consumer protections than Marketplace plans. USofCare [opposed regulatory efforts](#) to dramatically expand access to STLDI coverage.

STLDI plans aren't comprehensive and fail to cover what consumers expect or need, putting their financial health and wellbeing at risk. **USofCare strongly supports codifying a prohibition on this coverage, as well as consumer protections that ensure that people understand the type of coverage that they're enrolling in, the limitations their plan has, and protect against [concerning tactics](#) previously used by these plans to gain enrollment.**

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 Benefits

We request feedback on approaches to establish minimum requirements for standardized plans. (pg. 45-47)

The health care system puts too much onus on consumers to make sense of an overly complex, confusing, and unwieldy health care system – both in navigating through the options available for coverage and trying to make the best selection, as well as in using that coverage to access

care. People shopping for insurance options deserve those options to be clear. But people also deserve to have coverage that affords them with the care they need and that addresses the full spectrum of their health.

“Each year during open enrollment, we should get a sheet of paper that describes deductibles, in network, out of network, and all of that... I just think it is so confusing.”

- BLACK WOMAN, MICHIGAN

Plans with standardized benefits can simplify insurance for consumers. Standardized plans support consumers shopping for coverage by allowing them to better make “apples-to-apples” comparisons among different plan options, reducing confusion and making plan selection easier to navigate. Additionally, standardized plans can provide opportunities for more pre-deductible coverage for routine services that people rely on, like primary care and generic drugs, as well as reduce discriminatory benefit designs.

The 2023 NBPP [final rule](#) established requirements for insurers to offer standardized qualified health plan options at every product network type and metal level throughout each service area where they offer non-standardized QHP options with certain requirements for all standardized plans. Subsequent NBPP final rules made minor modifications to these standardized plan requirements. However, the 2027 NBPP [final rule](#) discontinues these standardized plan option requirements and the non-standardized plan option limit and exceptions process in the individual market.

Congress can take steps to simplify insurance leveraging standardized plans. **USofCare supports codifying and building on the 2023 standardized plan requirements to reflect successful state efforts to improve standardized plan design as it will help guarantee that insurers offer high-quality plans that are easy to compare and shop for.**

Codify Standardized Plan Requirements

USofCare supports Congress codifying standardized plan requirements finalized in the 2023 NBPP, including:

- Standardized cost sharing rules for covered benefits;
- Waiving the deductible on certain benefits and applying a fixed dollar copay for certain items and services;
- Requiring a comprehensive annual deductible that applies to both medical services and outpatient prescription drugs; and
- Establishing outpatient drug formulary tier requirements.

Build on Standardized Plan Requirements

USofCare has worked in a [number of the states](#), including Colorado and Washington, that have pursued reforms that help standardize and simplify the coverage options available to consumers, as well as ensuring that those insurance products are required to offer certain benefit designs that can diminish inequities in health care for the most marginalized communities. States have also leveraged standardized plans to reduce health disparities and promote health equity through pre-deductible coverage policies and more [culturally responsive provider networks](#). **In addition to codifying standardized plan requirements, USofCare urges Congress to build on these requirements – leveraging reforms pursued by states – to promote plan coverage of high-quality, cost-effective services.**

Requiring plans to provide certain high-quality, cost-effective benefits with limited or no cost sharing

Standardized plans can be leveraged to require plans to provide certain services with zero or reduced out-of-pocket costs. As part of establishing standardized plan requirements in statute, **Congress should establish a “floor” of services that must be covered pre-deductible and, if allowing cost sharing, emphasize predictable cost structures like copays over coinsurance to better help patients budget for care.** Congress could follow the lead of some states that have prioritized services that reduce health disparities, including regular primary care visits, mental health visits, care during and after pregnancy, diabetes supplies, smoking cessation programs, prescriptions, and language translation. CMS, through notice and comment rulemaking, and states should have the ability to go beyond the requirements established in statute.

Colorado, through the [Colorado Option](#), provides a valuable state model for standardized plan design that Congress can look to for federal uptake. The Colorado Option’s standardized plan offers an additional plan choice for Coloradans to select an affordable coverage option that aligns with their care needs. The standardized plans were designed through an [extensive stakeholder engagement process](#), with an emphasis on improving health equity, and are required to offer primary, behavioral health, and perinatal services with no cost sharing. In addition, cost sharing structures will be shifted to promote greater affordability of high-value services that drive better health outcomes and increase equity, including reasonable co-pay amounts for prescription drugs. It also helps reduce confusion among individuals shopping for and comparing coverage options, as standardized plans encourage carriers to compete on quality of network and customer services, rather than cost alone.

Expanding access to safety net care

Certain providers deliver elevated levels of high-quality, cost-effective essential physical and mental health care services to underserved populations. Currently, issuers are [required](#) to contract with at least 35% of available Essential Community Providers (ECPs) in a service area and must demonstrate that certain categories are represented within their provider networks, including: FQHCs, Ryan White Program providers, Family Planning providers, Indian Health providers, SUD treatment centers, mental health facilities, and others. USofCare’s listening [research](#) confirms that people value the care they receive from safety net providers, particularly

in underserved communities. Addressing this need will take more than increasing required thresholds but also stabilizing safety net providers through adequate reimbursement. As such, **plans should be required to contract with a higher percentage of ECPs than required under current federal regulations to ensure communities have access to regular sources of care while also simplifying the ECP certification process and properly ensuring adequate payment to allow ECPs to remain in the community.**

Policymakers should also include more providers and provider types in plan networks that have been proven to decrease health disparities, such as [doulas](#) and [community health workers](#), and implement culturally responsive care to promote health equity.

Culturally responsive provider networks

Culturally responsive health care seeks to close gaps and improves access to high-quality care and health outcomes for people with varied cultural origins and identities, regardless of their culture, race, ethnicity, language, geography, or ability. It provides an inclusive atmosphere where patients' cultural beliefs are respected and taken into account when providing care.

“I used to have a primary care physician, but I had to quit him. Because even though I'd gone to him for years, it wasn't until I had a very specific health question that he found out I was gay. And then, the relationship between us shifted, and it was very uncomfortable. So that's why I choose to find another primary care. It's not easy in the LGBT community to find a doctor that provides [culturally responsive care].”

- WHITE MAN, COLORADO

Colorado became the first state to require culturally responsive provider networks that reflect enrollees' racial, ethnic, gender identity, and sexual orientation, which can serve as a model for other states looking to address health disparities. Under this approach, plans are required to:

- Collect demographic data for both in-network providers and plan enrollees, which must be incorporated into network access plans that plans are required to submit to DOI;
- Expand provider directories to include information critical to people who face barriers to receiving care (i.e. office and exam room accessibility for people with disabilities, languages spoken by providers and front office staff);
- Require language accessibility services;
- Increase access to essential providers by including at least 50% of the Essential Community Providers in the plan's service area; and
- Submit reports that outline plans' efforts to create culturally responsive networks.

USofCare supports incentivizing or requiring insurers to build and maintain culturally responsive provider networks.

Network Adequacy

We request feedback on these proposals and additional reforms to ensure that consumers are not being misled by inaccurate provider directories. (pg. 47-48)

Federal Network Adequacy Standards

While cost is most consumers' top priority when it comes to their health care, the provider network (both hospitals and clinicians) of a plan is also top of mind, particularly for patients with ongoing or complex medical needs. For example, in [one listening project](#) in rural South Carolina, the people engaged cited an increase in the amount and quality of specialists and health care professionals as a critical need for their communities. Network adequacy is an [important](#) factor in determining whether people can access the care they need in a timely manner.

“I tried to find a very specific doctor. It’s really hard to find someone who meets your criteria and is in your insurance network. And on top of that, you never really know if they’ll be the doctor you expect. It’s just a lot, especially since there aren’t that many options depending on where you live.”

- LATINA WOMAN, MARYLAND

Federal network adequacy standards provide consistency for consumers across states and establish an important “floor” to help ensure that consumers have access to a range of health care providers necessary to access the care they need – and USofCare [opposed](#) the regulatory effort to eliminate the uniform federal network adequacy standards. In the absence of a federal standard there is [wide variability](#) in state laws, authority, and process for determining network adequacy. **USofCare supports a strong federal network adequacy standard and robust oversight and enforcement if there are network inadequacies.**

Standards on Essential Community Providers

Primary care is essential to improving prevention and achieving [better health outcomes](#). Consistent [access to primary care](#) leads to better overall care, more coordination among health services, [improved outcomes](#), and [lower costs](#). However, [our listening research](#) has found that the way people experience primary care varies and there are persistent barriers to access care, especially for underserved populations. In particular, we know that people living in rural areas often face [persistent and unique challenges](#) accessing primary care.

In light of these findings, **USofCare supports codifying strong federal thresholds of ECPs that insurers must contract with.** Increasing the number of available ECPs in plan networks will increase access to care for many people who need it. The availability of ECPs, such as federally qualified health centers and rural health centers, in plan networks is a critical step in providing and sustaining access to care for people who have been underserved by the health care system.

States have also recognized the value that increased availability of ECPs can have on access to needed care. For example, **Montana** which [required](#) marketplace plans to “strive to include” up to 80% ECPs in plan networks before returning to the federal standard in 2024. Additionally, **Maryland** increased its network standards for ECPs to improve the availability of mental health and SUD treatment for residents.

Culturally Competent Provider Networks

A robust provider network that reflects the community it serves is also an important policy lever in building health equity within the care delivery system. See “[Standardized Benefits](#)” section on pg. 33 for additional details and perspective on culturally responsive provider networks.

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

Streamlining Eligibility & Centralized Enrollment Platforms

Senate Democrats invite feedback on these proposals and other approaches to streamline eligibility and enrollment for all Americans and guarantee access to coverage throughout the plan year. (pg. 67-68)

Senate Democrats invite comments on the benefits of [a centralized enrollment platform] 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. (pg. 16)

The U.S. health care system – and the health insurance system – is [extremely complex](#) and difficult to navigate and that complexity breeds confusion, frustration, and [mistrust](#). Recent changes stemming from H.R. 1 and regulatory actions – including eliminating automatic re-enrollment, changing provision eligibility for premium tax credits, restricting Open Enrollment periods, and new eligibility verification requirements – [will create additional barriers](#) to enrolling in Marketplace and Medicaid coverage. However, [some challenges related to enrollment](#) existed prior to these changes, particularly among certain populations.

“Where does [a] person go to get health care access? After figuring that out, they now have to shop for insurance. Where do they go to do that? Also, if you have health insurance, it may be outlined that it covers one thing, but when you say you need to use it, what you need is no longer covered.”

- BLACK WOMAN, DENMARK, SC

USofCare supports efforts to reverse recent eligibility changes that make enrolling in coverage more difficult for people, as well as Congress taking additional steps to streamline the eligibility and enrollment process across coverage markets.

With respect to proactive changes to streamline eligibility and enrollment processes, there are some lessons from State-Based Marketplaces (SBMs) that Congress can look to. Most SBMs have a centralized eligibility and enrollment platform for all affordability programs so that people enrolling in either Medicaid, CHIP, or Qualified Health Plans through the Marketplace will have access to a one platform on the SBM’s website for enrolling in those coverage options – an approach that aligns with the ACA’s “no wrong door” principle. Because SBMs can be built with a state’s unique infrastructure and technology needs in mind, people enrolling in coverage will not experience the back-and-forth some [currently experience](#) when they enroll through [healthcare.gov](#). For people who are churning between Medicaid and marketplace coverage, for example, when their incomes and subsequent eligibility fluctuate, or families who have family members enrolled in multiple programs (e.g. parents on a Marketplace plan and kids in CHIP), a centralized enrollment platform can create a much easier pathway to enrollment. Some examples of innovative policy solutions pursued by SBMs include:

- *Fully Integrated Systems.* States have a range of options in designing their eligibility and enrollment systems. As noted above, most SBMs operate a centralized eligibility and enrollment platform on the SBM’s website; however, in fully integrated eligibility systems, the SBM platform can determine eligibility for and enroll applicants in Medicaid and CHIP based on modified adjusted gross income (as opposed to the SBM “flagging” people potentially eligible Medicaid and sharing information with the State Medicaid agency and vice versa). A number of states have established fully integrated systems through their SBMs, [including California, Connecticut, and Washington](#) (which allows Washingtonians to enroll in affordability programs through the Marketplace, Medicaid, and public option plans through [this system](#)).
- *“Easy Enrollment” Programs.* [Maryland](#) led the way in establishing the first “Easy Enrollment” Program, which allows Marylanders to indicate on their state tax form if they are uninsured and would like information on coverage options. From there, the Office of the Comptroller shares information with Maryland’s SBM, which conducts an eligibility determination. Maryland’s “Easy Enrollment” Program has been replicated by [other SBMs](#). [Maryland](#) and [New Jersey](#) leverage their unemployment insurance system in the same way.
- *Auto-Enrollment for Coverage Transitions.* During the COVID-19 PHE unwinding, [a number of SBMs](#), including [California, Maryland, Massachusetts, and Rhode Island](#), used auto-enrollment for people transitioning between Medicaid and Marketplace, which is a successful tool in preventing coverage gaps and reducing administrative burden on people. This can be particularly helpful for people who regularly churn between programs and those impacted by H.R. 1’s changes to Medicaid.

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

Private Equity

Senate Democrats are interested in feedback on these proposals as well as other approaches to ensuring that profit-driven corporate practices and private equity involvement in health care cannot extract value from the health care system at the expense of patient care. (pg. 72-73)

Corporate actors have become [increasingly involved](#) in health care, with private equity acquisitions of physician practices having [increased by 645%](#) between 2012 and 2021. When these actors [increase](#) their market share, they're able to use this as leverage to negotiate higher rates from insurers, which translates to [higher premiums and cost sharing](#) for patients. Corporations focused on higher profits may also [prioritize high revenue services](#) like elective surgeries over community-oriented services, such as behavioral health or preventive care services. Driven by lucrative financial opportunities, these entities often reduce competition, entering into [risky financial deals](#) with acquired hospitals and provider practices in the pursuit of quick profits before exiting the market after their initial investment. This growing corporatization of health care has raised questions about the degree to which corporate interests influence medical decision-making and patient care.

[Most states](#) have corporate practice of medicine (CPOM) laws on the books to prohibit corporations and other non-physician entities from taking over medical practices, though state approaches [vary widely](#). By requiring physician control of patient care, CPOM doctrine protects physicians from outside factors or influence, such as pressures to maximize profits, and ensures that clinical decision-making is made in the best interests of patients rather than financial investors. This helps to protect patients from rising concerns around the negative impact of corporate health care ownership on [patient safety](#), [care quality](#), and [access to care](#).

Unfortunately, exemptions and loopholes exist to allow hospitals, private equity, and other entities to exert control over medical practice despite state CPOM doctrines. Corporate actors will often employ third party vendors like Management Services Organizations (MSOs) to remain in compliance with state CPOM laws, skirt regulations designed to keep physicians in charge of clinical decision-making and exert pressure on clinical operations and procedures to maximize profits. In response, states like **Massachusetts, New York** and **Texas** have taken [steps](#) to more rigorously enforce existing CPOM regulations or update these laws entirely.

The [personalized care](#) that patients demand and deserve can only be realized through an ownership model that prioritizes clinician ownership, patient safety, and physician and medical control or medical decision-making. Strengthening states' CPOM doctrines addresses some of the underlying trends toward health care consolidation by promoting transparency and limiting the ability of corporate actors, such as private equity, to run these facilities for financial gain. At the same time, these laws also promote provider autonomy, boost independent medical

practices, and ensure that the care delivered is in the best interest of patients and not corporate bottom lines.

USofCare supports Congress taking action to establish minimum CPOM doctrines at the federal level, while continuing to allow states to take additional action.

USofCare has actively testified in states such as [Minnesota](#), [Oregon](#), and [Vermont](#) to strengthen existing CPOM doctrine, and support federal uptake of these policies. States have taken a variety of approaches that can be replicated at the federal level, including:

- **Prohibit corporate ownership** of facilities and address imbalanced financial incentives that benefit corporate actors;
- **Prohibit unlicensed entities and corporations from exerting profit-driven influence on providers' medical decisions and patient care** by limiting the ways in which physician practices contract with MSOs and other third-party vendors;
- **Promote added transparency** through disclosure requirements for any affiliated corporate interests, including private equity, as well as any third-party vendors, such as MSOs; and
- **Increase enforcement authority** to allow for investigations of CPOM violations

Additional detail on state CPOM laws that may be of interest include:

- [Oregon](#) boasts one of the strongest CPOM laws in the country, banning MSOs or anyone they contract with from having majority control or ownership over a practice or exercising ultimate control in the physician practice. The law also takes aim at anticompetitive contract clauses that corporate entities commonly impose on clinicians, such as noncompete, nondisclosure, and nondisparagement clauses.
- [Massachusetts](#) passed legislation to require corporate actors to submit quarterly reports detailing ownership arrangements and affiliations and testify annually before the state's Health Policy Commission.
- [New York](#), which already has some of the [strongest state CPOM protections](#), passed legislation expanding state review of health care transactions to include health care MSOs.
- [Texas](#) prohibits non-physician ownership or control of health care entities with strong enforcement by the Texas Medical Board. In effect, corporate actors are prohibited from practicing medicine in the state.

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

Vertical Integration

*Senate Democrats are interested in proposals and reforms that would strengthen oversight of vertically integrated insurance companies. We welcome feedback on...topics and concepts [to address vertical integration].
(pg. 74-75)*

Health care consolidation is contributing to the rapid [rise in health care costs](#) nationwide. While consolidation and vertical integration is a concern [across the health care system](#), vertical integration in health insurance is [widespread](#) and raises serious concerns about the ability of insurers to leverage these ownership structures to mask profits and game pro-consumer regulations, such as the Medical Loss Ratio (see “[Medical Loss Ratio](#)” section on pg. 44 for additional discussion).

Despite claims of improved efficiency, consumers consistently fail to reap any benefits from an increasingly vertically integrated health care system. A recent [piece](#) from the Georgetown Center for Health Insurance Reforms put it most succinctly: “While vertical integration could [theoretically](#) improve efficiency and care coordination, research suggests it has often enabled [profit extraction](#) through self-dealing and [higher prices](#), ultimately [increasing health care spending](#).”

“When they get big, we get small.”
- RESIDENT, CALDWELL COUNTY, NC

In [recent polling](#) from USofCare and Morning Consult, a majority of people expressed support for Congress taking action to prohibit anticompetitive mergers. **USofCare supports Congress banning common ownership of health care entities with financial conflicts of interest and establishing processes for vertically integrated entities to structurally separate.**

Transparency around Ownership Structures and Financial Relationships

Senate Democrats invite 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)

Health care markets are growing increasingly [complex](#) and [consolidated](#). [More than 75%](#) of physicians are now employed by hospitals, health systems, or other corporate entities. Aside from some basic ownership disclosure requirements, these health care entities are rarely required to disclose additional ownership information, leaving both patients and policymakers in the dark about who operates or controls these facilities. Unlike [action](#) taken by federal policymakers to promote hospital pricing transparency, [few federal requirements](#) exist to bring more transparency into health care ownership structures at a time when they are growing ever more complex and interconnected. Without [greater transparency](#) into these ownership arrangements, corporate actors will continue to act in ways that harm patient care.

We agree that ownership transparency alone will not solve issues related to profiteering among vertically integrated health care entities; however, policies to expand health care ownership transparency provide the foundation for other policy solutions to address health care

affordability and access. As corporate actors and private equity [continue to expand](#) their presence within health care, ownership data can also be used to expose harmful or deceptive ownership practices that [negatively impact](#) patient care. More broadly, regulators can review this information to identify trends in ownership and affiliation, the first step toward pursuing policies to address the root causes of consolidation.

At the same time, people struggling to navigate an increasingly complex health care landscape can benefit from increased ownership transparency rules to better understand who controls the hospitals and clinics they depend on for their care and make informed decisions accordingly. In one [recent poll](#), nearly 60% of respondents indicated support for Congress requiring health care entities to disclose ownership information. Importantly, these findings can reveal greater levels of support at the state level as evidenced by a recent [poll](#) in **Minnesota** showing that:

- 91% of voters support policies ensuring transparency in hospital ownership; and
- 89% support preventing corporate interests from controlling medical decisions of doctors.

Similarly, a 2025 USofCare [survey](#) in **Maine** found that a significant majority of voters (84%) support policies that require health care facilities to disclose their ownership to the public, and 80% support policies to notify the state when major changes to health care entities' ownership occur.

USofCare supports Congress developing and implementing robust ownership transparency requirements for health care entities. [States increasingly are taking the lead](#) to promote greater health care ownership transparency in the absence of federal action. Some state efforts that could form the basis of federal policymaking in this area include:

- [Indiana](#) passed a bill requiring providers, as well as issuers, pharmacy benefit managers and others, to submit ownership and related information on an annual basis for any individual or entity, including private equity, that has at least a five percent interest in the overall entity, or face financial penalties for non-compliance.
- [Massachusetts](#) passed legislation building upon the state's existing [Massachusetts Registration of Provider Organizations \(MAPRO\) Program](#) by expanding its annual ownership and financial transparency reporting requirements to include private equity, management services organizations, and other corporate actors. Providers are required to submit detailed organizational charts and disclose any clinical or corporate affiliates and parent entities. While this ownership transparency model is applied to providers, it also has potential applicability to vertically integrated insurance entities.

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

Insurers have ratcheted up premiums year after year, and consumers across income levels are feeling increasing pressure to keep up or forego coverage altogether. The [Medical Loss Ratio](#) (MLR) aims to ensure that health insurance companies are spending at least 80% (individual and small group markets) or 85% (large group market) of premium dollars on medical services and requires insurers to issue rebates to policyholders if they fail to meet these thresholds.

Consumer access and affordability challenges are further exacerbated by [increasing insurer consolidation](#), which leads to more complex, less transparent ownership arrangements that allow insurers to game the MLR thresholds by counting payments to affiliated subsidiaries as medical spending and then keeping any subsidiary profits, further limiting opportunities for consumer savings. The RFI acknowledges that the MLR is susceptible to gaming by the insurance industry. Congress should take steps to improve the MLR and direct more savings back to consumers with some targeted solutions.

MLR Oversight and Reporting

Senate Democrats invite feedback on proposals that would strengthen MLR reporting... (pg. 77)

USofCare supports Congress requiring standardized, more granular MLR reporting to identify where premium dollars are going, including breakdowns by services and entities, to provide regulators with additional information to hold insurers accountable.

Quality Improvement Activities

Senate Democrats invite feedback and comments on proposed reforms and improvements to QIA data collection and reporting requirements... (pg. 78)

Under current MLR reporting requirements, insurers must report quality improvement activity spending in [broad categories](#) (i.e. “prevent hospital readmissions through a comprehensive program for hospital discharge,” “implement, promote, and increase wellness and health activities,” etc.), as opposed to reporting this spending by itemized programs and activities. This limits public understanding of specific quality improvement activity or program spending, as well as the evidence behind them, their effectiveness, and insurers’ overall compliance with federal rules on permissible activities.

USofCare supports Congress taking steps to require insurers to provide more detailed, standardized reporting of quality improvement activities under the MLR to better understand the types of activities or programs insurers are engaging in and offering to policyholders. For each individual quality improvement activity or program, this could include:

- A description of the activity or program
- Evidence of the effectiveness of the activity or program
- Spending on that specific activity or program
- Number of members enrolled or targeted by each activity or program
- The intended outcome of the activity or program
- The metrics used to track progress towards the intended outcome
- The outcomes associated with the activity or program

More granular reporting of quality improvement activities and spending on them can help ensure that health insurers are complying with existing federal requirements related to permissible quality improvement activities and not “padding” their actual spending on these activities. Additionally, it can help lay the foundation for potential policy or regulatory action to establish more stringent standards for permissible quality improvement activities. This could range from only permitting the inclusion of certain quality improvement spending in the MLR if it meets a certain evidence-based threshold and/or achieves the intended outcomes, to placing a higher value on certain quality improvement spending on its evidence-base and/or outcomes.

MLR Modernization

Senate Democrats invite 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)

The [evidence](#) clearly demonstrates that vertically integrated insurers can subvert MLR requirements by directing spending to affiliated provider entities. USofCare supports Congress taking steps to limit insurers’ ability to game MLR thresholds by counting payments to affiliated providers as medical spending and then keep any provider profits through establishing standards, or a “benchmark,” for payments an insurer makes to one of its own subsidiaries for the purposes counting “medical spending” under the MLR in order to limit insurers’ ability to funnel profits into unregulated subsidiaries.

While the first priority should be to address current gaming of the MLR, USofCare believes there is room to further drive down health insurance industry administrative spending by increasing MLR thresholds beyond the current baseline under the ACA to ensure a higher percentage of dollars are being spent on medical care and refund any excess spending back to consumers. Some states have taken steps to enact MLR thresholds that exceed the federal threshold. For example, [Massachusetts](#) requires insurers to spend 88% of premiums on health care services in the individual and small group markets, while [New York](#) has established an 82% threshold.

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

Third-Party Administrators

Senate Democrats request detailed comments and analysis on [TPA oversight and regulation, transparency for plan sponsors, payment rates, profits, and unbiased administrative services]. (pg. 80-83)

As detailed on the “[Employer Coverage System](#)” section on pg. 17, USofCare’s [listening research](#) demonstrates that people with ESI face significant affordability challenges (81% agree that health care is unaffordable) – and 76% of people with ESI believe it’s Congress’s responsibility to act to ensure affordable health care, even if that means regulating health care companies. USofCare agrees that reforms to third-party administrators (TPAs) are necessary to end abuses and lower costs in the self-insured employer market.

People have high levels of [mistrust](#) with the current health care system. Corporate and institutional greed is perceived as the number-one driver preventing access to quality affordable health care. People perceive a bloated system with greedy and often faceless middlemen, who they view as profiting off of the system and worse, standing in the way of fixing it. And these perceptions are rooted in reality given the [complex web](#) of financial interests in the health care systems.

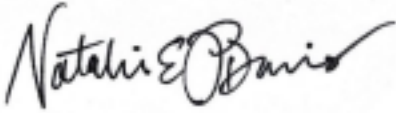
[TPAs](#) represent one area of the health care system where private entities are tasked with a specific function in health care benefits administration, but profit motivations and misaligned financial incentives have had negative implications for people. As discussed in the “[Employer Coverage System](#)” section in this RFI response, highly consolidated hospital and provider markets are [driving up prices](#) and overall costs in the commercial insurance market. However, TPAs employ profit-maximizing strategies that [capitalize](#) on these high hospital and provider costs, which further drives up costs for consumers (and their employers). Additionally, TPAs generate additional revenue by subjecting plan enrollees to prior authorization and other utilization management tools, which [increase](#) administrative costs and make accessing needed care more difficult for people.

We urge Congress to pursue reforms outlined in the “[Fair Pay, Fair Play](#)” (FP²) TPA proposal from Georgetown’s Center for Health Insurance Reforms, which would reduce out-of-pocket costs for employees and improve their access to a wider array of providers. Under this proposal, Congress would establish an independent entity (the FP² TPA) to perform traditional TPA functions without the profit motivations and conflicts of interest for employers that elect to use it over a traditional private market TPA. The FP² TPA would be paid a flat per-member-per-month fee, as opposed to the payment structures that currently exist in the TPA market that encourage and facilitate practices that harm people. Additionally, this proposal would establish reasonable provider payment rates and require that providers that participate in Medicare and Medicaid to be in-network with plans administered by the FP² TP; prohibit gag clauses and anticompetitive contracting terms in provider contracts; and provide fully transparent claims information from the FP² TPA to employers.

Conclusion

Thank you for your leadership in efforts to pursue bold reforms to ensure the health care system works better for everyday people, and for the opportunity to respond to this RFI. Please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org, with any questions.

Sincerely,



Natalie Davis
Co-Founder & CEO
United States of Care